

# Care homes market study

Final report

30 November 2017

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## Contents

	<i>Page</i>
Summary .....	6
Overview of the sector .....	6
Support and protections for those requiring care .....	8
Recommendations on supported decision-making and helping people consider their care needs earlier .....	10
Protecting residents and their consumer rights.....	11
Complaints and redress.....	12
State-funded care now and in the future .....	12
Meeting future care needs .....	15
Recommendations.....	16
Next steps .....	20
1. Introduction .....	21
Purpose of our market study .....	21
Scope of our market study .....	23
Conduct of the market study .....	24
Structure of the final report .....	24
State funded care now and in the future .....	25
Greater support and protections for those requiring care .....	25
Overall approach to remedies .....	25
2. Overview .....	26
Care homes within the wider care system .....	26
Moving into a care home.....	27
Social care funding .....	28
Regulation.....	31
Care homes market structure .....	32
Competition for care home residents .....	35
Geographic scope of competition .....	36
Nature of competition .....	38
Barriers to entry .....	38
Price differential between self-funders and LA funded residents .....	39
3. State procurement .....	43
The context for procuring care .....	43
Pressures on LAs .....	43
Contracting with providers .....	44
Approach .....	44
Relative merits of block contracts and spot purchasing .....	45
Fee setting .....	46
Approach .....	46
Use of electronic platforms .....	46
Cost of care exercises .....	48
Quality.....	50
Choice.....	51
Conclusion .....	53
4. Financial performance and future sustainability .....	55
Background.....	55
Stakeholder views regarding LA fee rates and funding shortfall .....	55
Increasing costs of running a care home .....	56
Our analysis of the sustainability of the industry .....	57

Approach to assessing profitability .....	58
Profitability analysis .....	59
The relationship between LA fee rates and total costs of care .....	69
Other issues relating to financial sustainability .....	71
Conclusion .....	77
5. Recommendation on market oversight .....	79
Market oversight framework.....	79
Recommendation on market oversight.....	80
6. Meeting future care needs .....	82
Future demand for care .....	82
Projections on need for care.....	82
Changing nature of care needs .....	86
Approaches to forecasting .....	87
Meeting future needs for care .....	90
Alternatives to care homes .....	90
Need for investment in care homes .....	91
What LAs do to ensure sufficient care home capacity .....	93
Conclusion .....	94
7. Conclusions on meeting future state-funded care needs .....	96
Introduction .....	96
Challenges to the sustainability of the sector .....	96
Future needs for care.....	98
Planning for future need .....	98
Investment in new capacity .....	100
Differences between the nations.....	101
Future needs for self-funders .....	102
Conclusion .....	103
8. Recommendations to deliver a capacity focussed policy for state-funded residents .....	104
Introduction .....	104
Objectives of our recommendations.....	105
Enhanced capability for planning for the future.....	105
Accountability and oversight.....	106
Confidence to investors .....	107
Our capacity recommendation .....	109
A sustainable framework for Capacity Planning and oversight.....	109
Cost assessment and commitment.....	109
Implementation of our recommendations.....	110
Role and identity of an independent body .....	110
Actions required in advance of implementation .....	111
Alternative approaches - statutory care pricing.....	111
Cost of the recommendation.....	113
Cost of an independent body.....	113
Approaches to capacity planning in Northern Ireland.....	114
Approaches to capacity planning in Scotland and Wales.....	115
Scotland .....	116
Wales – cost of care, capacity planning and ‘market shaping’ .....	118
Summary .....	120
9. Entering care and choosing a care home .....	122
Introduction .....	122
Context .....	122

The decision to move into a care home.....	122
Role of LAs.....	123
Planning for retirement and later life.....	123
Lack of understanding of the care system.....	124
Choosing a care home.....	125
Shortlisting.....	125
Support in decision-making.....	127
Visiting homes.....	128
What matters to people.....	129
Barriers to good decision making.....	131
Difficulty in having conversations about care.....	131
The urgency of the decision to move into a care home.....	132
Limitations on choice from vacancies and local availability.....	132
Lack of trust in the care sector.....	133
Difficulties judging quality.....	133
Difficulties comparing fees and terms and conditions.....	134
Moving between care homes.....	135
Conclusions.....	136
10. Recommendations to support individuals' decision-making.....	138
Introduction.....	138
Benefits.....	138
Approach.....	140
Supported decision-making.....	141
Effectiveness.....	141
Remedy implementation.....	141
Better information about local care options.....	143
Effectiveness.....	144
Remedy implementation.....	144
Helping people to consider and plan for their longer-term care needs.....	145
Effectiveness.....	146
Remedy implementation.....	146
Summary.....	147
11. Consumer protection and empowerment.....	149
Introduction.....	149
Consumer protection issues.....	150
Lack of indicative prices on websites.....	150
Resident Deposits.....	150
Other substantial upfront payments.....	151
'Hidden' extra charges.....	152
Not providing contract terms to prospective residents in a clear and timely way.....	152
Need to 'guarantee' the payment of care home fees.....	153
Fee increase terms.....	154
Relationship between NHS Funded Nursing Care (FNC) contributions and self-funding residents' fees.....	155
Termination clauses: residents being asked to leave the home.....	156
Fees charged after death.....	157
Other consumer protection concerns impacting on state funded residents.....	158
Complaints.....	160
What do we mean by complaints?.....	160
Overview of complaints processes.....	161

Barrier to complaints - findings .....	161
Conclusion .....	166
12. Measures to enhance consumer protection .....	167
Introduction .....	167
Ensuring care homes are complying with consumer law .....	168
Actions for the CMA to take .....	168
CMA consumer enforcement action .....	168
CMA consumer law guidance .....	170
Working with sector regulators to help 'embed' a culture of consumer law compliance across the sector .....	172
Industry to develop model contracts for use with self-funders .....	174
Additional sector protections for residents and their families .....	175
Providing contracts (and a summary of important terms and conditions) on care home websites.....	178
Protecting residents' deposits from the risk of insolvency .....	181
Requiring care homes to notify the sector regulator when they ask a resident to leave or impose a visitor ban .....	183
Clarifying existing sector guidance.....	186
Stronger protection and clearer policy and guidance on third party top-up fees for LA funded residents .....	186
Top-up fees agreed privately between a care home and third party.....	186
Third parties being asked by LAs to pay top-up fees directly to the care home .....	188
Clearer guidance on the relationship between NHS Funded Nursing Care (FNC) payments and a self-funding resident's own contribution to their fees (in England) .....	189
Clearer guidance on the permissibility of top up payments for NHS CHC residents .....	190
Other potential ways to enhance consumer protections: codes of practice .....	191
13. Measures to enhance complaints and redress systems .....	194
Introduction .....	194
Accessing support for concerns .....	194
Review of advocacy services.....	194
Sector regulators' role in improving feedback and advocacy services .....	196
Encouraging feedback culture .....	196
Advocacy support.....	198
Impact of amending inspection regime .....	198
Improving awareness of and access to the Ombudsman .....	199
Statutory signposting to the LGSCO in England.....	199
Extend remit of the NIPSO to consider complaints from private funders .....	199
14. Recommendations .....	202
Summary of recommendations .....	202
Capacity recommendations .....	202
Consumer protection recommendations.....	203
Consumer decision-making recommendations - Helping people make decisions about care.....	205
How our recommendations work together .....	206
Greater support and protection for those requiring care .....	206
State-funded care and capacity .....	207
Implementation of our recommendations .....	209
Capacity recommendations .....	209

Consumer protection recommendations.....	211
Consumer decision-making recommendations – helping people make decisions about care.....	216

*Appendices*

- A: Legal basis for our market study and conduct of study
- B: Journeys through the adult social care system by funding source
- C: Data, methodology and further results
- D: Financial analysis
- E: Analysis of consumer protection issues
- F: Overview of complaints systems
- Glossary

## Summary

1. This document is the final report of the Competition and Markets Authority's (CMA's) market study into residential and nursing care homes for older people.
2. We have looked at how well the care homes market is working, for self-funders who purchase care services themselves, as well as for those individuals whose care is funded by the state. The market needs to work well for current and prospective care home residents; they must be able to make well-informed choices, and must be protected if things do not work out as expected. But also, the market must support the state's intention to ensure that all those who have care needs have them met. This requires that the industry is sustainable, so that efficient care home providers can continue to operate, and that the sector is positioned to invest to meet growing future needs.
3. We have identified two broad areas where we have found problems in the market:
  - (a) those requiring care need greater support in choosing a care home and greater protections when they are residents.
  - (b) the current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority<sup>1</sup> (LA)-funded residents are unlikely to be sustainable at the current rates LAs pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs.
4. As set out below, we have made a set of recommendations to governments, sector regulators,<sup>2</sup> LAs, and the industry. In addition, we intend to take action to protect residents' rights and compliance with consumer law.

## Overview of the sector

5. This is a hugely important sector. Choices on care are an incredibly important decision taken by or on behalf of individuals who are often

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<sup>1</sup> Throughout this report, references to local authorities (LAs) should be taken to include their equivalents in the devolved nations as relevant in the context, including Health and Social Care Trusts (HSC Trusts) in Northern Ireland and Integrated Joint Boards in Scotland.

<sup>2</sup> The sector regulators that inspect care homes are: the Care Quality Commission (CQC) in England; the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland; the Care Inspectorate in Scotland; and the Care and Social Services Inspectorate Wales (CCSIW).



extremely vulnerable. The nature and quality of care has a massive impact on the person's happiness, health, and longevity.

6. The care homes sector is worth around £15.9 billion a year in the UK, with around 410,000 residents.<sup>3</sup> We calculate that there are around 5,500 different providers in the UK operating 11,300 care homes for the elderly.<sup>4</sup> Around 95% of their beds are provided by the independent sector (both for-profit and charitable providers). LAs generally commission care services from independent care providers. We estimate that the average cost for a self-funder in 2016 was £846 per week (nearly £44,000 per year), while LAs on average paid £621 per week.
7. LAs are directly responsible for care provision in their areas. LAs have a legal duty to meet people's 'eligible needs' subject to their financial circumstances. People with assets of more than £23,250 in England and Northern Ireland, £26,500 in Scotland, and £30,000 in Wales pay the full cost of their care, be it care homes, domiciliary care, or other types of care.<sup>5</sup> 41% of residents in care homes fund themselves (self-funders) and 49% receive LA-funding (around a quarter of these pay top-ups). Even for those receiving LA-funding, nearly all income, such as pensions, is offset against state contributions. The NHS also commissions nursing care services for people who have a primary health problem, around 10% of residents.<sup>6</sup>
8. As the population continues to age, demand for care will increase and the types of care needed will change. The Office for National Statistics predicts a 36% growth in persons aged 85+ between 2015 and 2025, from 1.5 million to 2 million. This is expected to lead to a substantial increase in demand for care home services.
9. Adult social care in the UK is a devolved matter (although there are considerable similarities in the state systems in the four nations). Consequently, some of our recommendations only apply in certain nations.

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<sup>3</sup> This figure is based on applying occupancy rates from LaingBuisson to an estimate of total occupancy from CMA analysis.

<sup>4</sup> 80% of care home providers only operate one home.

<sup>5</sup> Where individuals need nursing care, various rules apply in the different nations which will make a partial or full contribution to the nursing costs. Some personal care is available for everyone aged 65 and over in Scotland who have been assessed by the LA as needing it irrespective of any financial assessment. Currently the value of the person's home is not counted as an asset if a spouse or dependent also lives in the home, nor is the value of the home counted for funding of domiciliary care.

<sup>6</sup> For the purpose of this report, NHS refers to the four national health services of the UK: England – NHS; NI – Health and Social Care NI (HSCNI); Scotland – NHS Scotland; Wales – NHS Wales.

## Support and protections for those requiring care

10. In the main, the CMA's consumer research found that residents had received good care. The sector performs a vital public service that benefits many people, and is staffed by many dedicated and caring individuals.
11. Ideally, for the care home market to meet people's needs as well as it should, those entering care must be able to make an informed choice, and those within care must be sufficiently empowered to identify and address shortcomings in the service they receive.
12. However, the challenges faced by those entering and receiving care should not be underestimated; there are many inherent barriers to people making well-informed choices in this sector.
13. Choosing a care home is often an extremely difficult decision for people to make at a point in their lives when they are particularly vulnerable. Our consumer research found that there is often very little prior consideration of care needs and options by prospective residents, their representatives and their families. People don't want to contemplate growing old in poor health and this can be a very difficult and emotive subject to discuss within families. Frequently, decisions on care are faced for the first time following a sudden illness, injury or loss of a carer, meaning they are often made with urgency under extremely distressing circumstances.
14. It is only at that point that many people begin to try to understand a very complex system.<sup>7</sup> They need to assess their eligibility for funding, and try to find suitable, affordable care homes that have vacancies. Understandably, many people are overwhelmed by this process. The information and guidance they receive can be confusing and providers often do not clearly provide all the important information people need to make an informed choice.
15. Once in care, it is very difficult for residents to correct a poor choice, as once settled in a care home they find moving to a different home extremely stressful. The process of moving can severely impact on the residents' health.
16. Because of this, it is particularly important that people in care, their representatives and their families feel empowered to raise any concerns that they might have. However, we have found that many residents and their

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<sup>7</sup> Individuals have a very poor understanding of how the social care system works, what services and information is provided by the state, and what is required of the individual.

representatives find it difficult to make complaints and seek redress, partly due to complaints systems being perceived as confusing and poorly sign-posted. People were also worried that if they complain, there could be reprisals against the resident receiving care, or their friends and relatives could be stopped from visiting them.

17. As residents face barriers, both to moving care home and to complaining and obtaining redress, the consequence is that residents are more vulnerable to unfair practices. Therefore, the consumer protections they receive need to reflect this.
18. We are making a set of recommendations in relation to these issues as well as taking direct action where we have the powers to do so. These include measures to improve decision making for those requiring care, but also measures to strengthen protections for consumers and to enhance complaints and redress processes.
19. The protections of consumer law against potential exploitation and adverse outcomes are especially important in this market given the vulnerability of people, the harm that may arise from residents being treated unfairly, and the importance of social care as a service. Our study has found some significant shortcomings in this regard, with some care homes not treating residents fairly. Compliance with the law is essential, especially in this market, where such vulnerable people are involved.
20. The processes for making complaints must be designed to recognise the barriers that can stop people from being forthcoming with their views. Measures are required both to widen and systematise the best practice witnessed in many care homes, and to provide better access to external independent redress mechanisms when these are required.
21. In determining our recommendations, we have been very conscious of the challenges faced by those choosing and within a care home. We are grateful for the considerable constructive input that we have had from stakeholder organisations and those with first-hand experience of being in these situations. We also commissioned the Behavioural Insights Team and Research Works to undertake consumer research, assess what is currently working and can be built upon, and explore potential new ways of addressing these challenges.
22. Our recommendations to improve consumer choice and protection can be grouped into three broad areas:
  - (a) helping people to make good decisions about their care options;

- (b) protecting residents and their consumer rights; and
- (c) making the complaints system work well for care home residents, their representatives and families.

***Recommendations on supported decision-making and helping people consider their care needs earlier***

23. We are calling on governments to work with the NHS, LAs, care home providers and the third sector to deliver a sustained and coordinated programme of actions to help people make good decisions about their care needs. This work should focus on the following three areas:
- (a) Providing people with good quality, relevant and timely support when they are making life-changing decisions about care.
  - (b) Helping people quickly and easily identify the relevant, local care options that are available to them.
  - (c) Encouraging and helping people to prepare and plan for future care needs.
24. Such actions would help people make better choices, potentially live independently for longer, and reduce the stress associated with going into a care home. They would also mean providers would have to work harder to ensure they attract people to choose their care home. The research that we have carried out and commissioned has identified several specific actions that we recommend be taken forward, including:
- (a) requiring LAs to provide information on how the care system works and how people can engage with their LA, as well as information on care homes that are in the prospective residents' local area. Some LAs already do this well, but they should all effectively match best practice to meet their obligations (to both state and self-funded residents) to provide clear information and support, including guides on how to choose a home;
  - (b) increasing the use of supported decision-making to help people understand their local care options and enable them to make better-informed choices. Such support could be provided through a variety of means ranging from online tools, telephone advice and leaflets, and more tailored support provided by trusted care professionals; and
  - (c) asking national governments to undertake a programme of work to promote awareness and encourage and support people to prepare and

plan ahead for care they may need in later life. This would encourage individuals to consider their care preferences, improve their understanding of the care system, and enable measures such as financial planning for care, making appropriate home adaptations or choosing suitable properties that will allow them to stay in their own home for longer.

### ***Protecting residents and their consumer rights***

25. We have looked closely at specific concerns that have been raised about some care homes not treating residents fairly and potentially breaking consumer law. Problems include: the lack of indicative pricing information on websites; the non-provision of contracts in a timely way or at all; the charging of large upfront fees and deposits; care homes having wide discretion to increase fees after a person has moved in; requirements to pay fees for an extended period after a resident's death; and care homes having a wide discretion to ask residents to leave at short notice.
26. Care home residents must receive the full protections of consumer law, and the sector must ensure it complies with it. We are already taking forward enforcement action using our consumer powers against a number of providers that we think have been unfairly charging large upfront fees, and charging fees for extended periods after a resident has died. As part of this work, we will be making a statement in early 2018 on the steps care homes need to take to ensure that any charges they make after the death of a resident are fair.
27. We will be following this up in spring 2018 with further guidance on the standards of behaviour we think care homes should be meeting to comply with consumer law across the full range of concerns we have identified.
28. We will continue to monitor practices in the sector and will take enforcement action where appropriate on other issues of concern where we identify providers engaging in serious and harmful practices. We will be asking our enforcement partners in Trading Standards, as well as the sector regulators, to help us to hold care homes to account.
29. As part of our guidance work, we will also provide short accessible advice for residents and their representatives to help them understand their rights under consumer law. We are recommending to the industry that it takes steps to develop model contracts that could be used by care home providers, to help encourage best practice across the sector, and ease the workload of care homes in designing, preparing and updating their individual contracts so that they do not contain unfair terms. We would be willing to

offer appropriate support to the industry in it taking forward the recommendation.

30. We are also recommending that national governments introduce stronger sector rules so that compliance with consumer law is embedded into the existing regulatory regime for care homes and is monitored by the sector regulators as part of the inspection or evaluation regime. Further, we are making recommendations for specific rules requiring care homes to display indicative fees and their terms and conditions on their websites, to safeguard deposits against the risk of insolvency, and to notify the sector regulator when they ask residents to leave or impose any ban on a visitor.

### ***Complaints and redress***

31. To address the short-comings in the current complaints and redress systems we are making various recommendations including:
  - (a) sector regulators to embed an assessment of complaints systems within their inspections, in particular to include an assessment of what each care home does in practice to direct people to third parties such as advocacy services that may be able to help; and how effectively the care home's complaints and feedback systems work in practice. Where there are deficiencies, inspectors could recommend appropriate steps such as appointing feedback champions;
  - (b) in England, a statutory requirement for care homes to signpost to the Local Government and Social Care Ombudsman and the extension of the remit of the Northern Ireland Public Services Ombudsman to hear complaints from private funders;<sup>8</sup> and
  - (c) national governments to review the coverage of advocacy services for residents of care homes and consider increasing availability where there are deficiencies.

### **State-funded care now and in the future**

32. Public expenditure on adult social care of all types (including non-elderly care and care outside care homes) has been under pressure. For example,

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<sup>8</sup> The Local Government and Social Care Ombudsman and the Northern Ireland Public Services Ombudsman are the statutory bodies that hear individual complaints unresolved through the care home's or LA's processes.

aggregate expenditure has declined in real terms by 8% between 2009/10 and 2015/16 in England.<sup>9</sup>

33. The sector has reported facing challenges to its sustainability, due primarily to the low fee rates being paid for state-funded residents - those challenges being exacerbated by increased cost pressures due largely to wage costs. In its annual assessment of the quality of health and adult social care in England (October 2016), the Care Quality Commission (CQC) said that the sustainability of the adult social care market is approaching a tipping point.
34. We have undertaken an extensive profitability analysis of the sector using information provided directly by care homes and taken from company accounts. We understand that this is the most complete study of profitability in the sector in recent years.
35. Our assessment is that the average fees paid by LAs are below the full costs involved in serving these residents. Our financial analysis of the sector shows that, looked at as a whole, the sector is just able to cover its operating costs and cover its cost of capital. However, this is not the case for those providers that are primarily serving state-funded residents.
36. Many care homes, particularly those that are most reliant on LA-funded residents, are not currently in a sustainable position. Our analysis shows that while many can cover their day-to-day operating costs, they are not able to cover any additional investment costs. This means that while they might be able to stay in business in the near term, they will not be able to maintain and modernise facilities, and eventually will find themselves having to close, or move away from the LA-funded segment of the market.
37. This shows that the fees currently being paid by LAs are not sufficient to sustain the current levels of care under the current funding model. The implication is that public funding needs to increase if the current model of funding is to continue, or alternatively, if current levels of funding do not increase, the funding model for care will need to be changed.
38. Our analysis suggests that about a quarter of care homes have more than 75% of their residents LA-funded, and that these are the ones most at risk of failure or exit because of a funding shortfall. We estimate that LA-fees are currently, on average, as much as 10% below total cost for these homes, equivalent to around a £200 to £300 million shortfall in funding across the

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<sup>9</sup> Source: NHS Digital (2016), [Personal Social Services: Expenditure and Unit Costs](#), England 2015/16.

UK. This finding is based on an average result - there will already be a proportion of operators that are struggling and at risk of closure.

39. The large majority of care homes offer places to self-funded as well as LA-funded residents. Many care homes are relying on higher prices charged to self-funders to remain viable, even when providing the same services. Self-funded residents in mixed homes are meeting a much greater proportion of homes' fixed costs. Without this, the public funding shortfall would have a substantially larger impact than it currently has.
40. Our assessment based on larger providers is that self-pay fees are now, on average, 41% higher than those paid by LAs in the same homes, ie an average differential of £236 a week (over £12,000 a year).<sup>10</sup> We understand that fee differentials for smaller providers are slightly lower but still significant.
41. This difference between self-funded and LA prices for the same service is understandably perceived by many as unfair. The large majority of self-funders are not wealthy; the current thresholds for support are currently drawn so that practically anyone who owns their property will be ineligible for state funding, regardless of income.<sup>11</sup> Moreover, there is very poor visibility of the size of these fee differences so the public is generally unaware and LAs do not have to justify their approach to the fees they pay to care homes.
42. In addition to this, however, the situation may not be sustainable. Where LA rates are below total cost, those care homes that can attract self-funders are likely to move away from serving a mix of residents. We already observe that nearly all new care homes being built are in areas where they can focus on self-funders. While we would expect that many mixed homes with differential pricing could continue to operate for some time, there will be a need for additional funding to support further care homes that would not be sustainable without the benefits of this price differential.
43. Our assessment is that if LAs were to pay the full cost of care for all residents they fund, the additional cost to them of these higher fees would be £0.9 to £1.1 billion a year (UK wide, and assuming this money is directed specifically to those homes where LAs pay fee rates below total costs).<sup>12</sup>

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<sup>10</sup> This is the difference within mixed homes. The average fees quoted in paragraph 6 differ in that they include a small number of pure LA-funded or self-funded resident homes. 41% is an unweighted average across our sample of mixed homes.

<sup>11</sup> But see footnote 5.

<sup>12</sup> This £0.9 to 1.1 billion includes the £200 to £300 million referred to in paragraph 38. The smaller sum is the increase in LA fees targeted at the providers that are most exposed to LA-residents (greater than 75% LA-



## **Meeting future care needs**

44. The need for care will increase with an ageing population, and the acuity of care, particularly in care homes, will also tend to increase over time. Public expenditure on supporting adult social care will have to increase in line with the increasing demand unless there are significant changes to the way social care operates. A simple, illustrative extrapolation of the current costs to LAs of meeting needs for care home places is that an extra £1 to £2 billion a year will be needed by 2025.<sup>13</sup>
45. It is essential that there is sufficient capacity of different types of care available in the areas where it is needed. Our assessment, however, is that the sector is not able to attract the investment required to meet the future increase in demand to serve LA-funded residents.
46. For additional capacity to be in place to meet future demand, LAs need to be taking the appropriate action in good time to encourage appropriate investment. This requires three things:
  - (a) First, LAs need to carry out accurate and informed planning about future needs for care and the approach that will be taken to future care provision (eg whether care of different types will be provided through residential and nursing homes, domiciliary care or other means in the light of changing needs, technology, etc.).
  - (b) Second, LAs need to take the necessary commissioning steps on the basis of those plans. For the capacity to be in place to meet the future increase in demand, these decisions need to be made in good time.
  - (c) Third, LAs must be able to attract the investors to build required capacity, ie investors must have confidence to make the investment.
47. LAs in England and Wales already have a “market shaping” or equivalent duty. We have reviewed a sample of the approaches LAs have taken to this task and have found these to be very variable, with some LAs displaying detailed engagement and innovative approaches, but many not. For example, we reviewed 20 market position statements (the published market shaping reports) and similar documents representative of LAs across the

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funded), as these are the most likely to be at immediate risk of financial failure. The larger sum is the amount needed to ensure LAs pay fees covering full costs for all LA-funded residents in all homes. The two numbers are not cumulative requirements.

<sup>13</sup> This result is based on projections of increased demand for care homes of between 14% and 34% between 2015 and 2025, applied to current expenditure by English, Scottish and Welsh LAs on care homes for the elderly with a pro-rata adjustment for Northern Ireland. It does not take account of care user contributions, and does not attempt to model any future changes in costs, revenues, LA-fee rates or other aspects of policy.

UK. None presented estimates of additional future capacity needed, and only two indicated whether any estimates had been produced by the LA. There are also few tools for LAs to use to actively shape the market by providing credible incentives to operators to invest appropriately. Our assessment is therefore that the current market shaping duty is not proving sufficient to meet this important task.

48. This understandably reflects the current pressures on LAs and their lack of long-term certainty on future funding patterns and levels. Consequently, there is the risk that short-term funding pressures are leading to decisions about investment being deferred. Therefore, LAs need to be supported and funded to develop the necessary future capacity.
49. Lastly, the current funding situation combined with uncertainty about future funding means that investors are reluctant to come forward to build the additional capacity needed. For investment to be drawn to the sector, there must be sufficient certainty about future revenues. In particular, there needs to be a reasonable expectation that future fee rates will cover the associated costs. The current funding situation combined with uncertainty about future funding and policy direction means that investors are reluctant to invest in additional capacity focussed on LA-funded residents.

### ***Recommendations***

50. Given these concerns, we believe that significant reforms are needed to enable the sector to survive at current capacity levels and also to grow to meet the expected substantial increase in care needs.
51. Measures have already been taken in Scotland and in Wales. We welcome these as they seek to address the need for planning of care provision and provide improved confidence to potential investors in respect of future returns. In Scotland, the Convention of Scottish Local Authorities (COSLA), Scotland Excel, the Coalition of Care and Support Providers (CCPS) and Scottish Care are developing a cost of care model to guide the rates paid by LAs, and there are integrated health and social care boards, with central oversight of their long-term capacity planning. A similar system is being developed in Wales. Therefore, it is not appropriate to make recommendations for these countries until these initiatives have had a chance to deliver change. However, the same concerns around the need for planning, funding and delivery of state-funded social care apply in Scotland and Wales. It is important that the delivery of an effective and sustainable social care system is maintained. The impact of the existing initiatives will need to be assessed and further actions may well be required. We urge both governments to keep this under review and in particular to consider whether

improved planning and forecasting to facilitate the long-term development of capacity and provision of care is required.

52. We are making recommendations to the Departments of Health in England and Northern Ireland that they develop policies and practices to deliver adult social care for the elderly in a way that addresses these concerns. There are three elements to our remedy, reflecting the causes of the problem:
- (a) enhanced planning at local level, so LAs can make accurate and meaningful forecasts of future needs, and plan how best to meet them;
  - (b) oversight of LAs' commissioning practices to ensure LAs are supported in drawing up their plans, and that these plans are drawn up and carried out; and
  - (c) there is greater assurance at national level about future funding levels, by establishing evidence-based funding principles, in order to provide confidence to investors.

#### *Enhanced planning*

53. There needs to be effective and credible planning of future capacity needs of all types of care. As explained in paragraph 47, we do not think that this is fully effective at present. LAs are well placed to construct plans to address local circumstances and needs. To support LAs in this task, there is a need for measures to assist and guide them, providing them with evidence on care needs and capacity requirements now and projections for the future. Our view is that this guidance, information and coordination is best provided through a single independent body which is of a scale that can support the necessary technical and policy expertise.

#### *Oversight of LAs' commissioning practices and transparency*

54. LAs need to be sufficiently incentivised to treat future care needs alongside other immediate priorities. This can be achieved through greater accountability for LAs in delivering on their care obligations, and their planning and commissioning.
55. Our view is that this is best carried out through oversight by an independent body. This body would monitor and assess: whether the LAs' current delivery of care is meeting its obligations and, if not, whether commissioning and procurement is consistent with a sustainable sector; the quality of their plans for future provision; and whether the need for investment under those plans is being met.

56. An independent body would also be able to provide increased transparency on the extent to which higher prices paid by self-funded residents are being used to offset lower LA fees. Although eliminating the differential has very substantial funding implications, greater transparency would help improve local political accountability on how care is delivered in practice.

#### *Public funding and investor confidence*

57. Even with the above reforms in place, unless there is greater confidence in future revenues, investors will not be attracted to build the capacity needed. Clear and sufficiently robust funding principles need to be in place so as to provide the confidence that LAs will have the resources to deliver enhanced plans. These should be evidence-based and sufficiently credible to reassure investors.
58. While it will be for the government to make decisions on public funding, we recommend that there is a formalised process to provide advisory evidence to government on the costs of care. There should also be advice to government on future needs for care services and capacity requirements based on consideration of all relevant drivers, including changes in the acuity of care needs, the impact of demographic developments, and consideration of the appropriate balance of different care approaches (residential, domiciliary and other models of care) to best provide that care. While this does not guarantee certainty, it means reasonable expectations can be formed by investors on the basis of credible commitments to take account of the costs of providing care.
59. In order to ensure that existing care home capacity is maintained, it is important that those care homes most focused on LA-funded clients (ie greater than 75% LA-funded residents) receive fees that reflect the full cost of providing that care. As a minimum, an additional £200 to 300 million a year would be required for this purpose, and then only if that money were specifically directed at increasing fee rates for these particular care homes.
60. The government has stated it will publish a green paper on care and support for older people by summer 2018.<sup>14</sup> Decisions on the future of policy on social care for the elderly are essential. The uncertainty on future funding policies and frameworks means that the sector will further struggle to attract the investment needed to build the capacity required.

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<sup>14</sup> Press release (16 November 2017), [Government to set out proposals to reform care and support](#).

### *Role of an independent body*

61. In relation to the above recommendations, we recommend that an independent body takes on a series of functions:
- To provide oversight of LAs, for example to assess whether the LA's current delivery of care is properly meeting its obligations; ensure that future plans are well informed and made and consistent with duties, that steps are being taken to ensure the need for investment in the plans is being met, and that in practice the investment required is being delivered and the rest of provision maintained as in the plans.
  - To support LAs in planning by acting as a centre of excellence in developing planning and forecasting tools and facilitating sharing of best practice. It could also provide supporting analysis and data as inputs for the local analysis of future needs and how these can be met.
  - To advise central government on the costs of providing different types of care to feed into funding decisions. It could also advise on future needs for care services and capacity requirements.
  - To facilitate transparency on the delivery of social care, for example in relation to fee differentials.
62. It is important that these roles are determined independently of the process for determining public sector funding for adult social care. It would still ultimately be for central government to determine its funding of LAs and for LAs to determine how to deliver their duties.
63. Such a body would also need to have suitable skills and knowledge, and ideally would be able to accommodate these duties alongside existing functions. Our view is that in England, the CQC is best positioned to operate this function. While this would be a substantial extension to its role, it is highly complementary to other areas of its existing activities.

### *Review of effectiveness of the recommendations*

64. Our expectation is that these measures will be sufficient to ensure that capacity is there in the future for the increased numbers of people who will need it. If, however, oversight by an independent body turns out not to be sufficient to increase LA incentives to take the necessary timely decisions; or if uncertainty about future public funding remained a substantial deterrence to investment, it might be necessary to consider going further. In such circumstances, it would be worth considering the approach taken in Scotland and Wales, where LA fees are determined centrally to provide greater clarity

to providers, or to consider mandatory rules on LAs paying care rates that cover the full cost of care (with the requisite funding provided).

### *Fee differentials*

65. We have considered whether recommendations should be made to require that fees charged to self-funders are set at the same level than those charged to LAs in any specific home. We have not made such a recommendation, for two major reasons. First, to do so would impose an immediate and very substantial public funding cost. Second, such a measure would be likely to cause the market to split in two as those care homes that could concentrate on self-funders (particularly those that are well placed and with attractive facilities to meet areas of high local demand) might want to stop serving LA-funded residents altogether.
66. However, our recommendations if implemented would increase the fees paid by LAs to care homes to a more sustainable level. Higher LA-fees will not necessarily result in downwards pressure on self-funder rates, but they would reduce the need for care homes to charge higher fees to self-funders. We have recommended that the independent body's role should include disclosure of local fee differentials in order to increase local political accountability on how care is being delivered. In addition, our measures to improve decision making will increase competitive pressures in relation to self-funders. These measures will reduce existing fee differentials over time.

### **Next steps**

67. We look forward to working with governments, sector regulators, LAs, the industry and others to progress our proposals.
68. The government has announced that it will publish a green paper on care and support for older people by summer 2018, and begun a process of engagement in advance of the green paper. It has invited a panel of independent experts to provide advice. We strongly commend our analysis of these issues and our recommendations in helping shape the consultation, and look forward to opportunities to engage with government and the panel of experts on these issues. We have made recommendations in order to address the challenges we see in the context of the current system for the provision of social care for the elderly. If these are not accepted, there may need to be a fundamental reform of the operation and funding of the adult social care system.

# 1. Introduction

- 1.1 This section provides details on the purpose and scope of our market study, how we have conducted the study, the structure of this report and our overall approach to remedies.

## Purpose of our market study

- 1.2 On 2 December 2016, we launched a market study into the market across the UK for the provision of residential care for older people aged 65 years or more in residential homes (care homes that only provide accommodation and personal care) and nursing homes (care homes that provide personal care and nursing).<sup>15</sup>
- 1.3 In our statement of scope,<sup>16</sup> we explained our interest in exploring the care homes market.
- (a) It is a large sector that involves older people, many of whom may be vulnerable. Entering a care home is a major decision for those involved, and is often taken at a time of crisis or poor health. It is therefore important that the provision of care home services works well.
  - (b) Following the study of the market in 2005 by the Office of Fair Trading (the CMA's predecessor body)<sup>17</sup> there have been developments in the care homes sector, including significant legislative changes in each nation, but concerns remain. These include concerns about: care home providers treating their residents fairly in relation to information provision and contractual terms; care homes providing the right information to older people in order to help them in their decision-making; how local authorities (LAs) discharge their obligation on information provision and 'shaping' the care homes market; and whether the current market structures and policy and regulatory frameworks are effective, efficient and stable.
  - (c) Several organisations, including Citizens Advice, Age UK, and Citizens Advice Wales, have highlighted concerns that some care home providers might not be complying with consumer law in various ways, such as by

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<sup>15</sup> Generally, care homes provide residential accommodation with personal care for persons who, by reason of old age, illness or disability, are unable to provide it for themselves. For example, in England this corresponds to the provision of residential accommodation together with nursing or personal care (Section 2 of Regulation 8 and Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

<sup>16</sup> [Statement of scope of 2 December 2016](#).

<sup>17</sup> OFT, Care homes for older people in the UK, May 2005 (OFT780).

imposing hidden charges or giving very short notice periods for fee increases. There are also concerns that residents and their families face reprisals after making a complaint to a care home.

- 1.4 Our statement of scope set out four broad themes for the care homes market study to examine.<sup>18</sup> These were:
- (a) choosing care homes and whether there is sufficient information which is clear and easy to assess when older people and/or their representatives first choose a care home;
  - (b) regulation of care homes and how LAs and regulators affect outcomes in this sector, including through their commissioning and procurement practices and ‘market shaping’<sup>19</sup> activities;
  - (c) competition between care homes and whether competition is working well for residents and driving choice, quality and value for money in this sector for both self-funded and LA-funded residents; and
  - (d) consumer protection issues in the care homes sector and whether residents and/or their representatives are being disadvantaged through unfair contract terms and conditions.
- 1.5 Significant reforms of adult social care are ongoing in England, Scotland, Wales and Northern Ireland and some changes are yet to be fully implemented. Broadly, across each nation there is a common push towards enabling people to exercise choice across care options (through obligations around provision of information and advice by public authorities), ensuring diversity of supply, and enabling people to stay in their own homes so far as is possible.
- 1.6 In March 2017, the government in England 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.<sup>20</sup> On 16 November 2017, the government announced it will publish the green paper by summer 2018. Ahead of publication, the government will work with independent experts,

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<sup>18</sup> [Statement of scope](#), paragraph 5.1.

<sup>19</sup> Market shaping (as required in England) refers to a range of activities where an LA ‘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 and Support Statutory Guidance, paragraph 4.6](#)). 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.

<sup>20</sup> [Spring 2017 budget](#), page 3.



stakeholders and users to shape the long-term reforms that will be proposed in the green paper.<sup>21</sup>

- 1.7 In this study, we have focused on the causes of why the care homes market may not be working well for consumers, leading to recommendations on how it might be made to work better.<sup>22</sup> This market study has also enabled us to undertake a review of how providers are complying with consumer protection law. Our intention with this final report is to complement recent and ongoing considerations of adult social care policy and provision of services with our different perspective and analytical approach.
- 1.8 In relation to our role of making markets work well for consumers, we have explored whether LAs will be able to meet their duties to ensure care is available to those with eligible needs through the current operation of the market. We have therefore looked at the sustainability of the industry and its ability to grow and adapt to increasing and changing needs.
- 1.9 Our market study has not addressed issues which lie outside our scope, and which are the concerns of other regulators. For example, the CMA is not the appropriate body to examine questions such as whether the standards for quality of care set out in specific legislation on care, and which are regulated by quality regulators in each nation, could be set at different levels.<sup>23</sup>
- 1.10 Nor is the CMA an appropriate body to determine the appropriate levels of funding and ways to fund adult social care. However, in this final report, we are offering comments and advice to national and local government on the consequences of existing policy and regulatory frameworks, the application of these frameworks, and current funding levels, for the functioning of the care home market and the provision of services to users.

## Scope of our market study

- 1.11 Adult social care services can also be provided through home care, day care, sheltered-housing and other services. Sometimes providers may offer a variety of services or serve different types of residents (eg the under-65s) and care home residents may at times receive a variety of means of care. We have excluded these alternative means of social care, eg domiciliary care, as well as alternative accommodation services such as sheltered housing, 'extra care housing' and services provided in community homes. Our scope also

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<sup>21</sup> Cabinet Office press release (16 November 2017), [Government to set out proposals to reform care and support](#).

<sup>22</sup> 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.

<sup>23</sup> Responsibility for these rests with the national care regulators (see Statement of Scope, paragraph 6.9).

excludes services for working-age people with disabilities and temporary respite care, or hospices.

- 1.12 We recognise that there are many issues across all aspects of adult social care and there may not be a clear delineation between different services but we have focused on care homes in order to be able to explore the issues and evidence in depth. For reasons of practicality, we have not therefore looked in detail at alternative adult social care services but we recognise that care homes are part of a broader range of care services and a wider health and social care system. There may be opportunities to meet people's needs in different ways, and as technology and best practice evolves, and as typical needs change, the appropriate balance of different means of care will also change. Our findings and recommendations as set out in this report take account of that wider context.
- 1.13 Our market study has covered all older people regardless of their funding arrangements. This includes care home residents who fund all the care themselves (self-funders),<sup>24</sup> residents who are entirely funded by LAs (HSC Trusts in Northern Ireland) or the NHS, and residents who partly fund themselves.
- 1.14 The study has covered 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. While many issues relating to care homes are similar across all four nations, we have been mindful of the national differences in these frameworks, and differences in local circumstances and issues. Consumer protection law applies throughout the UK and is not a devolved matter.

## **Conduct of the market study**

- 1.15 Our market study has involved several steps to gather views and information. These are summarised in appendix A. We would like to thank all who have contributed to our market study.

## **Structure of the final report**

- 1.16 This report sets our findings and recommendations under the broad themes of state funded care now and in the future, and greater support and protections for those requiring care. Before detailing our findings and comments, section

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<sup>24</sup> In Northern Ireland many self-funders are placed by HSC Trusts, those who are not are referred to as 'private funders'.

two provides an overview of the care homes sector including our findings on differences in pricing for self-funders and state funded residents.

### ***State funded care now and in the future***

- 1.17 Sections three and four cover our findings on state procurement processes and financial challenges including results from our financial analysis in relation to sector sustainability. Section five sets out recommendation on market oversight.
- 1.18 Section six looks at how future care needs are expected to evolve and the current arrangements for forecasting and planning for those changes.
- 1.19 Section seven draws conclusions, from the material covered in sections three to six, on whether we can expect the market to deliver good outcomes for older people, looking particularly at future needs for state-funded individuals.
- 1.20 Section eight details our recommendations to deliver a capacity focussed policy for state-funded residents to address the issues we have identified.

### ***Greater support and protections for those requiring care***

- 1.21 Section nine covers our findings on people's understanding of the care system and decision-making about care homes, with section ten setting out recommendations to address the issues we have found.
- 1.22 Section 11 contains our findings on consumer protection and empowerment including unfair contract terms and conditions and complaints redress systems, and sections 12 and 13 detail our recommendations for measures to address our concerns in these areas.

### **Overall approach to remedies**

- 1.23 Our approach to developing the recommendations, including how our recommendations work together, the expected outcomes and our next steps, is detailed in section 14.
- 1.24 We now look forward to working with relevant bodies including governments, regulators and the industry to implement our proposals.

## 2. Overview

2.1 This section provides an overview of the care system and care homes sector in the UK noting differences between the nations. The section gives an overview of:

- care homes within the wider care system;
- moving into a care home;
- social care funding;
- regulation;
- the care home market structure;
- competition for care home residents; and
- the price differential between self-funders and LA funded residents.

### Care homes within the wider care system

2.2 Care needs arise when, because of frailty or medical issues, older people require help to carry out everyday tasks, such as cooking, cleaning and taking medication. There is no clarity about how older people navigate the social care system and many people find it complex and difficult to understand (see Section 9). Different routes through the system are set out in detail at Appendix B.

2.3 Care needs are managed in a variety of ways, including self-help; home adaptations; help from unpaid voluntary carers, family, neighbours or friends; or domiciliary care (home care) where a care worker visits to help with everyday tasks. There are also alternative types of accommodation, such as sheltered and 'extra-care' housing.<sup>25</sup>

2.4 Significant care is provided in specialist residential accommodation where this is needed. Care homes fall into two broad categories: nursing care homes and residential care homes. Nursing care homes provide care for people with medical needs outside of a hospital context; residential care homes provide care for people with less acute needs that are not primarily

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<sup>25</sup> Sheltered housing accommodation schemes are specifically designed for older people to allow them to live independently. They typically have communal facilities and some additional support, such as a warden and a 24-hour alarm system, but few provide personal care services. 'Extra-Care' housing schemes include access to on-site personal care services.

medical. An increasing number of older people have varying degrees of dementia and some care homes specialise in caring for these people.

- 2.5 Whatever the setting, care can be considered as a combination of providing for both someone's medical, care and support needs, and their living environment and accommodation. The setting in which they receive care depends on their level of needs, their choices, financial considerations and what best promotes their wellbeing, independence and dignity.
- 2.6 In the last two decades, adult social care policy, including for older people, has sought to improve people's wellbeing in the following ways:
- (a) increase in personalised services giving people and families choice and control, including through self-directed care through direct payments;
  - (b) a drive to keep people independent for as long as possible, prioritising care in people's own homes, through home adaptations, support for unpaid carers and through services that prevent or delay the development of people's social care needs; and
  - (c) the integration of health and social care services to provide a joined-up strategic approach to commissioning social care – anticipating demand, influencing providers to change, contracting and managing contracts, provide care that 'wraps around' individuals.<sup>26</sup>
- 2.7 In addition to the generally understood benefits, we consider that integration can increase people's awareness of the full range of services available to them across both health and social care, and therefore help people to make informed decisions about their care. We do not comment on the effectiveness of these initiatives in practice given that in England, Scotland and Wales, moves towards integrating health and social care are quite new or still in the process of being implemented.

## **Moving into a care home**

- 2.8 CMA consumer research found that a move into a care home was commonly triggered by an event, such as a fall or stroke that made it clear that an older person was no longer safe to live in their own home.<sup>27</sup> There is more detail on entering and choosing care homes in Section 9. There will typically be an assessment of the person's care needs looking at the extent to which a

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<sup>26</sup> Across the UK, steps are being taken to promote integrated commissioning for Care Home Places. This is taking place, for example, through the Better Care Fund in England, Regional Partnership Boards in Wales and Integrated Joint Boards in Scotland. In Northern Ireland these activities have been integrated for longer.

<sup>27</sup> Ipsos MORI, CMA consumer research, p21.

person has difficulty performing everyday tasks. This may be done by care home staff, hospital staff, social workers or GPs. If the LA is involved it will assess these needs against national eligibility criteria to decide whether a person is eligible for LA funded care.

- 2.9 If someone has eligible needs, their care may be funded by the LA. The current level of the means test threshold varies between the UK's nations: public support is available when assets are below £23,250 in England and Northern Ireland, £26,500 in Scotland and £30,000 in Wales. These thresholds mean significant numbers of people must pay their own care costs. Furthermore, those receiving publicly funded care typically still contribute almost all their income. This means that a significant proportion of the cost of LA funded care is recovered from contributions made by residents (for example, in England, around a third of LA expenditure is recovered from residents).<sup>28</sup>
- 2.10 For people eligible for LA funding, the LA is responsible for arranging a placement. The potential resident has a right to choose any care home within their 'personal budget' which is set by the LA. Subject to certain conditions, they can choose alternative accommodation if their family or friends 'top up' the fee paid by the LA. The intention is that the LA will continue to manage these placements to ensure the people for whom they have arranged care continue to have their needs met effectively.
- 2.11 The NHS also arranges and funds care for individuals who are not in hospital but have been assessed as having a 'primary health need'; this is called Continuing Health Care (CHC).<sup>29</sup> Unlike the LA process, CHC is not means-tested as it is part of the NHS commitment to health care that is free at the point of delivery. The NHS also contributes to the nursing care costs of some other people who are not in a care home primarily because of health issues. This is through funded nursing care contributions, which are flat rate contributions to fees, paid directly to care homes.

## Social care funding

- 2.12 Spending on care homes is a large element of local government spending. We estimate that LAs in England, Scotland and Wales spent around £6 billion on social care for older people in residential or nursing settings.<sup>30</sup>

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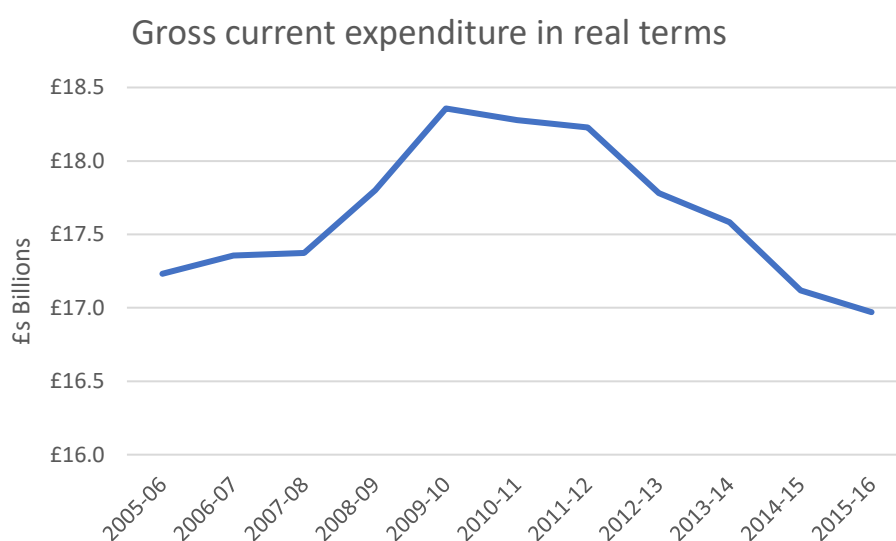
<sup>28</sup> Further detail in paragraph 2.12.

<sup>29</sup> NHS Continuing Healthcare in Scotland was replaced by Hospital Based Complex Clinical Care in 2015.

<sup>30</sup> £4.7 billion in England sourced from NHS Digital, Personal, Social Services: Expenditure and Unit Costs, England - 2015-16, final expenditure spreadsheet, expenditure filtered for age 65 and over and residential or nursing long-term care setting. £870 million in Scotland sourced from Data Spreadsheet for Expenditure on Adult

Residents make a contribution to these costs from their income, which can be considerable, for example in England LA-funded residents contribute around £1.6 billion to their costs of care.<sup>31</sup> Further public expenditure comes from the NHS spending directly on care homes and both the NHS and the benefits system paying benefits to those in care homes.<sup>32</sup> Public spending on care homes should be considered in the wider context of cuts in spending on adult social care and LAs more generally.<sup>33,34</sup> Figure 2.1 shows how LAs expenditure on adult social care has declined since 2009/10. Further pressure is expected, with a reported overspend against 2016-/17 budgets and further cuts to budgets planned in 2017-/18.<sup>35</sup>

**Figure 2.1: English local authorities spending on adult social care<sup>36</sup>**



Source: NHS Digital, (2016) [Personal Social Services: Expenditure and Unit Costs](#), England 2015/16.

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Social Care Services, Scotland, 2003/04 to 2013/14. £370 million in Wales in 2016/17 from Welsh Government, Revenue outturn expenditure: social services revenue, expenditure subjective analysis by authority, older people nursing and residential care placements. These sources may not be comparable.

<sup>31</sup> NHS Digital, (2016) [Personal Social Services: Expenditure and Unit Costs](#), England - 2015-16, final expenditure spreadsheet, client contributions filtered for age 65 and over and residential or nursing long-term care setting

<sup>32</sup> For example, Funded Nursing Care and the Attendance Allowance.

<sup>33</sup> 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. Overall the NAO estimate that LAs have experienced a real terms reduction in spending power of 23% over the same period.

<sup>34</sup> 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).

<sup>35</sup> The Association of Directors of Adult Social Services (ADASS) (2017), [ADASS Budget Survey 2017](#). The survey data shows that for adult social care LAs in England have a reported £366 million overspend in 2016/17 and are planning £824 million of further savings in 2017/18 bringing cumulative savings to £6 billion since 2010.

<sup>36</sup> This includes expenditure on social services for people below 65 and for older people not in care homes. Gross current expenditure excludes capital charges and expenses offset by other income (except for client contributions).

- 2.13 While spending has been declining in real terms since 2010, demographic changes are leading to an increase in care needs (see Section 6). There have also been cost pressures for the sector, most notably the National Living Wage.
- 2.14 Reduced funding is seen as leading to a reduction in support for those who need it. Some researchers claim that there is a substantial and increasing level of unmet needs. Age UK suggested earlier this year that some 1.2m people do not receive all the care they need.<sup>37</sup> However, it is unclear to what extent these estimates are driven by a lack of public funding and provision or by eligible people not accessing care or choosing not to pay for it. Further concerns have been raised about the impact on carers, providers' finances, care home staff and the NHS.
- 2.15 Reduced funding can also result in downward pressure on the care home fee rates paid by LAs. Some providers have told us that, since 2010, the real fee rates paid by LAs have reduced on average. This is consistent with the Care Quality Commission's (CQC) analysis, which reported that from 2010/11 to 2013/14 the rate per week paid by LAs in England for residential and nursing care fell from £673 to £611 (at 2015/16 prices).<sup>38</sup> The CQC noted that LA-focused providers have been exposed to 'severe financial strain'.<sup>39</sup> We examine the financial performance of care home providers in Section 4.
- 2.16 The UK government has proposed measures to address the funding shortfall in social care in England. Measures announced in the last 12 months have included:
- (a) £900 million extra funding for adult social care services over the next two years as announced in December 2016. This includes:
- an adult social care support grant of £240 million for LAs; and
  - a social care precept to allow LAs to raise council tax bills by 3% in the fiscal year 2017 to 2018 and by a further 3% in the following fiscal year.<sup>40</sup>

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<sup>37</sup> Age UK (2017), [Briefing: Health and Care of Older People in England 2017](#).

<sup>38</sup> 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*.

<sup>39</sup> CQC (2016), [The State of Health Care and Adult Social Care in England 2015/16](#), p43.

<sup>40</sup> An LA's ability to raise adequate funds depends on its council tax base. This can vary significantly depending on whether an area is economically disadvantaged, and whether such areas have a higher demand for LA funded residents coupled with a lower ability to raise the adequate funds via council tax increases.



(b) An additional £2 billion of funding for adult social care in England over the next three years was announced in March 2017, with £1 billion available in the fiscal year 2017 to 2018.

2.17 This additional funding addresses all aspects of adult social care, not just care homes. It is largely being delivered through the government's improved Better Care Fund, and guidance on conditions of use state that the money "may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from when they are ready; and ensuring that the local social care provider market is supported."<sup>41</sup> The guidance emphasised the importance of reducing delayed transfers of care between the NHS and social care. It is therefore unclear how much money will go towards the fee rates paid by LAs. The Local Government Association (LGA) estimated that by 2019/20 costs would increase by £1 billion a year due to increased need from demographic change, inflation and the National Living Wage<sup>42</sup>. We consider the financial performance and viability of the sector in Section 4.

## Regulation

2.18 Care homes are regulated for quality by national sector regulators.<sup>43</sup> Care home providers must register for the regulated services they provide and must be approved before operation. Care homes are then inspected by the sector regulator on a regular basis with reports made publicly available. Inspections can require improvements which the regulator can monitor. For serious breaches of regulations, the sector regulator can take enforcement action, which can include an enforced closure where the wellbeing of the people in the care home is judged to be at risk. Figure 2.2 shows that in England almost 30% of care homes received a rating of 'requires improvement' or 'inadequate'.

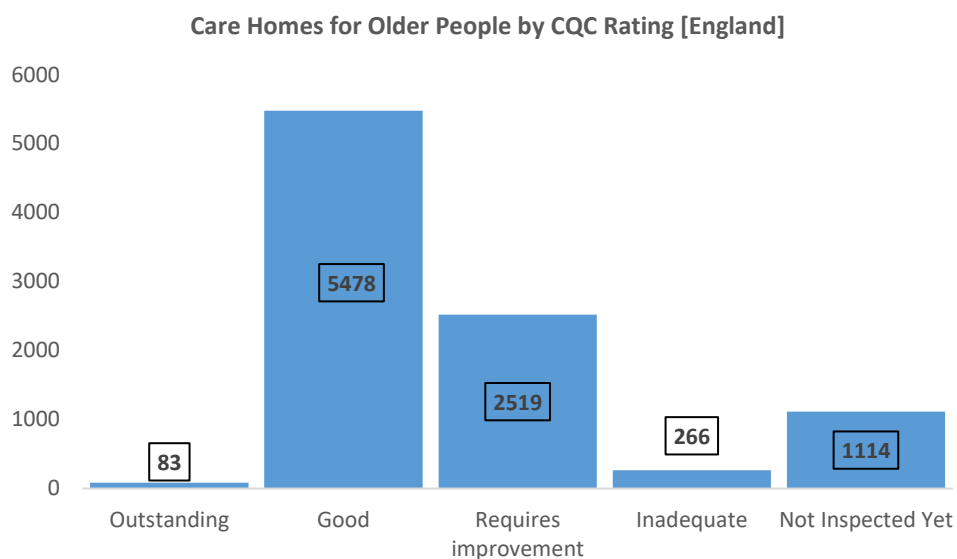
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<sup>41</sup> HM Government (March 2017), [2017 -19 Integration and Better Care Fund Policy Framework](#).

<sup>42</sup> LGA (2017), [Adult social care funding: State of the nation 2017](#), p13. These figures do not include the impact of other significant pressures facing the system, for example the cost of sleep-ins.

<sup>43</sup> The sector regulators are the Care Quality Commission in England; the Regulation and Quality Improvement Authority in Northern Ireland; the Care Inspectorate in Scotland; and the Care and Social Services Inspectorate Wales.

**Figure 2.2: Inspection results in England, January 2017.**



Source: CMA analysis of CQC data.

2.19 While the sector recognises the importance of the existing regulation for public confidence, we hear some concerns about duplication in the enforcement and monitoring activities of sector regulators and LAs. However, we have not received specific suggestions for removing duplication. Moreover, we have found sector regulators and many LAs which are trying to make improvements, for example by establishing joint quality assurance frameworks.<sup>44</sup>

## Care homes market structure

2.20 CMA analysis indicates that as of December 2016, there were around 5,500 providers of care homes in the UK operating about 11,300 care homes.<sup>45</sup> These provide care and accommodation (beds) to some 410,000 people.<sup>46</sup> 55% of beds are in nursing homes and 45% are in residential care homes. The number of older people in care homes has stayed broadly stable in recent years (see Figure 2.3). As the number of older people continues to increase, the number of people in care homes is projected to increase over the next decade (projections of future demand are further discussed in paragraphs 6.2 to 6.14). However, a regulator has told us that its evidence

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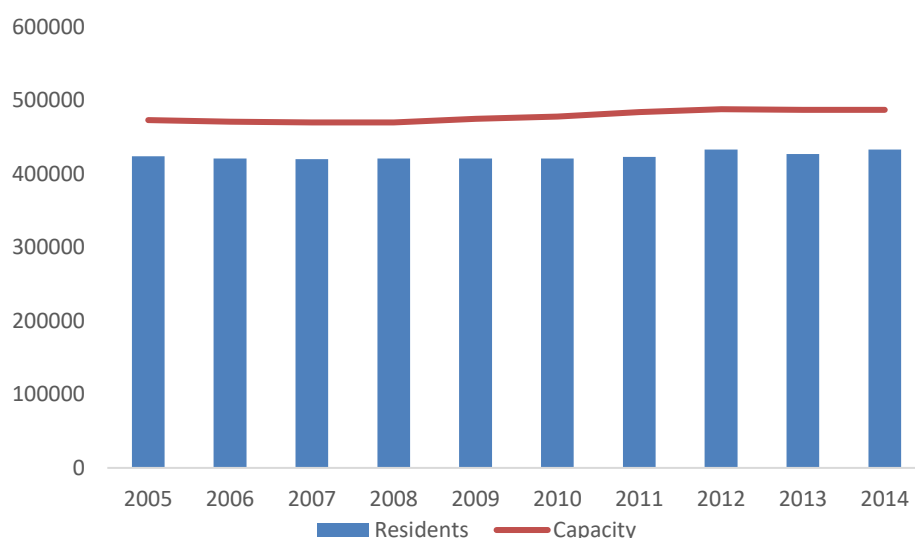
<sup>44</sup> See paragraph 3.8 for more details.

<sup>45</sup> Unless stated otherwise, the figures in this section are from the CMA analysis of LaingBuisson and Caredata.co.uk datasets and are for the UK in December 2016. Further details of this analysis are given in Appendix C.

<sup>46</sup> This figure is based on applying occupancy rates from LaingBuisson (see paragraph 2.23) to an estimate of total occupancy from CMA analysis.

suggested that there has been a significant loss in capacity in LA-funded beds, with an increase in self-funded beds.<sup>47</sup>

**Figure 2.3: The number of residents and capacity of care homes for older and physically disabled people,<sup>48</sup> 2005-2014**



Source: LaingBuisson.

- 2.21 For-profit providers account for 83% of care home beds and the voluntary sector a further 13%.<sup>49</sup> The remaining 4% of care home beds are run by local government or the NHS.
- 2.22 The sector is fragmented with the largest 30 care home providers supplying 30% of the overall capacity, and 80% of providers with one home supplying 29% of care home beds.
- 2.23 Care homes have 40 beds on average. The average size of a care home has been gradually increasing with the optimum size considered to be around 60 to 70 beds. Providers told us that, above that size, further scale economies are outweighed by disadvantages, such as the home feeling less personal for residents.
- 2.24 The cost structure means that maintaining a high level of occupancy is important. In the UK, occupancy rates are 90% on average in nursing homes

<sup>47</sup> Anecdotally, we have heard of lots of cases, particularly for older and smaller homes serving the local authority segment of voluntary exits where the land is used for alternative commercial purposes. But the evidence that we have received suggests that the total loss in capacity in the past few years has not been great. For example, the regulator has told us that the underperforming homes of large providers have generally been bought over by medium sized and regional providers and is an indication that some market participants do see some potential to make adequate returns.

<sup>48</sup> This LaingBuisson data includes physically disabled people, however, this group accounts for only around 5% of the totals shown.

<sup>49</sup> CMA analysis of LaingBuisson December 2016 data.

and 91% in residential homes.<sup>50</sup> Due to the strong incentive to avoid empty beds (as it is hard to reduce costs if beds are unfilled), we would not expect the industry to maintain the high levels of spare capacity that would be necessary to give prospective residents more choice. We consider that while prospective residents might not have much choice, the pressure on homes to maintain occupancy levels exerts a strong competition pressure to attract residents (as even a small drop in occupancy could have a large impact on profitability).

2.25 Industry research suggests that 41% of care home residents are self-funders, 10% are NHS-funded and the remainder are LA-funded.<sup>51</sup> Up to 2014, the number of LA-funded residents in the UK remained stable at around 200,000.<sup>52</sup> Results from LaingBuisson care home surveys indicate that around a quarter of LA-funded residents are in receipt of a third party top-up.<sup>53</sup> There are no firm figures for the average size of these top-ups but both we and LaingBuisson have anecdotally found them to be between £20 and £100 per week.<sup>54</sup> Table 2.1 shows how the proportion of self-funders varies across the country:

**Table 2.1: Proportion of self-funders by Region**

<i>Region</i>	<i>Percentage of self-funders</i>
North East	18%
North West	36%
Yorkshire and the Humber	42%
East Midlands	43%
West Midlands	39%
East of England	45%
Greater London	30%
South East	54%
South West	49%
Wales	24%
Scotland	30%
Northern Ireland and Isle of Man	16%
UK	41%

Source: LaingBuisson care homes surveys, 2014.

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<sup>50</sup> LaingBuisson, Care of Older People UK Market Report, 27th edition, Table 5.4 p150.

<sup>51</sup> LaingBuisson, Care of Older People UK Market Report, 27th edition, p198. Figures for September 2014. These figures are for private and voluntary care homes providing care for older and disabled people.

<sup>52</sup> LaingBuisson, Care of Older People UK Market Report, 27th edition, Table 7.1 p198.

<sup>53</sup> LaingBuisson, Care of Older People UK Market Report, 27th edition, p212.

<sup>54</sup> This is also in line with our finding that top-up fees accounted for under 2% of large providers' total revenues (see Appendix D).

- 2.26 The average fee for residential care is £588 per week.<sup>55</sup> Fees for nursing care are higher averaging £741 per week. Fees are also typically higher for self-funders than for LAs (see paragraphs 2.37-2.44).
- 2.27 Many of the aspects of the care homes market discussed above are similar across all four nations of the UK. However, there are some notable differences, such as the proportion of homes owned by LAs (see Table 2.2) and the proportion of self-funded residents (see Table 2.1). Table 2.2 provides some key statistics for the different nations.

**Table 2.2: Key statistics by nation**

<i>Feature of the market</i>	<i>England</i>	<i>Scotland</i>	<i>Wales</i>	<i>Northern Ireland</i>
Care home capacity (beds)	382,042	37,733	22,764	12,319
Proportion of capacity in nursing homes*	52.7%	69.3%	52.3%	75.0%
Care home occupancy – nursing	89.6%	90.1%	92.2%	86.4%
Care home occupancy – residential	91.1%	91.6%	91.3%	88.1%
Proportion of homes owned by local authorities/health social care trusts	3.2%	15.3%	13.5%	9.9%
Growth of 85+ population (from 2015 to 2025)	36%	37%	34%	42%
Average care home size (beds)	40.4	43.2	34.8	40.4
Average residential fee per week	£590	£640	£529	£471
Average nursing fee per week	£756	£732	£626	£595
Fee differential (SF-LA)	43%	38%	36%	**

Sources: CMA analysis and LaingBuisson.

\* The way in which care homes are classified varies depending on each of the nations' regulators.

\*\* Results have not been presented for Northern Ireland for confidentiality reasons. In addition, the system is different with a 'self-funder' being a person who pays the full cost of their 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.

## Competition for care home residents

- 2.28 This section considers how competition between care homes is affected by the ways in which people choose care homes.

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<sup>55</sup> The figures in this paragraph are average mid-points derived from CMA analysis of care home fee data collected from self-selecting samples of care home from LaingBuisson and Caredata.co.uk. Further details are given in Appendix C.

## ***Geographic scope of competition***

- 2.29 Competition between care homes takes place locally due to the importance of location for people choosing a care home. Our consumer research confirms that location is the main factor for potential residents and their representatives when choosing a care home (see Section 9). While some people may consider homes across a wider area, previous merger decisions by the OFT<sup>57</sup> suggest local markets defined by 15-20 minute drive times.<sup>57</sup>
- 2.30 We found that whilst 90% of post code districts had at least three different care home providers within a 15-minute drive time from the centre<sup>58</sup>. About 19% of post code districts had two or fewer different nursing home providers within a 15-minute drive time from the centre. These are mostly in rural areas with below average populations (see Figure 2.4). Our consumer research found that a lack of vacancies at care homes is another important limitation on choice.<sup>59</sup>

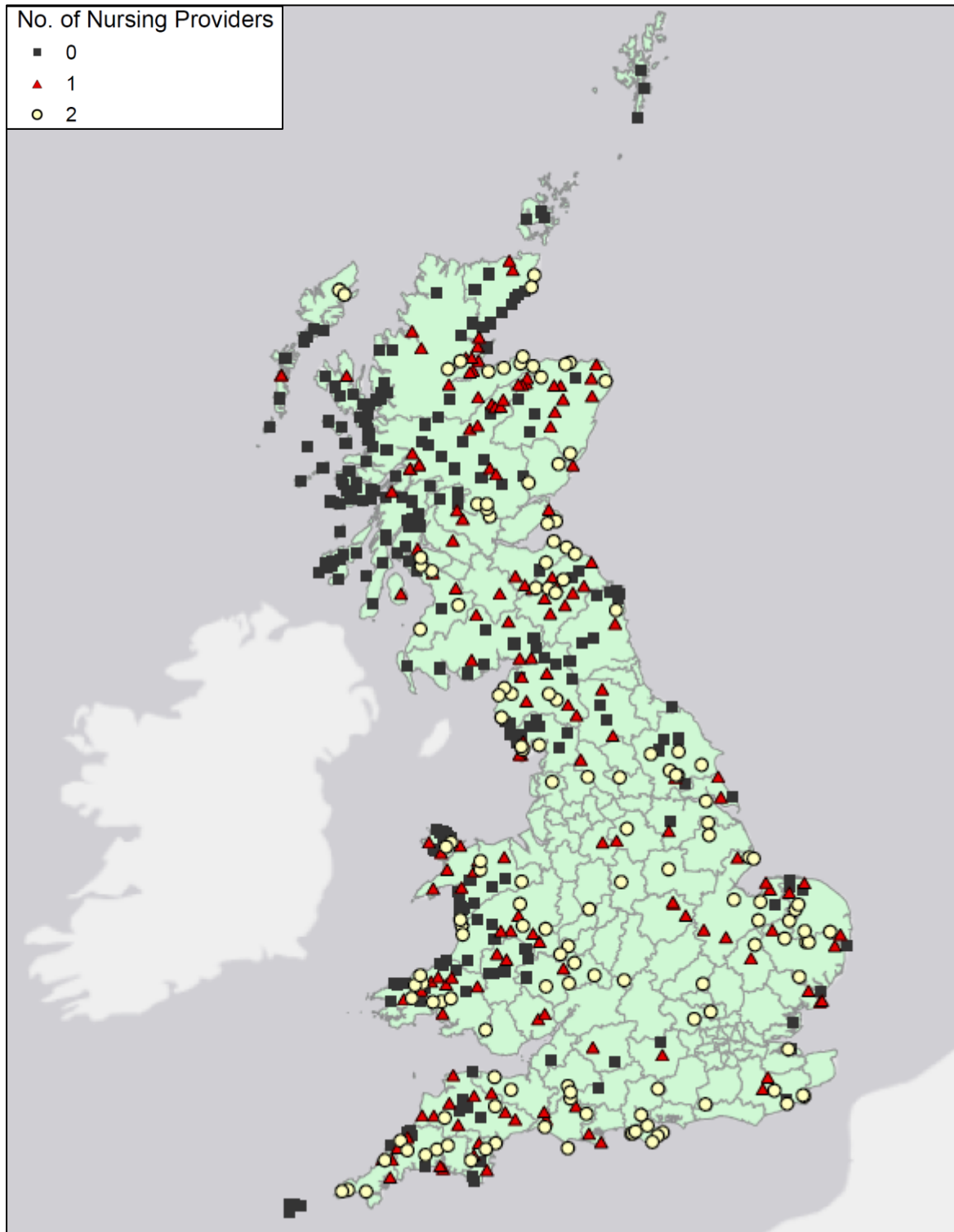
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<sup>57</sup> OFT (2005), [Final decision Blackstone Group / NHP plc](#) applied a lower bound geographic frame of reference based on a 15-20 minute drive time (equating to three miles for urban areas, five miles for suburban areas and 10 miles for rural areas).

<sup>58</sup> This analysis looked at which homes were within a 15-minute drive time of the centre of each of 3,006 post code districts in England, Scotland and Wales (data availability meant we were unable to include Northern Ireland in the analysis). A 15-20 minute drive time has been used in past UK merger cases as a lower bound geographic frame of reference, meaning that this area may be narrower than appropriate. A more detailed explanation is in Appendix C.

<sup>59</sup> [Ipsos MORI](#), CMA consumer research, p20.

Figure 2.4: Locations in Great Britain with two or fewer nursing home providers within a 15-minute drive time



Source: CMA analysis. Contains OS data © Crown Copyright and database right 2017.

2.31 Some LAs will place people anywhere within their geographic area, suggesting that there is an element of competition that takes place at a wider level.

## ***Nature of competition***

- 2.32 Our consumer research found that for people paying their own costs of care affordability (and, therefore, fees rates) was an important factor in shortlisting care homes, and that in choosing between shortlisted homes people prioritised their judgement on a home being clean, friendly and homely.<sup>60</sup> However, we also found that low expectations and pressure to make decisions quickly meant that people were often willing to accept the first home that was 'good enough'. We consider that this behaviour, combined with a lack of transparency on fee rates, has the effect of dampening competition on price and quality (see Section 9 for further discussion).
- 2.33 We have found that competition between care homes for LA-funded residents is more focused on price (see Section 3). LAs have competing pressures on their budgets and are better informed than self-funded residents. Care home providers have told us that LAs have been able to push fee rates down to low and unsustainable levels (see Section 4). We also found that some people will not have a choice of fully funded care homes. Where LA residents had a choice of care home, the findings on mattered to them were similar to those for self-funded residents.

## ***Barriers to entry***

- 2.34 Generally, barriers to entering and exiting the care homes market are low and there is widespread investment in homes focused on self-funders. However, there is limited investment in homes focused on LA-funded residents. We have been told that the factors that limit providers' ability to build new care homes are:
- (a) Adequate fee revenue. This implies an expectation that fees will cover build costs, operating costs and a reasonable profit. Build costs for a new care home can be considerable. According to providers and specialist care home builders a new 60 bed home will often cost around £8 million.
  - (b) Finding suitable sites. This is a challenge because sites have to be in areas where people want to live and must also be suitable for a large building. Providers and builders told us that they consider a lot of potential sites in order to find viable options and that finding a site in a given area can take years.

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<sup>60</sup> Ipsos MORI, CMA consumer research, p49.



(c) Planning permission and other construction issues. These are similar to issues faced by other large scale construction projects. Providers told us that these factors often slow down or add costs to a project rather than jeopardise it.<sup>61</sup>

(d) Recruiting staff. All the providers with whom we have been in contact have told us that finding staff, especially nurses, is a problem. This applies to new and existing homes and, as a result, providers consider the prospects for recruiting staff when choosing whether to build in a certain area. For example, they will look at the prevalence of rival employers, such as supermarkets, in the area.

2.35 These same factors apply to care homes aimed at serving LA-funded and self-funded residents. The key difference relates to the level of fees. LA fees appear just to cover operating costs and so are generally not enough to cover the costs of investment. These fees are too low to justify the building of new care homes (see Section 4). In contrast, fees from self-funders cover capital costs and currently appear to be sufficient to encourage investment in new care homes. Investors also need confidence that fees will remain adequate as care homes are long-term investments. Providers gave examples of LAs cutting fees without warning or other changes in approach leading to them needing contractual assurances when investing for the LA-funded segment. In contrast, homes focused on self-funders do not face one large customer with the ability to suddenly reduce fees.

2.36 While there are low barriers to providers responding to profitable opportunities, it takes time for new capacity to enter the market. It takes two to three years to open a new care home once a suitable site has been identified. This includes the time for due diligence on the land, getting planning permission, building and fitting the care home.

### **Price differential between self-funders and LA funded residents**

2.37 Most care homes serve a mix of self-funders and LA-funded residents. Many of these care homes charge much higher fees for self-funded than for LA-funded places. While there can be differences in the services individuals receive, such as size of rooms, we have been told by providers that the costs of LA and self-funded residents are very similar.

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<sup>61</sup> Getting planning permission was seen as a slow process but providers were confident that they would get it in the end.

- 2.38 We have conducted an analysis to understand the charges to self-funders and LAs, and the size of price differentials across the UK.<sup>62</sup> The method and detailed results are set out in appendix C. We used data on around 2,000 homes from 25 of the larger provider groups in the UK covering nearly a third of the industry by revenue.<sup>63</sup> We calculated average fee differentials by care home for financial year 2016.<sup>64</sup> We aggregated fee differentials to calculate simple averages across all care homes.<sup>65</sup>
- 2.39 In our sample, the average fee for a self-funder in 2016 was £846 per week, which is nearly £44,000 per year. This varies substantially between regions, with average weekly self-funder fees of £670 in the North East of England and £1060 in the South-East. In contrast, LAs on average paid £621 per week.
- 2.40 Our assessment indicates that fees for self-funded places are on average 41% higher than those paid by LAs.<sup>66</sup> This result is consistent with other published studies, which have found price differentials in the region of 25-50%.<sup>67</sup> Our result is based on data from larger care home providers and the differential may be smaller for homes that are part of smaller groups. One piece of unpublished research into smaller providers found a smaller price differential. In absolute terms, the average differential is £236<sup>68</sup> per week which means that on average a self-funding resident is paying over £12,000 a year more than an LA to have a place in the same care home.
- 2.41 Fee differentials tend to be proportionally greatest for care homes with a fairly even mix of self-funders and LA-funded residents (see Figure 2.5).

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<sup>62</sup> The price differential is calculated as the difference between SF and LA rates per resident divided by the LA rate per resident. Depending on the analysis, this could be produced using averages of fees over a period of time and across residents in a particular care home or group.

<sup>63</sup> Using LaingBuisson's estimate that the market size was £15.9 in 2014 in its report 'Care of Older People UK Market Report – Twenty-seventh edition'.

<sup>64</sup> Care homes serving only LA or only self-funded residents in this particular year had their average fee differentials set to missing for that year, as did those mixed care homes for which SF and/or LA fees were missing. This was the case for a total of 215 homes.

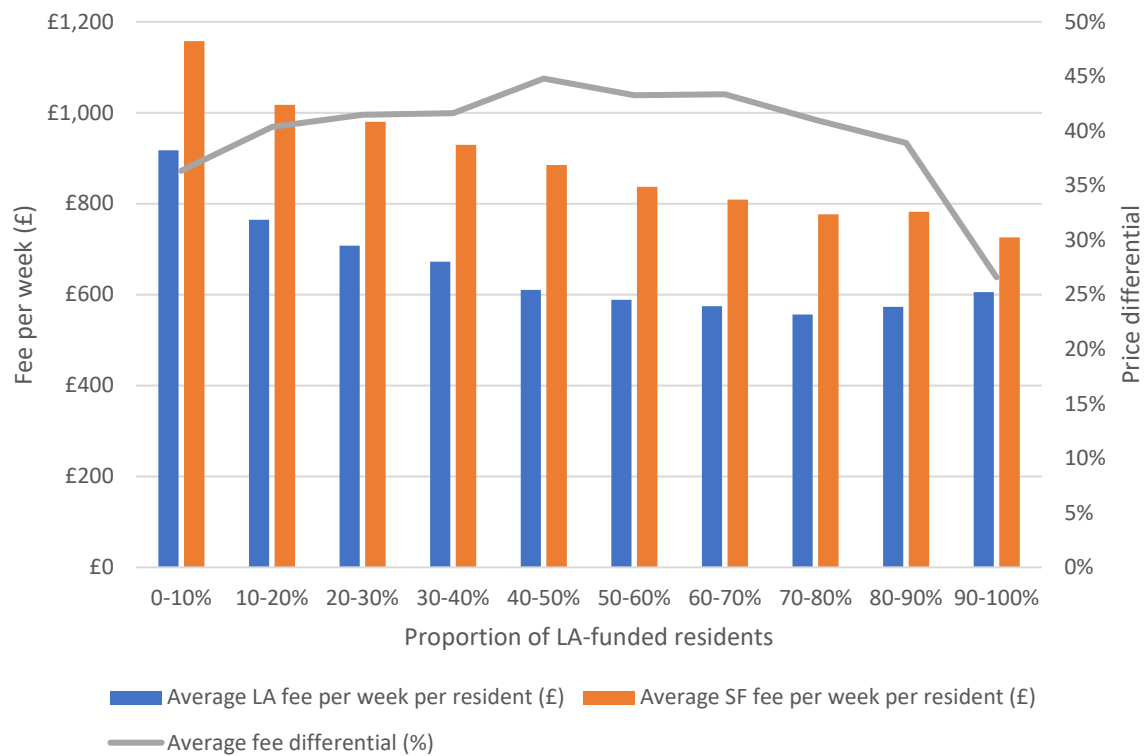
<sup>65</sup> Presenting results as simple averages gives equal weight to each care home in the sample (regardless of some care homes being larger than others). Nevertheless, we also produce averages across different subsets of care homes which provides a clearer picture of how outcomes differ across care homes of different characteristics.

<sup>66</sup> This difference is calculated as an average of the differential for each home with both LA and self-funded residents and so is different to the average differential as a percentage of the average LA fee.

<sup>67</sup> LB research for County Council Network (2014), LB 'Care of Older People UK Market Report' (2015), Mintel 'Residential Care for the Elderly – UK' (2016), Natwest 'Care Home Benchmarking 2016/17'. From the publicly available information, it is unclear how samples were drawn for most of these studies and, where it was clear, the samples do not seem to be representative of the UK, for example covering only England or a specific type of customer. The methodology used to calculate price differentials is also unclear for most of these studies, for example how observations were averaged.

<sup>68</sup> Note that this figure only includes homes that have both LA and self-funded residents and so is different to the difference between the average fees in paragraph 2.39.

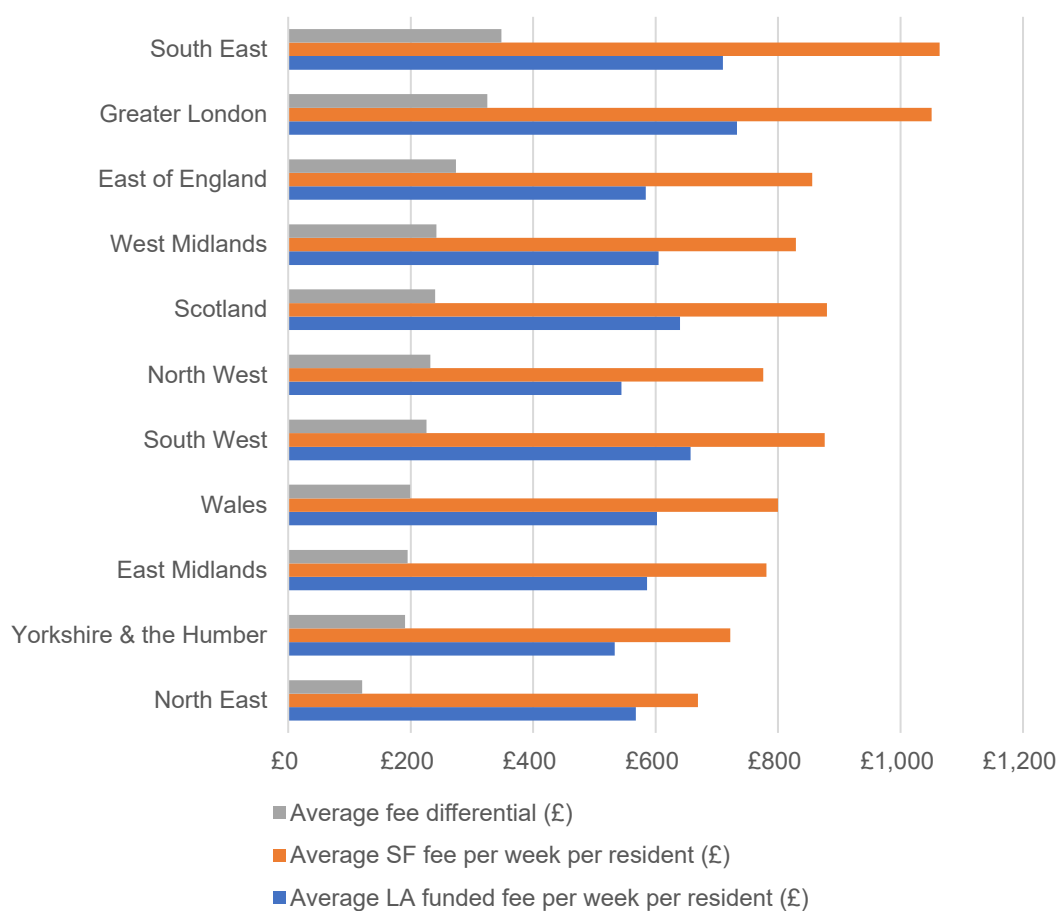
**Figure 2.5: Average fee levels and price differentials by proportion of LA-funded residents, 2016**



Source: CMA analysis.

2.42 We have also found considerable regional differences in these numbers. While there appear to be very small differences in prices paid in Northern Ireland, in the rest of the UK we see significant differences in average prices paid. Figure 2.6 below shows these in order of absolute size of the price differential.

**Figure 2.6: Average self-funder and LA-funded fee rates and differential (£ per week) by region, Great Britain, 2016**



Source: CMA analysis.

- 2.43 The incidence of differential pricing has increased markedly since 2005 when the OFT reported it found that only one in five homes charged differential prices.<sup>69</sup>
- 2.44 The consequence is that self-funded residents in mixed homes are meeting a much greater proportion of homes' fixed costs than LA-funded residents. This is often referred to in the industry as a 'cross-subsidy'.

<sup>69</sup> OFT (2005), [Care homes for older people in the UK](#), paragraph 1.56.

### **3. State procurement**

- 3.1 This section sets out our findings and some views on how LAs procure care home places for people with eligible care needs. We do not comment on NHS procurement of care home places as they account for only a small proportion of residents, but in Section 2 we give details of the steps being taken to promote integration in LA and NHS procurement and the associated benefits.<sup>70</sup>

#### **The context for procuring care**

- 3.2 The process of placing someone with eligible care needs who will be LA-funded in a care home generally involves the following: an assessment of their care needs and financial position; identifying suitable care homes with availability; agreeing with the person needing care which care home is selected from the available choice; and agreeing terms and fees with the care home. There will also be on-going monitoring of the placement including reviews of the resident's needs.

#### ***Pressures on LAs***

- 3.3 As explained in Section 2,<sup>71</sup> LAs are facing increasing financial pressures combined with increasing demand for care for older people.<sup>72</sup> Leaving aside funding, LAs are also constrained by the availability and capacity of care home places in their local areas. Most care homes are under no obligation to take LA-funded residents and may not have suitable vacancies.
- 3.4 There is a risk that LAs may respond to these pressures in how they exercise their judgement in meeting their duties. Specifically, LAs have a degree of flexibility in their assessment of eligible care needs and how they decide to meet eligible needs, the fee rates they pay and the quality of the care that they commission.<sup>73</sup>
- 3.5 In these circumstances, we consider that an effective procurement strategy should:

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<sup>70</sup> See paragraph 2.6, footnote 26.

<sup>71</sup> See paragraphs 2.12 to 2.17.

<sup>72</sup> In this context, we refer to LAs to denote any of the public bodies that procure care home places and so this includes CCGs and HSC Trusts.

<sup>73</sup> See paragraph 2.14.

- (a) recognise local market circumstances, including the balance between supply and demand for care home capacity, local labour market constraints and the quality of local care homes;
- (b) be responsive to changing market conditions;
- (c) encourage competition between care homes based on delivering good outcomes for residents (both self-funded and LA-funded and their friends and families), and value for money for the LA and taxpayer;
- (d) provide for effective communication between any LAs and NHS bodies that are purchasing care home capacity in the same local areas;<sup>74</sup> and
- (e) support the sustainable provision of capacity by encouraging the provision of flexible and diverse care home capacity and providing for effective engagement with providers.

## Contracting with providers

### *Approach*

- 3.6 LAs primarily procure care home places using either block contracts (ie long term contracts which ‘pre-book’ a certain number of placements at an agreed rate) or by spot purchasing (contracts used to place an individual, often supported by an overarching framework agreement or a standard contract).
- 3.7 In Scotland, there is a National Care Home Contract (NCHC), agreed annually between the Convention of Scottish LAs (COSLA), Scottish Care and the Coalition of Care and Support Providers (CCPS), which sets a common contract with terms and conditions and fee rates that apply to all LA placements in Scotland.<sup>75</sup> We have been told that many providers replicate the contract for their self-funded residents. In Northern Ireland, there is a regional contract which each of the HSC Trusts use to procure care in their area.
- 3.8 LAs monitor the performance or compliance of care homes with which they contract against the terms of these agreements. We have been told that many LAs are making efforts to make these processes more efficient including: establishing joint quality assurance frameworks with local partners

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<sup>74</sup> We note that several bodies have produced strategies, for example, ADASS in England published in 2015 its [Commissioning for better outcomes: a route map](#) which provides a framework for councils to assess their progress against best practice.

<sup>75</sup> LAs can opt out, however, we have been told that none have done so.

from health and/or regulators; holding regular meetings with partners (eg sector regulators health bodies, social workers etc) to discuss care homes in the area; and coordinating inspections to reduce the burden on providers. The majority of LAs delegate routine monitoring of out-of-area residents to the host LA.

### ***Relative merits of block contracts and spot purchasing***

- 3.9 LAs told us that they will generally pay a lower price for placements made using block contracts rather than spot purchasing and that this reflects the commercial value of block contracts to providers. For example, block contracts provide certainty on prices, which enables providers to minimise certain risks and better manage costs.<sup>76</sup> In addition, the certainty on price can help LAs to manage their budgets. The main trade-off for an LA is the commitment to buy a certain number of beds for a specified period, regardless of whether the bed is needed or whether local care needs change over time. LAs also told us that block contracts are commonly used for securing beds for short-term placements, such as respite care.
- 3.10 Beyond price, use of block or spot contracts can also affect planning and choice. Spot purchasing allows for more flexibility to meet changing needs or priorities. Similarly, engaging with a larger number of care homes could increase the ability for people to exercise a choice of home.
- 3.11 Block contracts and spot purchasing have different implications for competition between care homes. When places are procured using block contracts, competition takes place periodically (ie when agreements are signed) and, generally, between a smaller number of care homes. With spot purchasing, however, there is potential for ongoing competition for residents across a wider set of homes. Spot purchasing also allows greater scope for direct competition on elements of the placement eg location.
- 3.12 Notwithstanding the benefits of spot contracting, we consider that block contracts (and other types of longer-term contractual relationships) can be a more effective means for LAs to secure required investment in care home capacity because they:<sup>77</sup>
- (a) reduce provider exposure to uncertainty around future demand, national policy, and funding environment;

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<sup>76</sup> For example, the risk of void beds. In spot purchasing, where the risk sits with the provider, prices are higher.

<sup>77</sup> Subject to the concern that LAs do not know how much care of a given type will be needed in the future as local needs, technology and ways of delivering care change.

- (b) help providers to achieve scale, the benefits of which can be shared with LAs; and
- (c) remove the risk until the end of the contracting period that LAs could at some future date, if market conditions permit, reduce fee rates.

## **Fee setting**

### ***Approach***

- 3.13 Many LAs have a pre-determined fee set out in a block or framework agreement. This fee can either be fixed depending on the level of care required (eg residential, nursing, dementia care), or flexible through use of fee bands (ie a minimum and maximum rate set for each level of care). In Scotland, the fixed fee rate is set out in the NCHC, provision is made for additional care charges in exceptional circumstances. In Northern Ireland, the HSC Board sets a rate, which the HSC Trusts may use when they procure placements.<sup>78</sup>
- 3.14 Where spot purchasing is used, the fee might be determined on a placement-by-placement basis, sometimes through a bidding process. Traditionally, this has involved LAs ringing around different care homes to enquire about availability and then agreeing a price for a placement. This process might be informed by LA fee bands or benchmark prices. In England in particular, some LAs are moving to an automated process or electronic platforms such as dynamic purchasing systems as a way to determine fees.

### ***Use of electronic platforms***

- 3.15 Electronic platforms might be used to advertise placements and identify care homes with availability. Administratively, this is more efficient than the traditional approach of phoning around different care homes. The ability to communicate an available placement instantaneously to all participating care homes promotes competition, choice and reduces barriers to entry for new providers to the market.

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<sup>78</sup> The Health and Social Care Board (HSCB) is required to set, on an annual basis, the Nursing Home and Residential Home weekly tariff rate, representing a standard rate that will be paid towards care home fees. The HSCB does not set the fees that individual homes may establish. The assessment of whether an individual requires a care home placement is made by the relevant Health and Social Care (HSC) Trust. The Trust will be required to arrange care in the client's preferred home where possible; however, the HSC Trust must contract for placements at the most competitive rate available, which is the rate it considers suitable for meeting the client's assessed need, and which may be in excess of the tariff rate.



- 3.16 Dynamic purchasing systems are online auction processes where LAs advertise prospective placements and approved providers can bid to meet those needs. The LAs will then select a 'winner' depending on certain factors, including an individual's preferences (eg to be near family or religious services), price and quality.
- 3.17 Features of dynamic purchasing systems can vary. Some LAs have introduced either minimum or fixed fee rates and build quality into rankings. These systems are generally supported by new framework agreements and/or tenders for providers to join these frameworks.
- 3.18 Several LAs told us that dynamic purchasing systems had resulted in lower fee rates. Some providers said that the result was an excessive focus on price (at the expense of the needs or preferences of the prospective resident) and risked LAs pushing prices down. We have been told that there is spare capacity in some areas in the supply of residential beds (meaning that care homes will be more prepared to bid lower prices to secure placements to fill otherwise empty beds).
- 3.19 We have been told that there are a number of problems associated with the use of dynamic purchasing systems:
- (a) There is a greater focus on price with less opportunity for social workers to exercise judgement in finding a person a suitable home, making it more difficult for higher cost homes (for example those in more attractive locations) to compete for LA placements.
  - (b) Prices are particularly sensitive to current market conditions meaning that excess capacity could result in prices being bid down to marginal cost (which could also affect providers expectations of whether the procurement process will generate fee rates that will give a reasonable rate of return over the economic life of the home).
  - (c) Comparable homes offering much the same care might be paid different fees, and residents with similar care needs may end up paying different top-ups, for example, for identical rooms.
- 3.20 With regard to (a), we consider that any such concerns can be addressed in the system design of electronic platforms For example, by LAs ensuring that the posted specification of placements is sufficiently detailed to capture all

reasonable needs and preferences; ranking bids on price and quality;<sup>79</sup> involving social workers or other LA staff familiar with homes in the local area in the procurement process (thereby allowing for some judgement, based on experience, to be exercised in placing people); subjecting bids to minimum prices;<sup>80</sup> and by allowing for the use of top-ups to promote choice. Moreover, price overriding other considerations is not intrinsic to dynamic purchasing systems and proper specification of needs will be required in any procurement approach.

- 3.21 With regard to (b), it is costly for providers to invest in capacity that is surplus to requirements (we know that providers aim to operate at around 90% capacity) and short lead times mean that providers can be fairly certain of the competitive environment before committing to investments.<sup>81</sup> We consider that LAs could further mitigate any such risks associated with there being too much capacity by being transparent on required investment in their local area and working closely with potential investors (for example, on the specification of the facilities).
- 3.22 With regard to (c), we note that variation in fee rates from placement-to-placement are an inherent feature of dynamic purchasing systems. Nevertheless, we consider that the benefits of reverse auctions, (which, primarily, are about ensuring that LAs do not pay more than they need to, whilst having the flexibility to pay higher prices to secure a place when required), should be balanced against such concerns that LAs, providers or residents might have.

## **Cost of care exercises**

- 3.23 Some LAs use a 'cost of care exercise' to inform their fee rates. Typically, these exercises are carried out periodically (for example, every five years) and are used to generate a benchmark fee rate. The rates might be flexed to reflect market conditions in certain areas or the costs of meeting certain care needs. Fee rates will usually be updated between reviews to reflect any changes in costs, eg inflation or new policies such as the National Living Wage.

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<sup>79</sup> For example, one LA ranks homes based on quality (60%) and price (40%) weights, and will not contact any home with significantly poor ratings (as determined by the LA) and only contact homes with moderately poor ratings at the request of the resident.

<sup>80</sup> For example, one LA has guide rates and we were told that 70% of placements are made at that price.

<sup>81</sup> Several providers told us that, having found a suitable site, it would take them two to three years to build and open a new care home (see Section 2 paragraph 2.36)

- 3.24 In England, as part of their market shaping duty, LAs ‘must not undertake any actions which may threaten the sustainability of the market as a whole’, for example ‘by setting fee levels below an amount which is not sustainable for providers in the long-term’.<sup>82</sup> The Care Act Statutory Guidance also states that ‘[in] all cases the local authority must have regard to the actual cost of good quality care in deciding the personal budget to ensure that the amount is one that reflects local market conditions. This should also reflect other factors such as the person’s circumstances and the availability of provision. In addition, the local authority should not set arbitrary amounts or ceilings for particular types of accommodation that do not reflect a fair cost of care.’<sup>83</sup>
- 3.25 Scotland Excel in partnership with the sector has developed a model of notional representative average costs for nursing and residential care. This is based on unique Scottish benchmarks, for example reflecting the Scottish Living Wage and staffing ratios. Scotland Excel is further developing the tool to support local pricing variation to reflect different market conditions in different geographic areas. We understand that national cost modelling is being considered in Wales.<sup>84</sup>
- 3.26 We consider that cost of care exercises can foster ‘buy in’ from LAs and providers to negotiated prices, and give LAs a better understanding of the local market conditions and the sustainability of procurement policies. We have been told that the arrangements in Scotland are particularly robust because of the on-going collaborative effort in developing a representative cost model combined with the opportunity to negotiate inputs where current methodological issues remain unresolved.
- 3.27 We recognise that cost of care exercises can require substantial up-front investment, for example as specialist skills are required. There are, however, commercial providers of cost of care modelling tools available to LAs. Association of Directors of Adult Social Services in England and Wales and other bodies such as Institute of Public Care (IPC) have also developed methodologies for determining the cost of care.<sup>85</sup> These tools are based on public sources or, in some cases, open book exercises with providers.
- 3.28 We have been told that providers may be reticent to share cost information required to test, calibrate or populate such models. It can also be difficult to

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<sup>82</sup> Department of Health (March 2016, as amended), [Care and Support Statutory Guidance](#), paragraph 4.35.

<sup>83</sup> Department of Health (March 2016, as amended), [Care and Support Statutory Guidance](#), Annex A, paragraph 11.

<sup>84</sup> We understand that Professor John Bolton is undertaking this work on behalf of the Welsh Government.

<sup>85</sup> In Wales, ADSS Cymru and the Welsh Government are currently developing a methodology.

agree on an appropriate allowance for cost of capital,<sup>86</sup> particularly where providers in a locality have different cost pressures, and to account for local variations in costs.

## Quality

- 3.29 Most of the LAs told us that they will place residents only in homes that meet minimum standards of care. These authorities will not place prospective residents in homes that have poor regulator ratings or which raise concerns during LA inspections. Some LAs apply their own rating system to care homes when assessing quality. These rating systems might draw on: scores on health and safety; scores on food quality and safety; information on staff vacancies; numbers of falls; and details of complaints.<sup>87</sup>
- 3.30 In addition, where arrangements for placing residents allow for judgement to be exercised on the suitability of a care home, there is scope for LA staff to take account of what they know about the quality provided by care homes. We consider this to be a useful mechanism for LAs to deliver better outcomes for people by making use of the information that staff will acquire from their regular dealings with care homes.
- 3.31 A few LAs have mechanisms for explicitly rewarding higher quality. In Scotland, the NCHC provides for an 'enhanced quality award' in the form of an additional payment, where care homes achieve certain grades. However, we were told by LAs that incentivising quality beyond a minimum standard is difficult. It is particularly the case with financial incentives as funding pressures make it difficult for LAs to offer meaningful financial awards. Quality can also be subjective. Even where regulator ratings are used as a quality benchmark, providers argue that these can go quickly out of date or do not assess features that a resident would associate with quality.
- 3.32 LAs also told us that they are seeking other ways to reward quality, for example, through internal ranking systems that prioritise placements with providers higher up the rankings, and by providing advice and support to care homes. However, we recognise that the ability for LAs to choose a home with quality above a minimum standard depends on local

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<sup>86</sup> In addition to the work of Scotland Excel, ADASS and CIPFA have provided guidance on this.

<sup>87</sup> An Independent Age report '[Caring about the Care Act: A Freedom of Information Research Briefing November 2017](#)' stated that '[l]ocal authorities are not routinely taking Care Quality Commission (CQC) inspections and ratings into account when arranging residents' care home placements. Even most of those that do not keep a record of how many people they place in 'inadequate' or 'requires improvement' rated care homes. Local authorities also appear to have very varied approaches to managing their local market and fulfilling their Care Act duties to help shape a diverse market.' These findings are based on 119 full and partial responses to 152 Freedom of Information Requests sent to 152 local authorities in England.

circumstances. Their choice may be limited by the general quality of local care homes and the limited availability of places in the better quality homes.

## Choice

- 3.33 The Care Act Statutory Guidance states that LAs ‘**must**’ ensure that a person (with eligible care needs who is also eligible for LA-funding) is offered at least one option that is available and affordable within the person’s personal budget and it ‘should’ ensure that there is more than one of these options.<sup>88</sup> In keeping with this Guidance, in practice, some LAs will only offer one fully funded option. This approach is more common where LAs use reverse auctions to place residents. It can also occur where the individual’s care needs and availability of places in suitable care homes in the area limit choice.
- 3.34 The satisfaction of prospective residents with the care home or homes offered will depend on the extent to which the LA has been able to meet their preferences, including, for example, how close the selected home is to their friends and families. In certain circumstances,<sup>89</sup> a person might also be able to choose alternative options, including a more expensive setting, where a third party is willing and able to make a top-up payment.
- 3.35 In some local areas (particularly, Northern Ireland), the LA will pay the full amount to the provider (including the top-up) and recoup top-up payments from the third party. In other areas, the third party will pay the top-up to the provider directly. In these cases, the LA may or may not have knowledge of the top-up, which can lead to problems (see Section 11 paragraphs 11.49-11.52).
- 3.36 Third party top-ups can promote choice for residents with friends or families who have the financial resources to make additional payments. For residents who are offered only one fully-funded option by the LA, a top-up will be the only way to have a choice of more than one home.
- 3.37 Top-up payments account for a small proportion of the fees paid for LA placed residents. However, we consider that by giving some people more choice, top-up payments have the potential to promote competition, investment and innovation to the benefit of all LA residents (ie not just those

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<sup>88</sup> Department of Health, (March 2016, as amended), [Care and Support Statutory Guidance](#), paragraph 8.37. Note that a Personal Budget is the amount the LA calculates as needed to meet a person’s needs and, therefore, the amount for which it should be able to secure the required care.

<sup>89</sup> 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.

who make these payments). In particular, top-up payments are likely to increase the number and range of homes interested in competing for LA placements. Top-up payments can also be a mechanism for rewarding more attractive care homes, and an incentive for care homes to invest in facilities or locations for which people are prepared to make a top-up payment. However, it is important to stress that a top-up 'must always be optional and never as a result of commissioning failures leading to a lack of choice'.<sup>90</sup>

3.38 We recognise that there are concerns and risks associated with top-ups such as:

- (a) the cost for LAs to administer top-up payments, recovering debts, and the liability for further payments where third parties are no longer able to pay;
- (b) A lack of clarity for residents and their friends and families around top-up payments (for example, what they are getting in return for the additional payments) is added to the difficulties they face in understanding their choices and so making good decisions;
- (c) the anxiety and distress caused by a concern that failure to make the payment (for example, as a result of change in financial circumstances) could result in a resident having to move to another less costly home; and
- (d) a perception that the system is 'unfair' as only those residents with friends and family able to make top-up payments have a real choice of care home.

3.39 We consider that these risks should be addressed if top-ups are applied in accordance with the Care Act Statutory Guidance. For example, LAs must: examine the ability of people to maintain top-up payments when determining whether to agree to a top-up;<sup>91</sup> provide information to help parties understand their top-up;<sup>92</sup> ensure the third party is willing and able to meet the cost of the top-up and use written agreements to record details of the top-up.<sup>93</sup> We also consider that LAs should administer 'top-up' payments and

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<sup>90</sup> Department of Health, (March 2016, as amended), *Care and Support Statutory Guidance*, paragraph 8.37.

<sup>91</sup> Department of Health, (March 2016, as amended), *Care and Support Statutory Guidance*, paragraph 9.49.

<sup>92</sup> Paragraph 3.43 of the *Care and Support Statutory Guidance*, states that LAs must provide information to help people understand what they may have to pay, when and why and how it relates to people's individual circumstances.

<sup>93</sup> Annex A paragraph 23 of the *Care and Support Statutory Guidance* states that LAs must ensure that the person paying the 'top-up' is willing and able to meet the additional cost for the likely duration of the arrangement, recognising that this may be for some time into the future, and that LAs must enter into a written agreement with the person paying the 'top-up' and that this must, amongst other things, include a statement on the consequences of any changes in the financial circumstances of the person paying the 'top-up'.

actively discourage LA-funded residents and their representatives from entering any agreement with a provider for a top-up without the agreement of the LA. This gives them greater awareness of the fees accepted by providers and the possible risks associated with third parties being unable to pay at some later date. Consumers may also benefit from LAs being better informed and better placed to negotiate competitive terms, as well as being less likely to be exposed to more onerous terms than would otherwise be imposed on the LA by the care home.

- 3.40 We are making various recommendations on how the Care Act Statutory Guidance should be clarified in relation to the details on top-ups in Section 12 (paragraphs 12.99-12.110).

## Conclusion

- 3.41 We have found that LAs face certain pressures when procuring care home services. Notably, increasing financial pressures combined with increasing demand for care for older people, and more local pressures such as the limited availability and capacity of care home places in their areas. We have found that LAs take different approaches to managing these pressures in their approach to the procurement of care home places, for example, in how they contract with providers, determine fees and address quality and choice. Significantly, we have found that:
- (a) whilst spot purchasing accounts for the majority of placements in the UK, block contracts can be a more effective means for LAs to secure required investment in care home capacity;
  - (b) the use of electronic platforms in procurement are administratively efficient and some concerns relating to the use of dynamic purchasing systems can be addressed in the system design of electronic platforms;
  - (c) carrying out cost of care exercises can be helpful in fostering 'buy in' from LAs and providers to negotiated prices and giving LAs a better understanding of the local market conditions and the sustainability of their procurement policies;
  - (d) LAs are looking at ways of better rewarding quality in the procurement process, but their ability to choose a home with quality above a minimum standard may be limited by financial constraints and the availability of places in the better quality homes; and
  - (e) top-up payments have the potential to promote competition, investment and innovation to the benefit of all LA residents (ie not just those who

make these payments) and the risks for LAs associated with top-ups should be addressed by LAs following the Care Act Statutory Guidance.



## 4. Financial performance and future sustainability

### Background

- 4.1 Providers, regulators and industry analysts have raised concerns with us about the financial sustainability of the care homes industry.<sup>94</sup> In particular, they have suggested that many care homes, particularly those that are most reliant on LA-funded residents, are not currently in a sustainable position.
- 4.2 They have attributed this to low LA fee rates<sup>95</sup> and increasing staff costs.<sup>96</sup> Other reported difficulties faced by the industry include recruitment and retention of care workers<sup>97</sup> and nurses, potential inefficiencies of some smaller providers, and high levels of debt in certain provider groups.
- 4.3 In this section, we present our analysis of the financial sustainability of the industry. We have undertaken an extensive profitability analysis of the sector using information provided directly by care home providers and taken from company accounts. We understand this is the most complete study of profitability in the sector in recent years.
- 4.4 Finally, we make some observations on the challenges to the recruitment and retention of staff and, in particular, the nursing staff requirements in Northern Ireland.

### ***Stakeholder views regarding LA fee rates and funding shortfall***

- 4.5 In its 2015/2016 report, the CQC said that the sustainability of the adult social care industry in England was approaching a 'tipping point'.<sup>98</sup> In its 2016/2017 report, the CQC welcomed the £2 billion made available by the Chancellor of the Exchequer in the Spring 2017 budget as a recognition of the pressure the sector was under (see paragraph 2.16), but its overall position remained unchanged. The CQC's report covered both England in aggregate and regional trends. The report stated that in some areas of the

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<sup>94</sup> The independent sector, which, covers profit and not-for-profit providers such as charities, is responsible for operating almost all care homes in the UK. Only very few care homes are state operated.

<sup>95</sup> We have been told that LA fee rates have reduced in real terms over the past several years. See appendix D, paragraph 5 and paragraph 2.15.

<sup>96</sup> Staff costs have been increasing, due to increases in the National Minimum Wage and National Living Wage.

<sup>97</sup> Care workers refer to paid staff. This differs from carers, who can be unpaid such as family members.

<sup>98</sup> A point where deterioration in quality would outpace improvement and there would be a substantial increase in people whose needs were not being met. this based on five pieces of evidence – on quality, bed numbers, market fragility, unmet need and LA funding.

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

country, social care provision had moved further away from a tipping point, and in other areas it had moved closer to that point.<sup>99</sup>

- 4.6 Other parties have referred to the build-up of a significant ‘funding shortfall’ in respect of LA-funded residents that would need to be addressed for the industry to be sustainable. For example, a market analysis firm, LaingBuisson, estimated that the funding shortfall<sup>100</sup> in the care homes industry<sup>101</sup> in England was £1.3 billion a year.<sup>102</sup> The ADASS response to the CMA Update Paper stated that adult social care in England would be underfunded by £2.3 billion a year by 2020.<sup>103</sup> Providers have told us that similar funding shortfalls apply throughout the UK. In our analysis, we define the funding shortfall broadly as the extent to which LA fee rates must increase to ensure the sustainability of the industry.

### ***Increasing costs of running a care home***

- 4.7 The operation of care homes is staff intensive, with labour costs typically accounting for around 50-60% of a providers’ revenue. A sizeable proportion of staff employed in the industry earn close to the National Living Wage.<sup>104</sup> Consequently, increases in wage rates, both in the general economy and in respect of statutory minimum wages, have the potential to reduce the operating profit margins of providers across the UK, unless fee rates also adjust to compensate for this.
- 4.8 Providers have told us that they have been particularly affected by the recent increases in the National Minimum and National Living Wages. Recent and prospective developments for the UK are shown in Figure 4.1.

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<sup>99</sup> [https://www.cqc.org.uk/sites/default/files/20171017\\_stateofcare1617\\_report.pdf](https://www.cqc.org.uk/sites/default/files/20171017_stateofcare1617_report.pdf)

<sup>100</sup> An estimate of the average fee per resident paid by LAs less LaingBuisson’s estimate of reasonable total costs.

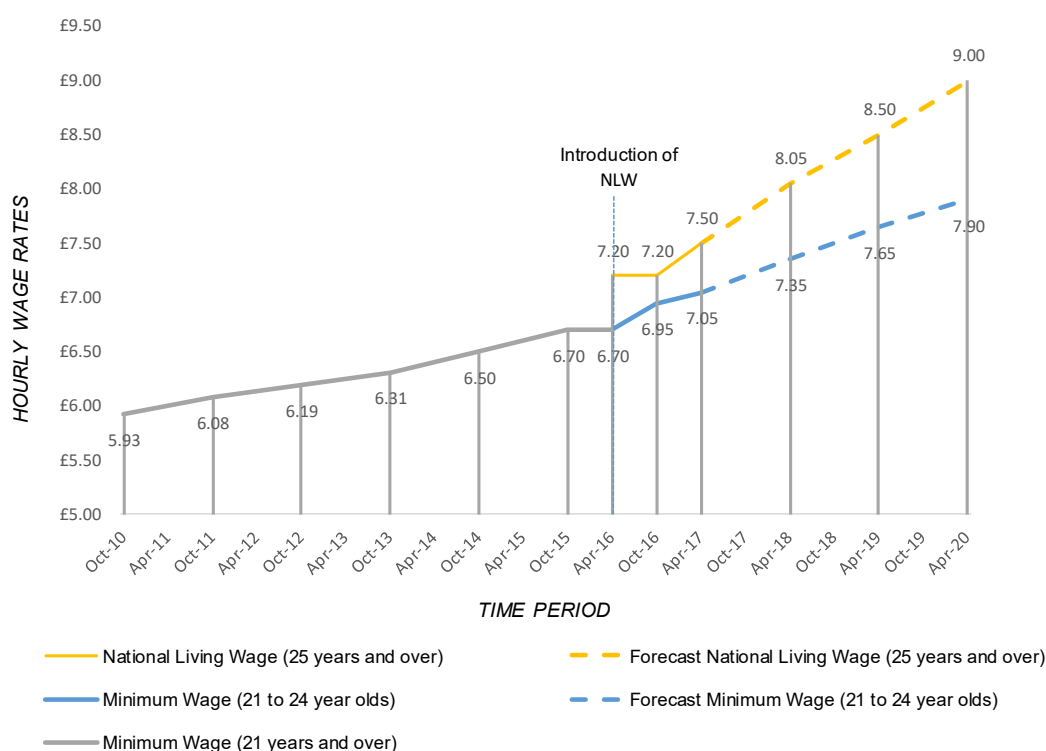
<sup>101</sup> The description of a ‘funding shortfall’ was specifically with regards to the LA-funded segment.

<sup>102</sup> LaingBuisson news (January 2017), ‘[Care home funding shortfall leaves self-funders filling £1.3 billion gap](#)’.

<sup>103</sup> [ADASS submission](#).

<sup>104</sup> Staff who were previously below the National Living Wage floor have now been brought up to at least the National Living Wage floor; and those staff at, or just above, the National Living Wage floor have, in some cases, also been given pay increases to maintain wage differentials.

**Figure 4.1: National Minimum Wage and National Living Wage historic rates and forecast rates 2010 to 2020 for the UK**



Source: [Current and historic rates](#); forecast rates: [Office for Budgetary Responsibility, Economic and Fiscal Outlook Supplementary Fiscal Tables – March 2016, Table 1.19.](#)

## Our analysis of the sustainability of the industry

4.9 We have performed a profitability analysis of the industry, which forms the majority of our analysis presented in this section. In addition, we have also assessed the:

- (a) financial risk faced by providers arising from high levels of debt (see paragraphs 4.52-4.57);
- (b) potential inefficiencies arising from the fragmented nature of the industry, with many microbusiness providers (see paragraphs 4.58-4.60); and
- (c) challenges to the recruitment and retention of staff (see paragraphs 4.61-4.67).

4.10 We first explain briefly the approach we have taken to assess the profitability of the industry. A more detailed explanation is provided in Appendix D.

## ***Approach to assessing profitability***

- 4.11 In running a care home, providers incur both operating and capital costs, which together can be termed, 'total costs'.
- 4.12 The operating costs of running a care home are the day to day expenses such as staff costs, consumables and maintenance. The capital cost is the capital employed multiplied by the required rate of return (return on capital), which is the return that investors require to invest in a business. This return is required both to cover the cost of providing finance and a margin to reflect the risk taken by investors.<sup>105</sup>
- 4.13 The capital cost is an actual cost for the provider, and it has a cash flow impact. For example, holders of debt finance are paid interest and equity investors are paid dividends. However, the capital cost is not directly measurable, and is therefore not part of the reported operating costs in the profit and loss accounts of providers. We have used a rate of return (on capital) of 6.5% in our economic profitability analysis and our estimate of the gap between LA fee rates and total costs. This is lower than the rates required by some private equity investors, but consistent with what we would expect investors to require based on our analysis of other markets. We explain the basis for this approach in Appendix D.<sup>106</sup>
- 4.14 The capital employed should, in principle, be based on the market value of care home assets such as land, building, and equipment. This is because the market value reflects what those assets could be sold for, as an alternative to using the assets for their current purpose in the care home.<sup>107</sup>
- 4.15 We have analysed the levels of 'operating profit', which is equal to revenues less operating costs, and 'economic profit', which is equal to revenues less total costs, including capital costs.
- 4.16 Where revenues from operating a care home are sufficient to cover the operating costs and to result in an operating profit, but are insufficient to

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<sup>105</sup> This relates to the time value of money. The essence is that an amount of money (eg £100) is worth more to an investor today, than the same amount of money on any given date in the future. This applies to both public and private sector investments. The public sector applies a discount rate of 3.5% with regards to its investments. The discount rate is used to convert all costs and benefits to 'present values'. See [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/220541/green\\_book\\_complete.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf)

<sup>106</sup> See Appendix D, paragraphs 138-155. We have estimated the required rates of returns based on comparisons with return from the CC's private healthcare investigation, and in regulated sectors.

<sup>107</sup> For our analysis, we have based the capital employed on actual market values, which we obtained from the larger providers. For example, we have estimated the land and building values for the industry based on market value submissions from large providers across the UK. For equipment, we have used estimates of £8,000-£15,000 per bed, based on submissions from a large provider. See Appendix D for further details.

cover the total costs and therefore result in an economic loss for providers, then:

- (a) providers will be able to continue to operate in the short term, or until such time that the assets would need replacing. The replacement of assets might arise out of wear and tear, or out of requirements to meet quality standards. Where a care home is generating an economic loss, investors would not build new capacity, and would not have the incentive to undertake capital expenditure in existing homes; and
- (b) some investors in existing care homes may choose to exit the market. For example, investors may be better off shutting a care home and selling the property assets at market value, rather than keeping the care home open.

4.17 On the other hand, if revenues are higher and sufficient to cover total costs (ie economic profit), and this is expected to continue in the future, then investors will remain in the industry, and are likely to be willing to undertake further capital expenditure.

### ***Profitability analysis***

4.18 We have undertaken a detailed profitability analysis of the industry. This includes an assessment of the trends in revenues, costs and profit margins. We have analysed the effect of LA fee rates on profitability, and the consequential funding shortfall (see paragraphs 4.46-4.48). This section should be read alongside Appendix D, which provides further details on the methodology, datasets and terminology.

4.19 We have obtained data from two complementary<sup>108</sup> sources, both covering UK wide data. As a result, we have been able to draw together an assessment of profitability based on the widest possible evidence base. The sources are:

- (a) Companies House financial dataset: We have used the audited financial statements for 5,763 care homes companies.<sup>109</sup> We understand that this

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<sup>108</sup> The two datasets complement each other. Some of the large providers, for whom we have obtained financial information, do not file their group consolidated accounts with Companies House, and are thus excluded in the Companies House financial dataset. However, these group level findings are included in the large providers' dataset.

<sup>109</sup> The dataset covers 2010 to 2016, although there were half the number of filed accounts in 2016 as not all companies had filed accounts by the time of this study. The average annual revenues that we used from this dataset was £10.4 billion from 2010 to 2015, and the dataset included just under three quarters of the estimated market size of £15.9 billion. Our financial analysis excludes the results of the smallest of the care home businesses (ie microbusinesses). These providers file abridged accounts, which excludes information of profits or

is the largest dataset that has been used for financial analysis of the industry; and

- (b) Large providers' dataset. We have obtained detailed financial information from 2015 to 2017<sup>110</sup> from 26 large providers. This includes the financial information of approximately 2,000 care homes operated by these providers ('care home level data').<sup>111</sup>

### *Industry operating profits*

- 4.20 We have analysed the industry's overall operating profit between 2010 and 2016.<sup>112</sup> Figure 4.2 below shows the trends in revenue, operating costs and operating profit margins, using the Companies House financial dataset. It indicates that the industry, in aggregate,<sup>113</sup> consistently generated positive, but not high, operating profit margins that have been broadly stable between 2010 and 2016.

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losses.<sup>109</sup> The financial results for microbusinesses should not be significantly different from the industry average (see paragraphs 4.58-4.60).

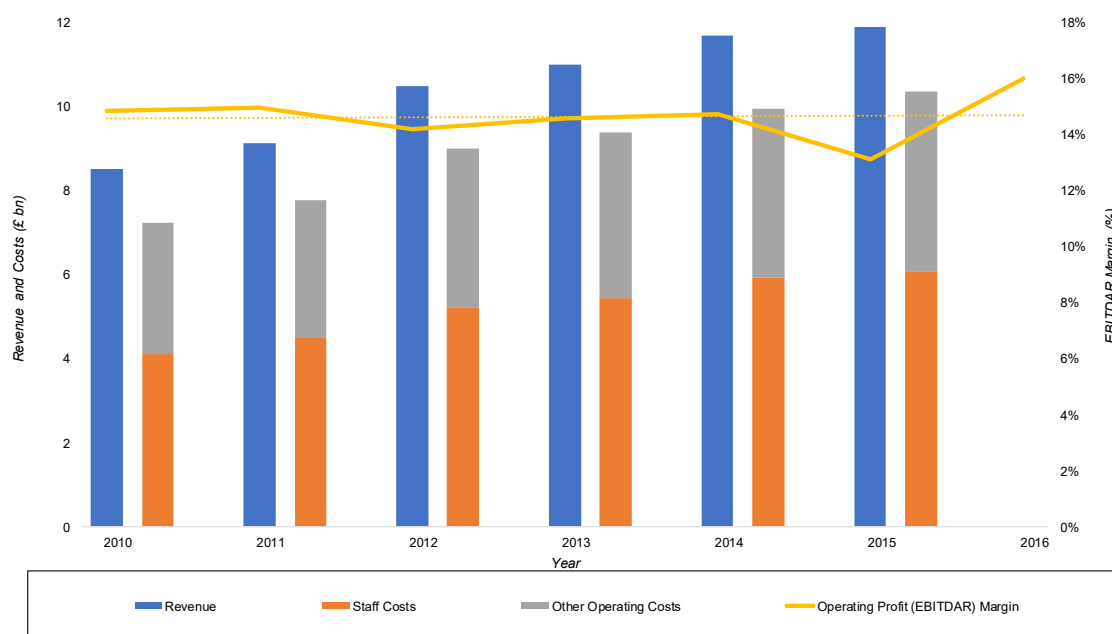
<sup>110</sup> We have used their actual results for 2015 and 2016, and forecasts for 2017.

<sup>111</sup> This dataset allows us to identify the resident mix of providers and individual care homes. It also includes data on the differing fees paid by LA-funded and self-funded residents within these care homes. The average annual group revenue for these providers during this period was £4.3 billion, thus comprising nearly a third of the estimated market size measured by revenue.

<sup>112</sup> See Appendix D, paragraphs 24-39 for further details on the aggregate profitability analysis.

<sup>113</sup> This includes providers focused on LA-funded and self-funded residents.

**Figure 4.2: Aggregate industry operating profits, 2010–2016**



Source: CMA analysis of P&L information of Companies House financial dataset.

Note:

1. This analysis includes the effects of self-funded and LA-funded residents on profitability.
2. We have excluded the disclosure of aggregate revenues and costs for 2016 because not all companies had filed their financial statements with Companies House during the course of our analysis (see Appendix D, paragraph 10a).
3. The yellow dotted line represents the trend in the operating profit margin between 2010 and 2016.

- 4.21 Using the large providers’ dataset, we also found that operating profit margins, in aggregate, were stable between 2015 and 2016, and are forecast to increase between 2016 and 2017.
- 4.22 The results from both datasets indicate that aggregate operating profit margins have held up, despite the reported challenges arising from LA fee levels (see paragraph 4.5), and increasing wage rates (see paragraph 4.8).
- 4.23 This is because annual increases in operating costs have been matched by similar increases in revenues (Figure 4.2). Our analysis suggests that increases in industry revenue have primarily been driven by increases in fee rates. Our analysis of the large providers’ dataset shows that the average fee per year paid by self-funded, NHS-funded and LA-funded residents increased from 2015 to 2016.<sup>114</sup> We understand that NHS Funded Nursing Care<sup>115</sup> payments increased significantly in 2016;<sup>116</sup> and more recently,

<sup>114</sup> See Appendix D, Figure 13.

<sup>115</sup> See paragraph 11.35 for an explanation of NHS funded nursing care.

<sup>116</sup> <https://www.gov.uk/government/news/nhs-funded-nursing-care-rate-for-2016-to-2017>

increased some LAs have increased fee rates in response to increasing wage costs.<sup>117</sup>

- 4.24 Several large providers have also told us that their operating profit margins increased in 2016, or are forecast to increase in 2017, because of higher occupancy levels and rationalisation on staff costs, for example by reductions in the proportions of agency staff which they employ.

#### *Industry economic profits*

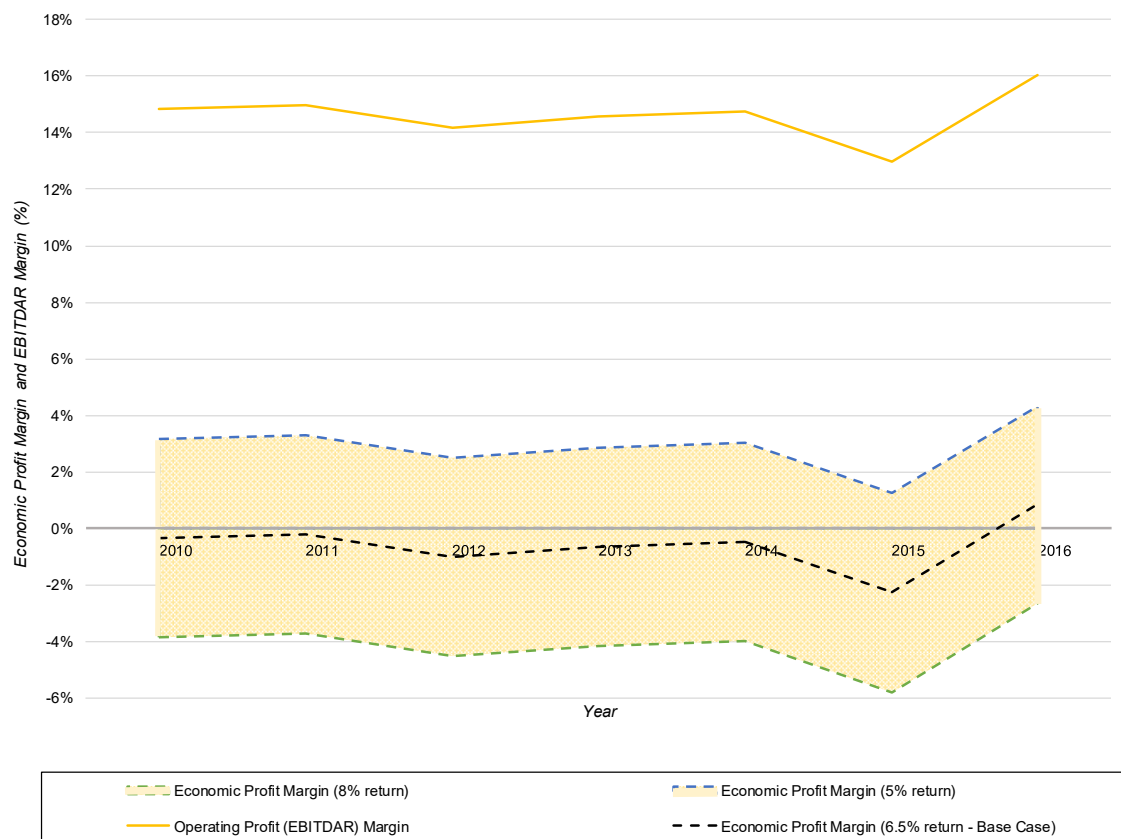
- 4.25 We now assess the economic profits of the industry. Economic profit is calculated by deducting total costs (operating cost and capital costs) from revenue. Figure 4.3, which illustrates the economic profits for the industry, is based upon the operating profits from Figure 4.2, adjusted to reflect capital costs. The operating profit line (yellow) in Figure 4.3 has been included for illustrative purposes.

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<sup>117</sup> Illustrated by the findings in the [ADASS 2017 Budget Survey](#), which showed that providers including those with LA-funded residents reported increasing fee rates between 2016/17 and 2017/18 (Figure 21).



**Figure 4.3: Aggregate industry economic profits, 2010–2016**



Source: For accounting profits: CMA analysis of P&L information of Companies House financial dataset; for economic profits: as above, and asset valuations based on submissions from some large providers.

Notes:

1. This analysis includes the effects of self-funded and LA-funded residents on profitability.

2. Note: Economic profit = EBITDAR – Capital cost. I.e. the gap between the operating profit margin (yellow) line and the economic profit margin (black dotted line) is explained by the capital cost expressed as a percentage of revenue.

4.26 Figure 4.3 indicates that the industry, in aggregate,<sup>118</sup> has consistently made close to break-even levels of economic profits between 2010 and 2016.

Specifically, the yellow shaded area shows the range of potential economic profits and losses depending on the applied rate of return of between 5% to 8%.<sup>119</sup> The black dotted line shows the economic profits and losses using our base case of 6.5% rate of return.

4.27 Our conclusion based on Figure 4.3 is that investors, in aggregate, have earned actual returns broadly consistent with their expected returns. These results suggest that the industry in aggregate has, by a narrow margin, remained financially sustainable over the past few years.

<sup>118</sup> This includes self-funded residents and LA-funded residents.

<sup>119</sup> See Annex D, paragraphs 138-155 for further details.

4.28 This assessment is also consistent with our findings that the number of care home beds in the industry have remained broadly constant, with no significant decline over the past few years (paragraph 2.20), and that there has been no evidence of an increase in financial strain on providers.<sup>120</sup> This stability is unsurprising because industry revenues have broadly equalled total costs, which indicates break-even levels of economic profits.

*Profitability of providers and care homes: LA-funded and self-funded residents*

4.29 The aggregate profitability results (Figures 4.2 and 4.3) do not reflect any variation in performance among different providers and care homes. Results vary across providers and an important reason for this variation in performance is that LA fee rates have been low relative to self-funded resident rates (see paragraph 2.40). We have assessed the impact of lower LA fee rates on operating and economic profits for care homes with different resident mixes of residents, which comprise LA-funded residents and self-funded residents.

*Operating profits: LA-funded and self-funded residents*

4.30 Our results show that providers and care homes with the highest proportions of LA-funded residents have, generally, earned lower operating profit margins, while those with the highest proportions of self-funded residents generated higher margins. We have used three approaches in assessing the issues using both datasets.<sup>121</sup>

4.31 First, we considered the profitability of corporate groups (ie by ownership structure) using the large providers' dataset. We found that the 26 providers in the large providers' dataset collectively generated average EBITDAR<sup>122</sup> margins of 21% between 2015 and 2017.<sup>123</sup> The providers in the dataset that generated the greatest proportions of revenues from LA-funded residents<sup>124</sup> earned significantly lower average EBITDAR margins at 17%. Their margins were lower than the margins earned by providers with higher proportions of

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<sup>120</sup> The number of insolvencies in the industry between 2010 and 2016 was stable and very low at approximately 44 per year, ie around 0.1% providers in the industry. The gearing levels in the sector have also been stable. See Appendix D, paragraphs 76-90 and 117-120.

<sup>121</sup> See Appendix D, paragraphs 43-46.

<sup>122</sup> Earnings before interest, tax, depreciation, amortisation and rent; a measure of operating profitability.

<sup>123</sup> Calculated using actual reported figures for 2015 and 2016 and forecasts for 2017.

<sup>124</sup> Greater than 67% revenue from LA-funded residents at the Group level using the large providers' dataset.

self-funded residents (and consequently lower revenue generation from LA-funded residents) that earned average EBITDAR margins of 27%.<sup>125</sup>

- 4.32 Second, we considered profitability at the care home level using the large providers' dataset. Our results show that these approximately 2,000 care homes collectively generated average EBITDARM<sup>126</sup> margins of 27% in 2015 and 2016. Those care homes with the highest proportions of self-funded residents generated significantly higher average EBITDARM profit margins at 37%, compared to the care homes with highest proportions of LA-funded residents that only generated average EBITDARM margins of 22%.<sup>127</sup>
- 4.33 Finally, we used region as a proxy to identify the resident mix of small and medium sized companies (SMEs) using the Companies House financial dataset. This approach is explained in Appendix D paragraphs 109-111. Our results show that the average operating profit margin for these SMEs was approximately 15% between 2010 and 2015. However, companies in regions with relatively higher proportions of LA-funded residents earned lower average EBITDAR margins at 13%, and companies in regions with mixed<sup>128</sup> proportions of residents, and consequently lower proportions of LA-funded residents, generated higher average EBITDAR margins of 17%.<sup>129</sup>

*Operating profits at a care home level: resident mix*

- 4.34 Given our finding that the proportion of LA-funded residents is a driver of the profitability of care home providers, we performed a more detailed profitability analysis at the care home level using the large providers' dataset. Our results are presented in Figure 4.4. The purpose of this analysis is to understand the effect of LA fees on operating profit, which we

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<sup>125</sup> For the purposes of the group level analysis using the large providers' dataset, providers with the highest proportions of LA-funded residents had greater than 67% revenue from LA-funded residents at the group level. Providers with the greatest proportion of self-funded residents had between 40% to 63% revenue from self-funded residents at the group level using the large providers' dataset. No provider generated more than 64% of its revenue from self-funded residents.

<sup>126</sup> As EBITDAR, but it excludes central management fees. The EBITDARM margin (paragraph 4.32) is higher than the EBITDAR margin (paragraph 4.31) because EBITDARM because it excludes these central costs.

<sup>127</sup> For the purposes of this care home level analysis, care homes with highest proportions of LA-funded residents had greater than 75% LA-funded residents within each care home using the care home level data from the large providers' dataset; and care homes with the highest proportions of self-funded residents had greater than 75% self-funded residents within each care home using care home level data from the large providers' dataset.

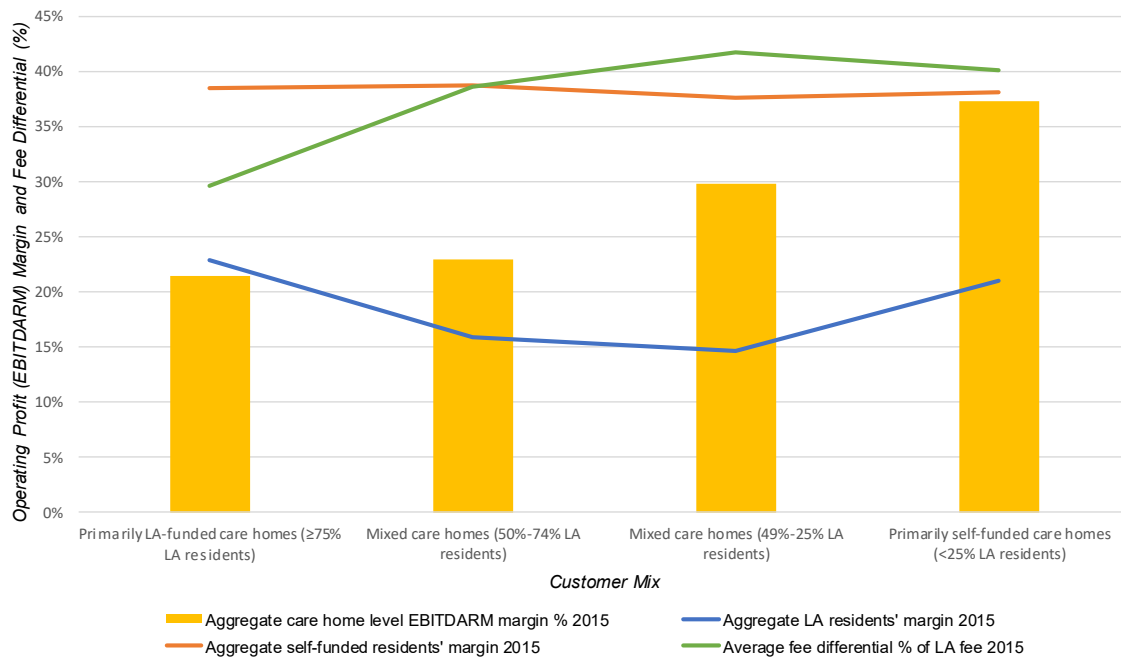
<sup>128</sup> Mixed regions include both LA and self-funded residents.

<sup>129</sup> For the purposes of this analysis using the Companies House financial dataset, we allocated companies to regions with higher proportions of LA funded residents if that region had greater than 60% LA-funded residents. Similarly, we allocated companies to regions with lower proportions of LA-funded residents if that region had less than 60% LA-funded residents.

can measure at the level of the individual care home.<sup>130</sup> We have tested this by separating care homes into the following resident mix segments:

- (a) primarily LA-funded care homes (greater than or equal to 75% LA-funded residents within a care home);
- (b) mixed care homes (50-74% and 25-49% LA-funded residents within a care home); and
- (c) primarily self-funded resident care homes (less than 25% LA-funded residents within a care home).

**Figure 4.4: Operating profits of care homes with differing proportions of LA-funded residents, 2015**



Source: CMA analysis of the large providers' dataset.

4.35 Our results in Figure 4.4 show that the:

- (a) aggregate operating profit margins are lower in care homes with proportionately more LA-funded residents. In other words, as care homes increase the proportions of self-funded residents, their operating profits increase (amber bars);
- (b) aggregate operating profit margins generated from self-funded residents (red line) are significantly higher than those generated from LA-funded

<sup>130</sup> We have used EBITDARM to assess the profitability at the care home level.

residents (blue line). This result holds across each of the resident mix segments of care homes. However, aggregate operating profit margins generated from LA-funded residents are lowest in mixed care homes (blue line); and

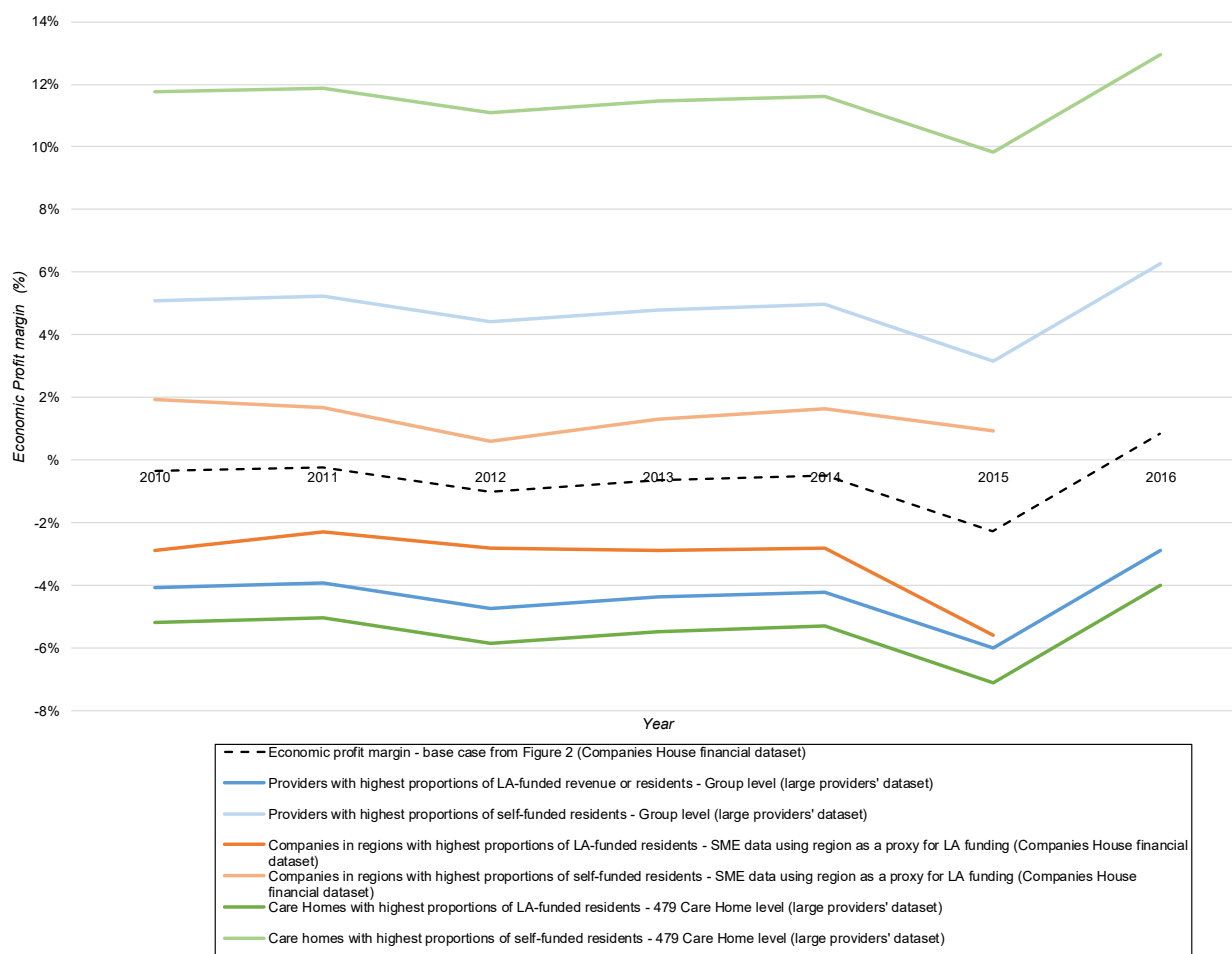
(c) the result in (b) is driven by the fee differential between LA-funded residents and self-funded residents, which is highest in mixed care homes (green line). We have found that the key driver of profitability is most likely to have been lower fee rates paid by LAs compared to self-funded residents (see the discussion of fee differentials in paragraph 2.40).

4.36 In the next section, we illustrate the effect of the relationship between operating profit margins and the number of LA residents on the economic profit earned by different groups of care homes. Our analysis indicates that operating profits from LA residents have been below average, and that there has been a reliance on self-funded residents to ensure financial sustainability across the industry, especially through higher fees charged to self-funded residents. This reliance on higher fees for self-funded residents is most pronounced in homes with a mix of self-funded and LA-funded residents.

*Economic profits: LA-funded residents and self-funded residents*

4.37 Figure 4.5 illustrates different measures of the economic profits of providers and care homes with the greatest proportions of LA-funded and self-funded residents. The split between self-funded resident providers and LA-focused providers has been made on a similar basis as described in paragraphs 4.30-4.33.

**Figure 4.5: Economic profits of providers and care homes focussed on LA and self-funded residents, 2010-2016**



Source: CMA analysis of P&L information of Companies House financial dataset and P&L and asset valuations based on submissions from some large providers.

Note:

1. We have used a 6.5% return for the base case and all modelling of scenarios.
2. Economic profit = EBITDAR – Capital cost.
3. See Appendix D Figure 4 for details on methodology used.

4.38 Figure 4.5 shows that providers and care homes with the highest proportions of LA-funded residents<sup>131</sup> have made economic losses; and those with the highest proportions of self-funded residents<sup>132</sup> have made economic profits for each of the years between 2010 and 2016.

4.39 In other words, the care homes and providers with the greatest proportions of LA-funded residents have generated adequate revenues to cover their operating costs (see paragraphs 4.30-4.31). These homes have, on

<sup>131</sup> Companies in regions with greater than 60% LA funded residents, providers with at least 70% revenue from LA funded residents and care homes with at least 70% LA funded residents.

<sup>132</sup> Companies in regions with less than 60% LA-funded residents, providers with 40% to 63% revenue from self-funded residents and care homes with at least 70% self-funded residents.

average, been operationally viable in their ability to meet day-to-day expenses. However, they have not been economically viable in terms of being able to provide a sustainable return to investors, ie a positive economic profit, which would be required for investors to provide the level of capital required for ongoing modernisation and investment in new assets for the longer term (see paragraph 4.15).

- 4.40 This implies that these providers can be expected to remain in the industry only until they require significant levels of capital expenditure on their assets. These providers and care homes have been and can continue to operate profitably<sup>133</sup> until such time.
- 4.41 On the other hand, the results suggest that the providers with the highest proportions of self-funded residents are most likely to be sustainable. These providers and care homes have economic incentives to remain in the industry and to invest in new capacity that is targeted at self-funded residents. Providers have told us that new investment has been almost entirely directed at care homes focused primarily on self-funded residents, and not LA-funded residents (see paragraph 4.17).<sup>134</sup>

#### ***The relationship between LA fee rates and total costs of care***

- 4.42 We have used the data presented above on fee rates and capital costs for different care home providers, together with our analysis of capital costs, to estimate the difference between LA fee rates and the total cost to providers of delivering care to LA-funded residents.
- 4.43 Based on our analysis as illustrated in Figures 4.3 and 4.5 above, we have estimated that the total gap between LA fees and the total costs for those LA-funded residents across the UK is in the range of £0.9-1.1 billion. We describe in Appendix D the methodology and the assumptions we have used.
- 4.44 We found in Figure 4.3 above that the sector, in aggregate, has been covering its total costs, ie that economic profit has been close to break-even levels. Given that LA fees have been below total cost, this indicates, consistent with Figure 4.4, that this is offset by self-funded resident fee rates being above total cost.

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<sup>133</sup> In that they have generated positive operating profit margins.

<sup>134</sup> We have seen a few instances where local authorities have offered investors a) non-fee incentives such as the allocation of free land; and b) long term certainty on fee rates by way of block contracts, see paragraph 6.51, and Appendix D, paragraph 5a.

4.45 In homes with primarily LA-funded residents, the result of this is that revenues have been lower than total costs, and this threatens the sustainability of these homes. In mixed homes, the analysis indicates that the gap between LA fees and costs is largely offset by higher fees charged to self-funded residents. However, we also expect that, where there has been a significant gap between fees and total costs, the financial sustainability of the current level of provision of LA capacity within mixed homes will come under threat. This is consistent with evidence provided to us, that investment in the sector is primarily focused on homes, or in areas, with large proportions of self-funded residents. This creates a risk whereby there is a need to replace or enhance existing care homes, but the level of investment targeted at LA-funded residents is insufficient to maintain existing levels of capacity.

#### *Funding shortfall in primarily LA-funded care homes*

4.46 Our analysis shows that the immediate threat to financial sustainability is in the homes primarily serving LA-funded residents. These homes rely on state funding, and we have found that the level of funding has not been sufficient to cover total costs in these homes.

4.47 We have estimated the size of this gap, which can be viewed as a funding shortfall, by analysis of the gap between LA fees and cost for LA-funded residents in those homes with the greatest reliance on LA-funded residents, ie the segment with 25% or lower self-funded residents. Our analysis suggests that about a quarter of care homes have more than 75% of their residents LA-funded, and that these are the ones most at risk of failure or exit because of a funding shortfall. We estimate that LA-fees are currently, on average, as much as 10% below total cost for these homes, equivalent to around a £200-300 million shortfall in funding across the UK. This finding is based on an average result - there will already be a proportion of operators that are struggling and at risk of closure.

4.48 In the absence of action to ensure that these care homes are covering their total costs, we would expect to see a gradual reduction in the capacity available as some providers exit the market over a number of years. To be sufficient, this level of additional funding would need to be focused specifically on those care homes most reliant on LA-funded residents.

#### *Gap in mixed care homes*

4.49 We also expect that, where there is a significant gap between fees and total costs, the financial sustainability of the current level of provision of LA capacity within mixed homes will come under threat. This is consistent with



evidence provided to us, that investment in the industry is primarily focused on homes, or in areas, with a large proportion of self-funded residents.

- 4.50 We have estimated that the funding shortfall with regards to LA-funded residents in mixed care homes (ie 25-74% LA-funded residents) ranges from £700-800 million. We observe that most of the gap between LA fees and total cost is within mixed homes because, looked at in total, this segment has the highest numbers of LA-funded residents. We also found that the difference between fees and costs per resident is higher in these homes, possibly reflecting that there is greater ability of LAs to negotiate lower fees for homes with a greater proportion of self-funded residents to offset the costs.

#### *Future developments in the need for additional funding*

- 4.51 The size of the funding shortfall in the future will depend on several factors, such as:
- (a) the projected growth in the care home population of between 1.4% and 2.8% annually between 2015 and 2025 (see paragraph 6.3);
  - (b) increases in staff costs (Figure 4.1);
  - (c) the increasing levels in the acuity of need; and
  - (d) whether care for the elderly can be effectively provided outside of care homes and the use made of these other options, including the use of technological innovation in the provision of care.

#### ***Other issues relating to financial sustainability***

- 4.52 In the rest of this section, we consider some other issues raised by various parties relating to the financial sustainability of the industry.

#### *Risks due to debt*

- 4.53 Some parties raised concerns about the high levels of financial gearing (debt), and off-balance sheet<sup>135</sup> risks in the industry, especially among some of the large providers that are owned by private equity funds. High levels of debt (gearing) can increase the financial risk profile of a provider, and a default on debt obligations could trigger an insolvency.

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<sup>135</sup> These are liabilities that do not appear on a provider's balance sheet, but could materialise. In the care homes industry, off balance sheet liabilities could originate from sale and leaseback transactions.

- 4.54 We have reviewed evidence of the levels of debt in the sector. Our financial analysis shows that:
- (a) the level of debt in the industry is not particularly high, when compared to net assets,<sup>136</sup> and it has fallen between 2010 and 2015;
  - (b) debt is more heavily concentrated in large companies, compared to small and medium sized companies; and
  - (c) debt is not concentrated in either private equity owned providers, or non-private equity owned providers.
- 4.55 We would not normally expect care home providers to face significant levels of financial risk, unless it is due to very high levels of borrowing, where providers are required to make very large fixed debt payments out of operating profits. Cash flow management for care homes, with moderate levels of debt, is generally straightforward and carries relatively low levels of risk. Our analysis suggests that risks arising from debt are unlikely to pose a significant threat to the overall financial sustainability of the industry.
- 4.56 However, certain highly geared providers may be carrying unsustainable levels of debt, and therefore may be at risk of default or financial distress. As detailed in paragraphs 5.4 and 5.7, the CQC (and equivalents in the devolved nations) undertake a market oversight function to monitor the financial viability of large and significant providers. This process challenges providers who may be at risk, and potentially warns LAs when they are going to need to take action to provide continuity of care to residents in homes at risk.
- 4.57 The decision to take on higher risk debt is at the discretion of the provider, and is not a requirement to operate in the industry. The majority of providers do not have very high levels of debt. Even if a provider with a risky capital structure became unable to meet its debt obligations, we expect that if the underlying business and care homes within the portfolio of that provider were operationally sound, other care home providers would be interested in purchasing those care homes. We would not expect that financial difficulties resulting from high levels of gearing would necessarily result in a large scale and permanent exit of capacity. However, we do acknowledge that in the event of a financial failure there could be a risk of disruption to residents while LAs step-in to ensure continuity of care provision.

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<sup>136</sup> Net assets are total assets minus total liabilities.

### *Potential inefficiencies arising from the fragmented nature of the industry*

- 4.58 It was put to us that the fragmented nature of the industry with thousands of microbusinesses could suggest that these providers are relatively inefficient.<sup>137</sup> In other words, they have higher operating costs, per resident or as a proportion of revenue, compared to larger care homes.
- 4.59 Overall, a well-functioning market encourages efficient providers. Moreover, markets can offer suppliers a variety of different possible models. There are reasons why small providers can be as efficient or more efficient than larger providers. The evidence that we have gathered suggests that the microbusinesses have several countervailing strengths that supports their financial viability:
- (a) many microbusiness providers are owner managed with the owners and their family members often working on site. They are less impacted, compared to larger providers, by increases in the National Minimum and National Living Wage.
  - (b) many microbusinesses have relatively low cash costs in respect of property. We understand that a sizeable proportion of microbusiness providers either have relatively low or no mortgage payments. This is because many of these properties were purchased many years ago, and thus their mortgages would be based on historic property valuations or paid off entirely.
  - (c) smaller care homes tend to provide a higher quality of care. They are less likely to receive a poor-quality rating from the CQC, and therefore are at less risk of being put out of businesses due to a low rating.
- 4.60 There are also benefits from operating large chains with large care homes. For example, a large care home has the potential to have a lower operating cost per resident. However, the scale of this benefit is not overwhelmingly significant in the wider context of the key drivers of profitability. For instance:
- (a) staff costs represent a significant 50% to 60% of revenue. However, staff numbers vary with the number of residents in small and large care homes. Also, minimum numbers of staff are required to maintain the quality of service. Thus, the ratio of staff to resident would not significantly differ between small and large care homes. This presents

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<sup>137</sup> Microbusiness providers are the smallest operators in the industry. Their size ranges from a single care home with a few beds to a provider with a few care homes with few beds. They also tend to be owner managed businesses.

limited opportunities to reduce staff costs or have significantly lower staff costs per resident even in large care homes;

- (b) opportunities to achieve cost savings in large care homes arise in non-staff cost overheads such as consumables, and maintenance costs. However, our analysis suggests that these represent a small proportion of revenue; and
- (c) large providers, unlike smaller operators, also incur significant management charges and group level (eg head office) expenses. Our analysis suggests that this ranges from 5% to 10% of their group revenue. In other words, these costs reduce their operating profit margins by this range.

### *Challenges to the recruitment and retention of staff*

- 4.61 Regulators, providers and industry analysts have submitted that the recruitment and retention of staff is a significant challenge for the industry, and that this is likely to become acute soon. They have highlighted that it is already acting as a constraint on providers to expand or for potential providers to enter the industry.
- 4.62 In particular, we understand that providers in the UK are facing significant challenges to recruit frontline workers such as: care workers, managers and especially nurses. We have heard that the challenges to recruit nurses are acute in Northern Ireland, and in certain rural areas of Scotland.
- 4.63 We have been told that these UK wide challenges have been driven by several factors: demanding work conditions, and the lack of a structured career path and pay levels. This has resulted in providers increasing their reliance on costly agency staff, or in some instances limiting their ability to operate or expand.
- 4.64 These challenges have been amplified by the unfavourable public perceptions of the industry following media reports such as those about care workers mistreating residents. This may have resulted in potential care workers and nurses viewing the industry as a less attractive career option.
- 4.65 Looking forward, a sizable proportion of frontline staff are from overseas including from the European Union. Providers have told us that they are already experiencing challenges to recruit and retain such staff due to the UK's planned exit from the European Union, and that this is expected to increase. They stress that this challenge could be augmented without adequate safeguards in place for providers to recruit frontline staff from overseas.

- 4.66 We note that some of the causes that make it challenging to recruit and retain staff in the care homes industry also affect the wider economy. Therefore, we are not making specific recommendations to address those causes.
- 4.67 We have also heard of ongoing initiatives in the industry to improve recruitment and retention of staff:
- (a) In England, Skills for Care has been developing training for care staff,<sup>138</sup> and the National Audit Office has been reviewing labour issues in the social care industry;<sup>139</sup>
  - (b) In Scotland, the Scottish government has been developing a National Health and Social Care Workforce Plan;<sup>140</sup> and
  - (c) In Wales, Welsh government has been developing a programme to *'raise the profile and status of social care workers, through improving employment conditions and remuneration, so social care becomes a positive career choice, where people are valued and supported responsibly.'*<sup>141</sup>

#### *Nursing staff in Northern Ireland*

- 4.68 The Care Standards for Nursing Homes (2015)<sup>142</sup>, which are published by the Department of Health in Northern Ireland (DH NI), currently require 'a minimum skill mix of at least 35% registered nurses and up to 65% care assistants over 24 hours'.<sup>143</sup> The sector regulator, RQIA, is responsible for ensuring that these standards are met in nursing homes. We recognise that the intention of this standard is to ensure that the number and ratio of staff on duty at all times meet the care needs of residents.
- 4.69 However, providers have raised concerns about this staffing ratio requirement in Northern Ireland. They have told us that because of the pre-existing difficulties to recruit and retain nurses in Northern Ireland, the staffing ratio could:

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<sup>138</sup> [Skills for Care: Care certificate.](#)

<sup>139</sup> [National Audit Office: Adult social care workforce.](#)

<sup>140</sup> [Scottish Government: National Health and Social Care Workforce Plan.](#)

<sup>141</sup> [Welsh Government: Programme for government.](#)

<sup>142</sup> [The Care Standards for Nursing Homes \(2015\)](#)

<sup>143</sup> See standard 41, page 119, criterion 4 (These are written under the provisions of Article 38 of the Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 which gives powers to the DH NI to publish minimum standards that the RQIA must take into account in the regulation of establishments and agencies.

- (a) prevent nursing homes from operating efficiently;
  - (b) require nursing homes to use agency nursing staff at very high cost; or
  - (c) prevent nursing homes from being able to operate, and result in closure.
- It also acts as a barrier to entry and expansion of nursing homes.

4.70 In particular, some providers have told us that the staffing ratio specified in the Standard could diminish the ability of providers to reduce the operating costs of their nursing homes, as they may need to hire greater numbers of registered nurses than necessary to meet the needs of their residents. They have said that the ratio could even diminish the quality of service provision, as a nursing home may be unable to recruit an additional care assistant to improve the quality of service provision without hiring additional nurses. Non-nursing roles may not then be optimally staffed. It could also result in registered nurses being more likely to spend a greater proportion of their time doing non-nursing activities, without necessarily increasing the quality of care.

4.71 It is not clear whether the ratio of carers and nurses as set out in the Standard provides an assurance that residents will receive adequate nursing care since it does not itself prescribe the level of nursing (and other) care residents should receive. Other measures are, therefore, necessary to ensure that the required level and quality of care is provided.

4.72 The Care Standards for Nursing Homes already require that ‘at all times suitably qualified, competent and experienced staff are working at the nursing home in such numbers as are appropriate for the health and welfare of the patients’.<sup>144</sup> Hence, it is not clear that a nursing ratio requirement adds to the protections to patients this offers.

4.73 We also note that restrictions on the role of care assistants in the other nations are, potentially, becoming more relaxed. At the same time, they are ensuring that the care home staff in place are “suitably qualified, competent and experienced”. For example:

- (a) England has introduced the function of Enhanced Care Assistants who can undertake certain tasks under supervision that were previously carried out by registered nurses, thus reducing operating costs and freeing up nursing time;

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<sup>144</sup> See standard 41, criterion 2 of The Care Standards for Nursing Homes.

- (b) Skills for Care in England has sought to work with care home providers to help develop the workforce and co-created the Care Certificate with Health Education England and Skills for Health as a basis for career and learning and development progression (paragraph 4.67(a));<sup>145</sup>
  - (c) England has the role of Nursing Associate, which bridges the gap between a healthcare assistant and a registered nurse. Nursing Associates are expected to deliver care in primary, secondary, community and social care, and training will give them clinical knowledge and skills to support registered nurses;
  - (d) the Care Inspectorate in Scotland has enabled some care homes to test changes to the skill mix of their workforce, including the use of an Enhanced Senior Carer Role<sup>146</sup>; and
  - (e) CSSIW in Wales has proposed changes to the regulations so nursing homes do not always need nurses to be present on site 24 hours a day.
- 4.74 We are not aware of concerns that these approaches have diminished the quality of care that residents receive and the relevant sector regulators fully accept the important role nurses play in clinical leadership in homes.
- 4.75 We fully accept the need to ensure the safety and care of residents in nursing homes. However, in the light of providers' concerns and the approaches being taken in the other nations, we suggest that DH NI consider:
- (a) undertaking a full review of the staffing ratio requirement for nursing homes, and
  - (b) whether there is scope for other care professionals to take on some functions, under suitable nursing supervision, in light of the difficulties currently faced in recruiting and retaining nursing staff.

## Conclusion

- 4.76 The key findings from our analysis are that the:
- (a) industry operating profit margins been positive and have been broadly stable between 2010 to 2016. Operating costs have been increasing, but

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<sup>145</sup> [Skills for Care: care certificate.](#)

<sup>146</sup> [Care Inspectorate's response to update paper](#), p4, June 2017. Care Inspectorate states 'we are aware of the specific challenges around nurse recruitment and have supported some care homes to test an enhanced senior carer role to support the staffing mix within the home. That said, we recognise the importance of the nurse role in clinical leadership and the centrality of that role in many – but not all – care homes.'

this has been matched by increases in revenues. This suggests that the industry, in aggregate, has been generating adequate operating profits to continue trading, at least for the short term;

- (b) industry, in aggregate, has just about covered its total costs during the same period. This suggests that industry, in aggregate, has generated adequate revenues not only to continue operating, but also to maintain existing levels of investment;
- (c) primarily LA-funded care homes, in aggregate, have covered their operating, but not total costs. This suggests that while these care homes may continue to operate in the short term, they may not be able to undertake future investments in order to: update their existing capacity when required; prevent closure; or increase their capacity towards LA-funded residents;
- (d) therefore, unless LA fee rates are increased in the short term for primarily LA-funded care homes, there are risks to their sustainability in the medium term. We estimate that this funding shortfall ranges from £200 million to £300 million; and
- (e) our best estimate of the total gap between LA fees and costs across all homes ranges from £900 million to £1,100 million (approximately £1 billion). This includes mixed resident care homes, which have remained financially viable by charging higher fees to self-funded residents than for LA-funded residents within the same care home. There are risks to the sustainability of this operating model.

4.77 The demand for care home spaces, including spaces for LA-funded residents, is expected to increase in the future. This should be a signal to investors to develop new capacity for LA-funded residents. However, the evidence that we have gathered suggests that this has not been happening. Our analysis shows that this is because LAs, in aggregate, have been paying fees that have been below total cost, in part as costs have increased and LA fees have not increased at the same rate. We consider that this is the key factor affecting the profitability and sustainability of the industry.



## 5. Recommendation on market oversight

5.1 This section sets out our recommendation relating to market oversight.

### Market oversight framework

- 5.2 If providers become unable to continue to deliver care to people because of business failure, LAs must 'step in' and make arrangements for anyone affected so that their needs carry on being met. LAs must do this for everyone in their area whose care needs were previously being met by a failed provider.
- 5.3 The financial problems which Southern Cross Healthcare Group plc, a major care home group, faced in 2011 clearly highlighted the risk that LAs might find themselves in a position of having to make arrangements for a large number of displaced residents at once. This prompted the government to explore what could be done if another large or highly specialised care business failed and, specifically, how to prevent the people using its services being adversely affected.
- 5.4 In England, the statutory Market Oversight Scheme<sup>147</sup> was established in 2014 and this requires the CQC to assess the financial sustainability of those care organisations that LAs would find difficult to replace should they fail and become unable to carry on delivering a service.<sup>148</sup>
- 5.5 The CQC is required to inform LAs where these services are delivered as soon as it believes that business failure is likely to happen, and that such failure is likely to result in a cessation of service provision. By giving a warning of likely failure giving rise to probable service cessation, the Scheme will help LAs to carry out their statutory duty to ensure continuity of care when providers fail.
- 5.6 The CQC requires regular provision of detailed financial and operating information from such providers to allow it to monitor their health. If there are any concerns, the CQC increases the intensity of its monitoring activity.<sup>149</sup>
- 5.7 The devolved nations have alternative arrangements:

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<sup>147</sup> Sections 53 to 57 of the Care Act 2014.

<sup>148</sup> The Care and Support (Market Oversight Criteria) Regulations 2015 ((SI 2015/314) set out the criteria for entry to the scheme. The criteria relate only to how difficult a provider would be to replace and bear no relation to any judgement of actual or potential risk of failure.

<sup>149</sup> CQC (March 2015), [Market Oversight of 'difficult to replace' providers of adult social care: Guidance for providers](#).

- (a) Wales plans to implement a similar regime to the market oversight scheme in England, from 2019;<sup>150</sup>
- (b) Scotland does not have a statutory regime, but the Care Inspectorate collects intelligence about the operation and performance of all care home providers. Scotland also has a National Contingency Planning Group. This includes representatives of COSLA, Scotland Excel, Care Inspectorate, providers, contract leads and IJBs; and
- (c) In Northern Ireland, there is no statutory market oversight body. The Department of Health in Northern Ireland and Health and Social Care Board regularly communicate with key operators to gauge possible supplier failure. The RQIA monitors and inspects the quality of care in a range of bodies, including care homes, and encourages improvements in the quality of those services.<sup>151</sup>

5.8 We have identified a potential weakness in these arrangements. While CQC's financial oversight activities look at the financial performance of care groups, other oversight is generally undertaken at a national level so this tends to cover oversight of care homes, operated by cross-national providers, only within each respective nation. Therefore, there is a lack of oversight of the group level results of providers that operate in more than one nation (cross-national providers). It is possible that a significant financial risk could arise in one nation, which would be a threat to the overall group, but this may not be picked up in the other nations. Such risks could arise from, but may not be limited to, unsustainable levels of debt taken on at the group level, or off-balance sheet risks.

### ***Recommendation on market oversight***

5.9 We are therefore making a recommendation to the Departments of Health in England, Wales, Scotland and Northern Ireland that mechanisms be set up for the sharing of critical information and market intelligence among the relevant national regulators and other bodies to facilitate continuity of care for residents.

5.10 The purpose is to provide early warning in each nation of the potential failure of key providers who operate across the nations.

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<sup>150</sup> The Regulation and Inspection of Social Care (Wales) Act 2016 (sections 59 to 62) which will come into force in April 2018 and will be implemented in various stages by April 2019.

<sup>151</sup> In addition, in December 2016, former Health Minister Michelle O'Neill commissioned an Expert Advisory Panel on Adult Care and Support to identify proposals for change.

- 5.11 We consider that the four governments, regulators and other bodies would have to work collaboratively and with stakeholders in order to reach the outcome described in paragraphs 5.9 and 5.10.
- 5.12 We consider that the national governments, regulators and other bodies in the UK are well placed to determine how best to implement the recommendation, and so we recommend that the detail of the method of implementation should be agreed between them. Possible options include:
- (a) each nation to do its own work but share its intelligence with others;
  - (b) one body to review the financials of the same cross-national providers, but at a UK group level.
- 5.13 The key risks are that the need for sharing of information between them could result in significant complications, particularly where there may be sensitive information relating to a provider that is largely based in one country. There would need to be clear legal arrangements relating to under what circumstances it might be appropriate for information gathered in relevance to one nation to be passed to another.
- 5.14 We consider that the set up and running costs with regards to providing more sharing of market intelligence would not be significant if the approach at paragraph 5.12(a) is followed. The costs would be outweighed by the greater efficiency gains and by the benefit of continuity of care for residents.

## 6. Meeting future care needs

6.1 Sections 3 and 4 have looked at how the state currently procures care home services and the sustainability of this provision. In this section, we look at how future care needs are expected to evolve and the current arrangements for forecasting and planning for those changes. We look at evidence on investment and barriers to investment.

### Future demand for care

#### *Projections on need for care*

6.2 There are various published academic and industry forecasts of future demand for care homes, as well as forecasts of the key underlying drivers of demand for care homes. These underlying drivers include factors such as the number of older people and health and disability rates.

6.3 We have reviewed projections of demand for care home places from four sources: The Personal and Social Services Research Unit (PSSRU), LaingBuisson, Newcastle University and Institute of Public Care (IPC).<sup>152</sup> For comparison we have also undertaken our own calculations based on population growth figures from The Office for National Statistics (ONS).<sup>153</sup> All four forecasts and our own calculations indicate that demand will increase, but there is a wide range in the level of growth projected.<sup>154</sup>

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<sup>152</sup> The Personal and Social Services Research Unit (PSSRU): Wittenberg R and Hu B, PSSRU, Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015 to 2035, 2015. LaingBuisson, Care of Older People UK Market Report 27th edition, 2016. (Behind Paywall). Newcastle University: 'Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies (CFAS)', Kingston A, Wohland P, Wittenberg R, Robinson L, Brayne C, Matthews FE, Jagger C; Cognitive Function and Ageing Studies collaboration ('Kingston et al'). The Lancet, 2017 ('the Newcastle Study'). Institute of Public Care, Oxford Brookes University, 'Projecting Older People Population Information' (POPPI), 2017.

<sup>153</sup> Office of National Statistics – National population projections, 2015 (Table A2-1); Changes in the Older Resident Care Home Population between 2001 and 2011, 2014. The percentage of each age group of older people residing in the care homes in the ONS paper 'Changes in the Older Resident Care Home Population between 2001 and 2011' is applied to the projected number of older people in each age group in 2015, 2020, and 2025. These percentages only cover England and Wales and use a different definition of 'a person residing in a care home' to the other sources.

<sup>154</sup> The studies on demand for care homes which we reviewed applied different methodologies and assumptions, in terms of base year, estimates of the current care home population, geographical areas, and propensity for older people to enter care homes. To aid comparison across the sources, we standardised the projections to a common base year (2015) and geographical coverage (the UK). The PSSRU, the Newcastle Study Kingston and IPC POPPI projections only cover England. The other two projections cover the entire UK. The PSSRU, ONS, Kingston et al Laing-Buisson, and IPC POPPI papers all include projections for 2025.

- (a) The care home population is projected to grow between 1.4% and 2.9% annually between 2015 and 2025 (or by 14%-34% in total over the period).<sup>155</sup>
- (b) The number of care home residents is projected to increase by between 63,000 and 119,500 between 2015 and 2025.
- (c) Based on these studies, the number of care home residents could reach over 500,000 by 2025.<sup>156</sup>

6.4 In consequence, the public cost of providing LA-funded care home provision will increase in line unless there is some reform of the system. On simple illustrative extrapolation of current LA-expenditure on care homes using the growth rates in paragraph 6.36.3(a), implies an additional cost increasing to £1 to 2 billion a year by 2025, based on current fee rates.<sup>157</sup> This does not take account of any other potential changes in care homes costs or any possible future revisions to public policy.

6.5 People aged 85 and over make up the majority of the care home population<sup>158</sup>. All the demand forecasts that we have reviewed relied on the ONS projections of population growth which project that:<sup>159</sup>

- (a) the number of people aged 85 and over will increase at an annual rate of 3.1% between 2015 and 2025;
- (b) the total number of people aged 85 and over will increase by 36% between 2015 and 2025, from 1.5 million to 2 million; and
- (c) in the longer term, the growth rate of the older population will accelerate and the number of people aged 85 and over will grow at an average annual rate of 4.62% between 2025 and 2035.

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<sup>155</sup> Assuming a constant growth trend over the period.

<sup>156</sup> LaingBuisson projects the lowest growth of care home population, mainly because it assumes that the proportion of older people going to care homes will fall as they move towards other forms of care. By contrast, the other studies assume a constant proportion of older people going into care homes.

<sup>157</sup> This result is based on projections of increased demand for care homes of between 14% and 34% between 2015 and 2025, see paragraph 6.3. The cost estimate is based on current expenditure by English, Scottish and Welsh LAs on care homes for the elderly with a pro-rata adjustment for Northern Ireland (see paragraph 2.12). It does not take account of care user contributions, eg from pensions. See paragraph 2.12.

<sup>158</sup> 60% of residential home residents are aged 85+, while 48% of nursing home residents are aged 85+. Source: LaingBuisson, Care of Older People UK Market Report 27th edition, 2016, page 167.

<sup>159</sup> The ONS also publishes projections of the number of older people up to 100 years in the future. They are updated every two years, based on changes in assumptions regarding fertility, migration, and deaths in future years. Historical ONS projections have underestimated the number of older people, and have proved very inaccurate over long time periods.

- 6.6 Some studies have also considered other factors that influence the demand for care homes. People usually enter a care home because of disability.<sup>160</sup> The length of time someone spends in a state of high dependency before death determines the amount of time they spend in a care home. Increases in life expectancy will only result in increases in care home demand if the average number of years people spend in a state of high dependency also increases.
- 6.7 A study by public health and policy academics, published in *The Lancet*, projected that the number of older, disabled people in England and Wales will increase by 25% between 2015 and 2025 at an average annual growth rate of 2.3%.<sup>161</sup> The main finding of the study was that this life expectancy increase is associated with an increase in the number of older people who are disabled, because more of the additional years are spent with a disability.<sup>162</sup> The study projects that life expectancy at age 65 will increase by 1.7 years between 2015 and 2025, and that an average of 0.7 years of this additional life expectancy will be spent with a disability.<sup>163</sup>
- 6.8 If an increasing number of people in each age group are disabled, the proportion of each age group residing in a care home would be expected to increase.<sup>164</sup> The LaingBuisson and PSSRU projections (which assume falling and constant proportions respectively) might underestimate care home demand as a result.
- 6.9 There are likely to be variations across local areas in the average amount of time older people spend with severe disabilities, due to variations in diet, exercise, and other lifestyle choices. This means that a given number of older people in one area could have very different demands for care home places than those in another area.<sup>165</sup>

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<sup>160</sup> Some self-funded individuals enter a care home setting as a lifestyle choice, before they have a severe disability.

<sup>161</sup> Guzman-Castillo M, Ahmadi-Abhari M, Bandosz P, Capewell S, Steptoe A, Singh-Manoux A, Kivimaki M, Shipley M J, Brunner E J, O'Flaherty M, 'Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study', 2017, *The Lancet*. ('Guzman-Castillo' et al)

<sup>162</sup> The paper assumes that the proportion of people in each age group with cardiovascular disease or dementia will decrease over time. This reduction in cardiovascular disease and dementia will result in more people living to advanced ages, so people will live long enough to become disabled (whereas before they may have died of a heart attack at a younger age).

<sup>163</sup> Guzman-Castillo et al projects that total life expectancy at age 65 will increase from 20.1 years to 21.8 years between 2015 and 2025. The average duration of this time which is spent without a disability is expected to increase from 15.4 years to 16.4 years, while the average duration with a disability is expected to increase from 4.7 years to 5.4 years. The Newcastle Study presents similar results, using a different methodology.

<sup>164</sup> The Newcastle Study also calculates the total number of older people with disabilities, but bases its definition of disability on different criteria to Guzman-Castillo et al. The Newcastle Study also projects the number of additional care home places required, based on the increase in the number of older disabled people.

<sup>165</sup> The nature of the disability also influences the cost of care in the care home.

- 6.10 There are many other factors that influence the size of the care home population besides growth in older population and disability rates, which we discuss qualitatively in the following paragraphs.
- 6.11 In its State of Care report, the CQC noted that people are living longer with increasing health issues resulting in greater, more complex demand for health and social care in England.<sup>166</sup>
- 6.12 One of the main influences is government policy. For example, a drive to keep people independent for as long as possible has led LAs to increasingly consider alternative forms of care (see paragraphs 6.40-6.42).
- 6.13 Other influences on care home demand that are discussed in the studies we have reviewed, (some of which feed into the PSSRU model), are as follows:
- (a) preferences of self-funders for alternatives to a care home, such as domiciliary care, or sheltered housing;
  - (b) home ownership rates and house prices. This will influence the number of self-funders and the funding they have available for care, which, in turn, will have an impact on demand. This could be significant if self-funders continue to enter care homes with lower levels of need as has been suggested by some LAs;
  - (c) marriage and co-habitation rates. A spouse or partner can sometimes act as a carer for someone who would otherwise need to enter a care home;
  - (d) trends in the size of the informal care sector. Children or relatives can act as carers, providing an alternative to care homes; and
  - (e) improvements in technology, allowing people to stay at home for longer. For example, monitoring of residents at home and tele-care might allow people to remain in their homes for longer.<sup>167</sup>
- 6.14 As set out above, it is difficult to forecast the impact that these factors will have on the demand for care home places with any precision. However, there is little doubt that demand for care will increase, in the near future, as the first of the baby-boom generation reach the 85 and over group, a proportion of whom will require LA-funded care.

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<sup>166</sup> CQC (2017), [The state of health care and adult social care in England, 2016/17](#).

<sup>167</sup> [Which?](#) describes telecare as follows: 'Telecare systems are designed to give warning to a call centre or carer if there is a problem in risk areas such as a fall, inactivity or fire, floods and gas leaks and can be tailored to suit the needs of the individual. They are especially valuable for people with dementia.'

## ***Changing nature of care needs***

- 6.15 As well as increases in the number of care home beds that will be needed, there is also likely to be a shift to people in care homes having more acute needs.
- 6.16 Several providers and LAs told us that residential homes are caring for residents who a few years ago would have been in nursing homes, and that those who would in the past have been in residential homes are only receiving domiciliary care.
- 6.17 This is consistent with what LAs have told us. Firstly, LAs have been implementing policies to enable people to remain at home longer, such as giving advice on home improvements and introducing more innovative options such as tele-care. Secondly, LAs have been encouraging the use of alternative care options, such as extra care housing.
- 6.18 This shift towards care home residents having more acute needs has an impact on the type of care homes that are needed. In particular, there is a growing need for care homes that provide nursing care and can accommodate residents with dementia.
- 6.19 Many care homes require investment to remain suitable for the needs of their residents. Just under half of care home beds are in homes that were purpose built.<sup>168</sup> The layout of homes that were not purpose built may be less suitable for residents requiring nursing care, or those with dementia. The majority (72%) of care homes were first registered between 20 and 30 years ago,<sup>169</sup> and another 5% were registered more than 30 years ago.<sup>170</sup> The extent to which these older care homes have been modernised is not known. However, according to a report by Knight Frank, there are 250,000 rooms in care homes that do not have en-suite bathrooms.<sup>171</sup>

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<sup>168</sup> CMA analysis of LaingBuisson and Caredata.co.uk datasets indicates that, as of December 2016, 35% of care homes (containing 46% of UK beds) are in purpose build care homes, reflecting the tendency for purpose built care homes to be larger than care homes that are not purpose-built.

<sup>169</sup> Here 'first registered' refers to the earliest date the premises were known to be used as a care home. The ownership of the care home can change without affecting the first registration date.

<sup>170</sup> Source: CMA analysis of LaingBuisson and Caredata.co.uk datasets.

<sup>171</sup> Knight Frank 2015 report [Care Homes Trading Performance Review](#) states that 'structural under supply of bedroom capacity which is further accentuated when one considers the vast amount of poor existing stock....it would cost circa £15bn to upgrade the 250,000 non en-suite bedrooms to wet room status. The quality of the existing built environment remains a major concern but is further compounded by only circa 6,000 new care beds constructed per annum and an ageing population' p11.



## Approaches to forecasting

- 6.20 In England, LAs have ‘market shaping’ duties, which mean that they must ‘encourage and facilitate the whole market’ in their area for care, support and related services.<sup>172</sup> In doing so, they must ensure that they are ‘aware of current and likely future demand for such services’ and ‘have regard to the need to ensure that sufficient services are available for meeting the needs for care’.<sup>173</sup>
- 6.21 NHS Clinical Commissioners in England face a similar need to ensure services for their patients, but do not have market shaping duties. However, they purchase fewer beds (see paragraph 2.25). Depending on how far integration with LAs has progressed, forecasting future demand may be a joint exercise.
- 6.22 LAs are encouraged to publish a Market Position Statement (MPS), to signal to the market the likely need to extend or expand services, encourage new entrants to the market in their area, or if appropriate, signal a likely decrease in needs.<sup>174</sup>
- 6.23 In Wales, LAs and Local Health Boards (LHBs) must also assess the extent of needs for care and support in their area and assess the range of services needed to meet those needs and publish plans setting out how those needs will be met.<sup>175</sup> They must also publish a local market stability report which must include an assessment of the sufficiency of the provision of care and support in the area.<sup>176</sup> These reports will feed into a national market stability report prepared by the CSSIW.<sup>177</sup> Some LAs have produced MPSs in the past as an aid to effective commissioning.<sup>178</sup>
- 6.24 Responsibility for local social care planning resides with IJBs in Scotland. Each IJB must produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over the period of the plan.<sup>179</sup> Strategic plans are intended to set out high level information about vision, direction and planned changes along with detailed budgetary plans to support the plans.

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<sup>172</sup> Department of Health (March 2016, as amended), [Care and Support Statutory Guidance](#), paragraph 4.6.

<sup>173</sup> Sections 5(1) and (2) of the [Care Act 2014](#).

<sup>174</sup> Department of Health (March 2016, as amended), [Care and Support Statutory Guidance](#), paragraph 4.34.

<sup>175</sup> Section 14 of the Social Services and Well-being (Wales) Act 2014.

<sup>176</sup> Section 144B of the Regulation and Inspection of Social Care (Wales) Act 2016.

<sup>177</sup> Section 63 of the Regulation and Inspection of Social Care (Wales) Act 2016.

<sup>178</sup> The Institute of Public Care has a template that Welsh LAs can use to produce an MPS.

<sup>179</sup> Section 29(2) of the Public Bodies (Joint Working) (Scotland) Act 2014.

- 6.25 A market facilitation plan, which is a summary of the key requirements to meet current and future demand, should be incorporated within the strategic commissioning plan, stating the level and the type of services required. Market facilitation plans are currently being prepared by IJBs across Scotland.<sup>180</sup>
- 6.26 In Northern Ireland, the HSC Board must prepare and publish a 'commissioning plan' setting out details of the health and social care that the HSC Board intends to commission and the costs involved.<sup>181</sup> The HSC Board Local Commissioning Groups focus on the planning and resourcing of services.
- 6.27 Although there is no legal obligation on HSC Trusts to shape the market, they submit delivery plans in response to the commissioning plans. They also have meetings with providers, but these are usually organised to look at local issues and may cover matters such as recruitment and training.
- 6.28 HSC Trusts and Local Commissioning Groups may work together to carry out a needs assessment in a specific locality and this may shape future commissioning decisions. However, it is unclear whether this process is likely to have much immediate or even medium-term impact on any market.
- 6.29 Several LAs we have spoken to prepare multi-year strategic plans and some forecast ten years ahead. These include forecasts of local demand, and are based on population estimates for the local area and can be supplemented with the LA's knowledge of local demographics.<sup>182</sup> The plans usually cover all adult social care, and therefore look across a range of services which may be able to meet needs of the elderly needing care and incorporate the LA's policies in this area. Some LAs update their plans annually, and others update plans where relevant changes have occurred. The strategic plans are typically internal documents and may therefore not be available to potential investors.
- 6.30 We reviewed the most recent MPSs documents for 20 LAs across the UK to find out what information the LAs were making publicly available.<sup>183</sup> The

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<sup>180</sup> [Strategic Commissioning Plans Guidance](#), page 22.

<sup>181</sup> Section 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

<sup>182</sup> Several LAs in England told us they use IPC POPPI data, which is based on ONS statistics.

<sup>183</sup> Where we refer to MPSs in the rest of this section, we are referring to MPSs in England and the equivalent public documents produced by LAs in Wales, Scotland and NI. While the 20 LAs include areas with diverse demographics across the nations, they are not exhaustive nor necessarily representative of the UK. The size of the care homes market varies considerably between the 20 LAs. The 20 LAs together accounted for around 14% of care homes (13% of beds) in the UK in 2016.

MPSs that we reviewed were published between 2011 and 2017, with 16 published in the last two years.

- 6.31 These 20 MPSs provide a broad outline of the current state of the local markets and general plans for the future. All the LAs expect the number of older people in their local areas to increase. However, none of the MPSs contained projections for the number of older people with care needs or comprehensive details of the investment required to meet these needs. Only one LA provided projections on the need for care home places.
- 6.32 Our review of MPSs also found that:
- (a) the level of detail and sophistication (in terms of published information on understanding and planning for future development) in the MPSs varies across LAs;<sup>184</sup> and
  - (b) nearly all LAs state that they intend to care for more people for longer in their own homes and in the community, and to use prevention or rehabilitation to reduce the need for care home services. Several LAs mention the use of 'extra-care housing' (or similar services) as alternatives to care homes.
- 6.33 The findings from our MPS review were broadly consistent with the findings of the IPC.
- 6.34 We found that, based on the 20 MPSs that we reviewed, we could not evaluate whether LAs could afford to deliver a good outcome for people with eligible care needs.
- 6.35 Moreover, many of these documents lack the kind of evidence and insight that would be useful in helping the private sector determine appropriate investment. In particular, the uncertainty on the level and type of needs going forward increases the risks for potential providers, and thus reduces the likelihood of investment in homes serving primarily LA funded residents.
- 6.36 LAs told us that, aside from MPSs, they communicate regularly with providers about current and future needs, either when placing individuals requiring care, or when the provider is considering modifying existing capacity or building additional capacity. In addition, many LAs told us they

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<sup>184</sup> The level of details covered in MPS varies widely across LAs. MPS cover all aspects of social care. Even when covering adult social care, most of the content of the MPS is not related to care homes, and much of the coverage relates to younger adults.

are open to and are actively exploring new and innovative ideas for meeting care needs.

- 6.37 While they appeared confident in their ability to forecast their demand for services and plan care for their areas, the LAs we spoke to told us that they have limited sight of what is happening in the self-funder sector. We consider that this could lead to missed opportunities for LAs to take advantage of developments in the self-funded sector.
- 6.38 On the basis of our conversations with LAs, we are also concerned that they are typically narrowly focused on their local areas and do not, in most cases, cooperate with neighbouring LAs in planning or optimising capacity, making it more difficult to optimise capacity across their areas (see paragraph 6.23 for developments in Wales).
- 6.39 Finally, it is not clear to us that all LAs have the necessary resources to forecast future care needs effectively. There is considerable variability in the size and resources of LAs, and some have relatively limited understanding of how changes in local demographics will impact on care needs, or of the best options for meeting needs through different types of care. We note that there are some central sources of information, for example on population projections, which LAs can access.

## **Meeting future needs for care**

### ***Alternatives to care homes***

- 6.40 LAs are increasingly looking for alternative care options to meet the needs of older people with eligible care needs. This means that over recent years, the number of LA-funded people in care homes has not increased at the same rate as the number of older people, and in some cases, numbers of placements have been reducing.<sup>185</sup> LAs have been using and promoting investment in alternative services. We do not know how far funding constraints may be the key driver behind these approaches and if so, whether these constraints mean that people do not obtain the most appropriate form of care that they need.
- 6.41 Many LAs have been using and encouraging investment in extra care housing and/or sheltered accommodation. This is also reflected in MPSs documents (see paragraph 6.32). These services cover a wide range of community living alternatives with varying degrees of care and support

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<sup>185</sup> There have been recent reductions in number of people placed in care homes by five LAs. One LA achieved this reduction through preventive services, support for carers, and community care solutions.

available, and are typified by people having their own self-contained apartments with the provision of care separated from the provision of accommodation.<sup>186</sup> LAs are also providing services to support people to stay in their own homes.

- 6.42 Some LAs are providing community based prevention and rehabilitation services, including community services to help people with dementia (examples given were a ‘memory skills group’ and initiatives to develop a ‘dementia friendly community’)<sup>187</sup> and rehabilitation services that teach older people to live independently again after an incident such as after a stroke or fall. Other examples of community services include working more closely with ambulance services to allow people to stay at home, better integration with end of life care, and a support service for Black and Minority Ethnic carers.

### ***Need for investment in care homes***

- 6.43 While there are uncertainties, the evidence outlined above indicates that:

- (a) there will be a need for substantial investment in care homes and alternative facilities to meet the care needs of an aging population;
- (b) many care homes would need investment to meet modern standards; and
- (c) there will likely be a need for investment in capacity with the facilities and staff required to care for people with more acute care needs.

- 6.44 Moreover, while several LAs told us that there are many vacancies in their local areas at any one point in time, many LAs identified capacity shortages in care homes able to take care of people with nursing and dementia care needs.<sup>188</sup> In particular, several LAs told us that:

- (a) they have a shortage of places in care homes able to look after older people with dementia or mental illness in their area;

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<sup>186</sup> The advantages for residents include: accommodation designed for frail and disabled people, on-site care workers, a package that includes maintenance, laundry, guest facilities, gardens, assisted bathing, hairdressing, the ability to keep pets, and tenancy rights. Such housing with care also enables economies of scale for the delivery of care and support, by having people co-located in one site. They offer opportunities for people to engage in activities that prevent or delay care needs from increasing.

<sup>187</sup> The ‘memory skills group’ helps people to develop skills to improve their memory and share ideas on how to improve memory with others. The ‘dementia friendly community’ is a programme run by the Alzheimer’s Society.

<sup>188</sup> One LA told us there are 200-250 vacancies at any time, another that around 10% of beds are vacant, and a third that there are more beds than required in the area, with high numbers of vacant beds at various points in time.

- (b) they have a shortage of places in nursing homes; and
- (c) they have a shortage of places in specialist dementia care homes.

- 6.45 A survey of LAs undertaken by The Family and Childcare Trust in 2017 found that whilst 81% of LAs in the UK said they had enough care home places, only 37% reported that they had enough places in nursing homes with specialist dementia support. The survey also found wide regional variations and no funding authorities in the South West of England or Northern Ireland reported having enough care to meet demand in their area, while in the North East the equivalent figure was 56%.<sup>189</sup>
- 6.46 We were also told by two LAs that they had a shortage of extra care housing. One LA noted the possibility of turning their surplus sheltered housing into extra care housing. The Family and Childcare Trust survey found that in 2017 only 46% of LAs in the UK had enough availability for domiciliary care and 50% for extra care housing.<sup>190</sup> We consider these findings to be relevant for the ability of LAs to deliver their plans to look after more people for longer in community-based facilities.
- 6.47 We are aware that LAs can benefit from investment in care homes focused on self-funded residents. Care home providers and developers told us that when they plan new homes focused on self-funders, they often expect around 20-30% of beds to be taken by LA-funded residents. Furthermore, an LA may find that it has more care home places for residents whom it is funding if a new care home attracts self-funders and thereby frees up space in the existing care homes. However, this capacity is likely to be concentrated in more affluent areas where there are fewer LA-funded residents. There is also no guarantee that the capacity primarily focused on self-funders will be sufficient, of the right type, or in the right location to meet the needs of LAs.
- 6.48 If a lack of investment results in a shortage of capacity, LAs could be forced to increase the fees they pay in order to secure the necessary places to fulfil their responsibilities to people with eligible needs.<sup>191</sup> This would be costly for LAs as they would be competing for capacity with self-funders and may result in some self-funders not receiving the care they need.

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<sup>189</sup> Family and Childcare Trust (November 2017), *Family and Childcare Trust: Older People's Care Survey 2017*. Results were obtained from a Freedom of Information Act request to all 206 English, Scottish and Welsh LAs and all five of the HSC Trusts in Northern Ireland in September 2017. The results are based on self-reported information from 185 LAs which responded.

<sup>190</sup> Family and Childcare Trust (November 2017), *Family and Childcare Trust: Older People's Care Survey 2017*.

<sup>191</sup> Another option is using out of area placements, though this would only work if there is spare capacity in nearby LA areas.

- 6.49 We have also heard concerns that LAs are not identifying the need for investment in capacity early enough. We have been told that LAs are often reactive: only taking steps to address capacity issues once problems occur. We have been told that it can take, at the very least, two to three years to go from finding a suitable site to opening a care home.
- 6.50 A lack of capacity (even if this is only for a short period) for LA-funded care home residents has implications for LAs, the NHS, those with eligible care needs and those self-funding their care. The specific consequences depend on the approach an LA takes to dealing with a shortfall.

### ***What LAs do to ensure sufficient care home capacity***

- 6.51 We found examples of LAs using various solutions to overcome existing shortages in capacity, such as:
- (a) LAs commissioning new care homes;<sup>192</sup>
  - (b) encouraging, or incentivising providers to change registration and/or modify existing space to make small increases to capacity;<sup>193</sup>
  - (c) using a combination of services where shortages are not as severe (or present) to meet needs;<sup>194</sup>
  - (d) placements out of area;<sup>195</sup>
  - (e) higher fee rates for particular services where there are shortages; and
  - (f) block purchasing beds.
- 6.52 However, some of these solutions are mainly focused on the short term, and several utilise existing capacity, thus limiting the number of placements that can be made with the aid of these initiatives.

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<sup>192</sup> One LA has opened a care home primarily for short stays following a stay in hospital, with the aim of maximising the potential for reablement. [The Social Care Institute for Excellence](#) defines reablement as follows: 'Reablement is meant to help people accommodate illness or disability by learning or re-learning the skills necessary for daily living'. Reablement also gives residents time to reach an informed decision about future care. However other LAs told us that the capital required to build a care home is prohibitively high.

<sup>193</sup> One LA told us that having identified a shortage of capacity it contacted existing providers, several of which were able to add a small number of beds each and thus expand existing capacity to cover the immediate shortage. Another had used one-off grants to support providers and increase capacity, and a third told us it is working with providers to encourage them to change their registration to provide dementia care.

<sup>194</sup> One LA told us that it had placed residents in residential homes with provision of district nursing, instead of in a nursing home.

<sup>195</sup> One LA told us that an increase in demand for care home nursing dementia beds resulted in it making placements outside its area.

- 6.53 Even in areas where LA fee levels may be too low to encourage new capacity, there are examples of LAs leveraging assets, such as other care homes or land, and/or using long-term contracts at higher fee rates than generally offered.
- 6.54 Though these are more likely to deliver additional capacity in the longer term, the concern is with the timing. LAs may not implement the initiatives until a shortage arises.
- 6.55 From speaking to LAs and providers, we found that the main challenges LAs faced in implementing initiatives aimed at increasing capacity in the longer term were:
- (a) financial. LAs have limited budgets which need to cover several services, only one of which is social care. In addition, budgets have been decreasing in real terms over the last few years (see Section 2, paragraph 2.12-2.17). Therefore, LAs tend to allocate resources to meet current needs across the range of services covered, at the expense of longer-term planning;
  - (b) political. LAs' priorities tend to be shaped by short-term considerations linked to the political cycle. LAs are held to account on current performance, and therefore their incentives are not always aligned with longer-term needs; and
  - (c) skills/capability. LAs do not always have the right expertise to plan the level and type of care provision needed going forwards, which creates a risk of inadequate or insufficient capacity being built.

## Conclusion

- 6.56 Demand for care home places is forecast to increase in the near future due to demographic changes. Although there is uncertainty over the magnitude of the increase, in particular for LAs, where variables such as home ownership will affect the proportion of older people who will rely on the LA to arrange their care.
- 6.57 As well as increases in the number of care home beds needed, there is also likely to be a shift to people in care homes having more acute needs, which means there is a growing need for care homes that provide nursing care and can accommodate residents with dementia.
- 6.58 Our review of published documents and information gathered through calls with stakeholders found that LAs are typically not publishing sufficient information on their likely future needs for care homes and any



communication of current and future needs is mainly with existing providers. Further, it is not clear to us that all LAs have the necessary resources to forecast future care needs effectively.

- 6.59 LAs are increasingly planning on supporting more people through non-residential care, eg domiciliary care, and are developing strategies with greater focus on prevention and rehabilitation, and alternative care models (such as extra-care housing). Nonetheless, investment will be needed to ensure sufficient provision of care home capacity. We have concerns that LAs are not planning for this capacity early enough, which could potentially have serious implications for LAs, the NHS, and those with eligible care needs.

## **7. Conclusions on meeting future state-funded care needs**

### **Introduction**

- 7.1 In this section we draw conclusions, from the material covered in Sections 2 to 6, on whether we can expect the market to deliver good outcomes for older people with residential or nursing care needs, looking particularly at future needs for state-funded individuals.
- 7.2 In summary, we are concerned over whether:
- (a) LAs will be able to meet the needs of those who require care but cannot self-fund; and whether
  - (b) the market will be able to provide the capacity required by LAs in the future.
- 7.3 Below, we set out our conclusions in relation to these points.

### **Challenges to the sustainability of the sector**

- 7.4 As set out in Section 4, we have found that while the industry overall is covering its full costs, the parts of the care home sector that primarily serve LA-funded residents are receiving returns, on average, below the full cost of provision. While such operators are, in the main, able to cover their operating costs, these returns provide no basis for suppliers to invest further money into the business, for example to maintain and modernise existing care homes, let alone to expand or build new facilities. Without this investment, we anticipate a continuing deterioration in the quality of the existing care home stock primarily serving LA-funded residents, and an increasing number of closures of care homes, as significant capital expenditure is needed.
- 7.5 Moreover, we have found that the financial position of many care homes would be significantly worse if they were not offsetting below cost LA fees with higher fees for self-funders. This applies to some care homes that are primarily serving LA-funded residents, but also those with a more even mix of both self-funded and LA-funded residents (which tend to have the highest levels of price differentials).
- 7.6 However, differentials of this scale will not be sustainable. Where LA rates are below total cost, those care homes that can attract self-funders will eventually move away from serving a mix of residents (and we are seeing

that investment in new capacity is focussed where providers expect to recruit primarily self-funded-residents). We would also expect that self-funded residents would prefer to go to care homes focused on self-funders where available. Therefore, if this price differential persists, we would expect there will be a growing divide in the market over time, between homes increasingly serving only self-funders, and the rest, leading to more rapid closure of capacity in homes primarily serving LAs.

- 7.7 In addition, the sector is subject to increasing cost pressures and operational challenges. Labour costs are increasing, and there are increasing difficulties in attracting and retaining nursing staff, but also care home managers and carers.
- 7.8 Funding pressures on LAs have been reflected in the decline in rates that LAs pay (see paragraph 2.15). We have noted that funding to LAs has declined (see paragraph 2.12), while they have a wide variety of different demands to be met, covering not just social care for the elderly, but also, for example, other aspects of social care, education, housing, highways and the environment.
- 7.9 It is therefore understandable that LAs would seek to push down the fees they pay for care home placements and to prioritise current delivery of public services.<sup>196</sup> Despite the duties on LAs arising from the Care Act 2014 in England, set out in paragraph 3.24, LAs (as they are major purchasers of care home placements) are likely to have considerable negotiating power to force prices down to levels that may not be permanently sustainable. While it is unsurprising that LAs could negotiate a discount on fees (as a sizeable and low-risk purchaser), we would not expect fee rates to be at the level shown in Section 4.
- 7.10 The consequence of these financial challenges is likely to be that LA-focused care homes will be unable to invest, modernise and upgrade their services over time. Instead they will keep operating as currently until a point is reached where major investment is required, at which time we would expect them to close and for the buildings or land to be deployed for different uses. Meanwhile, care homes that are able to attract self-funders will be more likely to seek to specialise in serving that segment. How quickly this is

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<sup>196</sup> LAs may not, in deciding on how best to meet their duties to people with eligible care needs, give full weight to the impact of their decisions on services that they do not fund. One clear example is that looking after more people in their own homes is likely to impose additional costs on community health services (such as GP services) and hospital services. This is a particular problem in England. By contrast, in each of the devolved nations there are integrated health and social care bodies to facilitate joint commissioning, planning and budgeting. Despite some positive examples of integration initiatives (eg Manchester Combined Authority), progress with integration of health and social care has been slower and less successful than envisaged ([National Audit Office: Health and social care integration](#) (8 February 2017)).

likely to happen will vary, according to a wide range of factors including local fee rates and operating costs, the financing costs the care home faces, its ability to attract higher paying self-funders, the efficiency of the particular home, its age, facilities, layout and needs for modernisation.

## **Future needs for care**

- 7.11 Demand for care is forecast to increase substantially in the near future due to demographic changes (see paragraphs 6.2 to 6.19).
- 7.12 There is inevitable uncertainty over the magnitude of the increase and the extent to which this will impact on LA-funded care (for example while the acuity of care needs may increase as more people live longer, the proportion of older people needing care who are home owners is expected to increase). LAs are increasingly planning on supporting more people through non-residential care, eg domiciliary care, which tends to be cheaper up to a limit of need, and are developing strategies with greater focus on prevention, rehabilitation, and alternative care models (such as extra-care housing).<sup>197</sup> While there is a wide range of forecasts, all the forecasts we reviewed still expect a substantial increase in the need for care home spaces (see paragraph 6.3).

### ***Planning for future need***

- 7.13 As noted in paragraphs 6.20 to 6.28, LAs often have specific duties to help facilitate planning in relation to the provision of care. Measures to address this are required because:
- (a) this is a market where the state is a major customer and where there is a policy commitment that all those with eligible needs who cannot self-fund will receive suitable care; and
  - (b) there is currently a high level of uncertainty among providers about the shape of future policy and on the fees LAs will pay (and would continue to pay if investment occurred). Consequently, there will be a reluctance to make investments focused on LA-funded residents. At best, it will become increasingly expensive for LAs to procure care and to encourage the industry to build new capacity for LA-funded residents.

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<sup>197</sup> There is a limit to how far this process of moving away from care homes can be taken before the quality of care is compromised, and there is a risk in the future if funding pressures continue that decisions could be more influenced by relative costs of different types of care.

- 7.14 In relation to England, the requirement for LAs to publish MPSs was intended to give a clear picture of the gaps present in the existing care market. This could be used by providers to inform business choices and plans, such as investment in capital or personnel. However, we have found that MPSs are high-level documents covering all adult social care. Typically, they do not contain forecasts of the need for care home places or comment on the needs for investment.<sup>198</sup> Thus they are not fully effective as a supporting information tool to help the private sector plan investment.
- 7.15 LAs have little ability to take a long-term view where they do not have the resources and certainty of future funding to take long-term measures. We have, however, found some examples of LAs who are aware of long-term capacity challenges in their areas and who have sought to engage with private providers to address shortfalls, eg through providing land, agreeing block contracts, and building and leasing homes (see paragraph 6.53). But LAs have seen substantial cuts in their budgets, or have had to make difficult choices between competing demands on their funds, and many have told us that the lack of sufficient funds is a constraint on their ability to support measures designed to develop long-term capacity. Without such tools to ensure that their actions will shape the market, and as LAs are less obviously accountable for future outcomes as they are for current ones, the incentive on LAs to undertake fully effective planning is reduced.
- 7.16 Based on discussions with LAs and our review of MPSs, it appears to us that some LAs are more sophisticated, engaged, and active than others in this area, and better placed to deal with complexity. Consequently, we have concerns over whether all LAs have the necessary capabilities to develop forecasts of future needs and the best ways of meeting these needs. While there are some sources of information and some sharing of approaches and best practice between LAs, there is considerable variability in their resources. Some LAs, particularly the smaller ones, might not have the financial resources, or the people with the skills or experience needed to undertake the specific tasks adequately. In some aspects of planning, there may be considerable duplication of analysis between LAs (perhaps in relation to aspects of needs forecasting or determining how different types of care might most efficiently meet those needs). As a result, more coordinated support and advice, both in providing information and some aspects of analysis, in advising on process and sharing best practice, would be beneficial.

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<sup>198</sup> Although more detailed information may be found in strategy documents, even this typically does not provide sufficient certainty for potential investors to incentivise investment.

## ***Investment in new capacity***

- 7.17 We observe that there is substantial investment currently in new care home facilities primarily aimed at self-funders, but we have found that investment in capacity primarily aimed at meeting LA-funded residents is very limited. It is possible that LAs will benefit to an extent from some new self-funder focused care homes that have some spare capacity, but the incidence of this will be variable. LAs are therefore unlikely to be able to find appropriate care for all those with eligible needs in the future.
- 7.18 It is expectations about the future that will shape the willingness of investors to build new capacity. We think that levels of, and uncertainty over, current and future funding are the main barriers to future investment, as fee rates are unpredictable or expected to remain low, and the levels of future LA demand for care home spaces or other types of care are unclear. Providers have told us their perception is that funding rates have been the primary cause of the reduction in LA-fee rates, and that they would be reluctant to invest in capacity largely aimed at LAs without some long-term commitment from the LAs (several examples of this are set out in paragraph 6.51). This reflects both the uncertainty around LAs' future needs and the commercial risks in providing services to the LAs (including the fee rates that are paid).
- 7.19 Under the current system, public expenditure on LA-funded care services would need to increase substantially to ensure fees are at a level that can sustain adequate capacity, and to care for the increasing numbers of elderly people. In order for central government to make informed choices on an appropriate level of funding, central government will need to have robust and comprehensive information on both the nature and scale of investment that is needed and the cost of providing this capacity.<sup>199</sup>
- 7.20 Related risks are around the continued uncertainty around government policy for England on the future funding of care homes, the uncertain impact of possible changes in policy on the demand for care homes from self-funded and LA-funded residents, and their ability to pay for care in the long term.

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<sup>199</sup> We understand that government has considered the case for an overarching national MPS that would, amongst other things, provide a national perspective on how demand and supply might change. However, the decision was taken not to take forward a National MPS, but rather, to develop a National Markets Hub on Gov.UK to make available known data and projections, showcase guidance and advice on market issues, and LA examples of best practice. Note that the National Markets Hub does not assess overall national demand. This was launched in October 2016.

## Differences between the nations

7.21 The discussion above relates particularly to England. A very similar situation applies in Northern Ireland.

7.22 In Northern Ireland, the HSC Board Local Commissioning Groups focus on the planning and resourcing of services. Some ‘market shaping’ type intentions can be found in some health authority documents but there is no requirement to produce market position statements.<sup>200</sup>

7.23 Some stakeholders have told us that there is more to do on planning for future care needs in Northern Ireland.

(a) The HSC Board said one of its key issues at present is ‘long-term planning to ensure continuity of service for existing residents and to match supply to projected demand in the appropriate locality.’<sup>201</sup> It also said that in Northern Ireland ‘we do not have a good track record in shaping market development’ as the HSC Commissioner cannot influence planning applications/approvals so cannot guarantee levels of business, and there is uncertainty over future HSC budgets.<sup>202</sup>

(b) DH NI told us that a new body assisting with future planning could be useful especially for understanding changing demographics and capacity requirements. DH NI suggested that changes in the existing structures in Northern Ireland (with the proposal to break up the HSC Board and distribute its functions between DH NI and the Public Health Agency) could result in developments along these lines. There might be scope to establish a data analytics unit as part of the new arrangements to help gather and analyse data for the care homes sector more effectively.

7.24 In contrast, in Scotland and Wales, structures are in place that should provide for joint determination by health and social care bodies of longer term care needs and for planning capacity to meet those needs.

(a) In Scotland, each IJB must establish a ‘strategic planning group’ comprising different stakeholders and publish a ‘strategic plan’ (also known as a ‘strategic commissioning plan’).<sup>203</sup> Strategic plans are intended to set out high-level information about direction and planned

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<sup>200</sup> For example, 2014/15-2015/16 corporate action report of the Western Health Authority, Mid-Ulster 2016 report ‘Our Community Plan’, 2015/16 Southern Delivery Plan, and the Corporate Action Plan of the Northern Health Authority.

<sup>201</sup> [HSC Board response to update paper](#), page 1.

<sup>202</sup> [HSC Board response to update paper](#), page 7.

<sup>203</sup> Section 35 of the Public Bodies (Joint Working) (Scotland) Act 2014. From 1 April 2017, the Care Inspectorate has had joint statutory responsibility with Healthcare Improvement Scotland to examine the quality of strategic commissioning and recommend improvements.

changes, a strategic needs assessment of local need, and a plan of how that need will be met along with detailed budgetary plans. This incorporates a summary of the key requirements to meet current and future demand.

- (b) In Wales, LAs 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.<sup>204</sup> Seven Regional Partnership Boards will jointly commission care home services from April 2018 and produce 'area plans' based on local population assessments undertaken by LAs. There is a statutory requirement for LAs to produce market stability reports from 2018/19.<sup>205</sup> At a national level, the National Commissioning Board, on behalf of the Welsh government, has recently conducted market analyses to support the development of market reports at the regional and local level.

7.25 The structures in Scotland and Wales are relatively new so it is too early to say how these are working in planning for future care needs and developing capacity to meet these needs.

- (a) Scotland Excel has told us that, in time, the new IJBs will help 'shape' care homes markets through market facilitation plans. Scotland Excel anticipates the 'market shaping' role will develop over the next few years with the partnerships now seeking to 'work with stakeholders including providers to articulate the use and extent of care homes in future alongside other care models.'<sup>206</sup>
- (b) The trade association Care Forum Wales has said that future capacity planning in Wales is at a very early stage. Only the first iteration of population assessments have been developed to date.

## Future needs for self-funders

7.26 In contrast to the situation for LA-funded residents, we have observed providers taking measures to develop capacity to meet future care needs in areas where there are enough self-funders to support new capacity aimed specifically at them. We have not found that barriers are inhibiting expansion and entry (see paragraphs 2.34 to 2.36), albeit that some barriers, such as planning permission and land availability, may exist locally. We discuss

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<sup>204</sup> Section 14 of the Social Services and Well-being (Wales) Act 2014.

<sup>205</sup> The [Regulation and Inspection of Social Care \(Wales\) Act 2016](#) requires LAs to publish annual 'Market Stability Reports' from the 2018/19 financial year. The [Institute of Public Care](#) has a template that Welsh LAs can use to produce an MPS.

<sup>206</sup> Scotland Excel response to update paper, p9.



issues in relation to helping prospective residents make good, well-informed decisions and in protecting them against potential breaches in consumer law in Sections 9 to 12.

## **Conclusion**

7.27 In summary, we are concerned that the market will not deliver the capacity LAs will need to meet the needs of older people in their areas who have eligible care needs. We consider these risks to be particularly acute in England and Northern Ireland, whereas in Scotland and Wales initiatives are in progress for greater co-ordination of health and social services generally and across LAs with improved planning and measures that can help encourage appropriate investment. If the situation persists, this could result in people not getting the care that they need, or care being provided in less efficient and more costly ways, in the future.

## **8. Recommendations to deliver a capacity focussed policy for state-funded residents**

### **Introduction**

- 8.1 This section explains our recommendation to address the issues identified in Section 7. Without these proposed changes, we expect that there will not be sufficient provision of care homes to meet the needs for residential and nursing home care in the future and that the existing system of social care provision for the elderly will be unsustainable.
- 8.2 Our recommendations apply to England and Northern Ireland. Scotland and Wales have already put in place, or are developing, measures to address the risks of lack of future capacity and needs being unmet. We discuss these at paragraphs 8.46-8.62 below.
- 8.3 We are making recommendations to the Department of Health in England and Northern Ireland that they develop policies and practices to deliver adult social care for the elderly in a way that addresses these concerns. There are three elements to our recommendations, which are as follows:
- (a) enhanced planning at local level, so LAs can make accurate and meaningful forecasts of future needs, and plan how best to meet them;
  - (b) oversight of LAs commissioning practices to ensure LAs are supported in drawing up their plans, and that these plans are drawn up and carried out; and
  - (c) greater assurance at national level about future funding levels, by establishing evidence-based funding principles, in order to provide confidence to investors.
- 8.4 Our recommendations do not seek to change the structure of how the sector operates: we expect the vast majority of residential care to continue to be provided by the independent sector, and LAs to remain responsible for the planning and procurement of care in their areas.
- 8.5 We believe that the approach we propose for addressing these concerns is practicable, and that the structures can be established quickly, and at a relatively small cost in the context of the size of the sector and the scale of issues identified.

## Objectives of our recommendations

- 8.6 The objectives of our recommendations are to redress the current situation and enable the sector to grow to meet increasing demands for care needs. This in turn requires that: LAs have the necessary capabilities for planning; and there is oversight to ensure planning is delivering the required changes in the market to incentivise LAs regarding long-term capacity needs, and to provide the confidence to the private sector that is required for it to invest in capacity to meet future needs.
- 8.7 We have identified the following elements as requirements of a new and sustainable framework for the delivery of state-funded care home services, in order to address the concerns we have identified.

### ***Enhanced capability for planning for the future***

- 8.8 There needs to be effective and credible planning by LAs, so that they can both determine the need for different types of care and deliver the required capacity in time for it to be in place when needed. Because care markets are generally local and needs and priorities vary between areas, LAs are well placed to best plan for how local care needs should be met, reflecting local issues, existing supply and local needs.
- 8.9 LAs in England have ‘market shaping duties’ (see paragraph 6.20). Our review (see paragraphs 6.20-6.39) found that existing planning is inconsistent and often does not provide sufficient information needed to promote investment, including aspects such as quantitative forecasts of the need for different types of care capacity. Nonetheless, we do not think there is a need for a recommendation to change these existing statutory duties since they already require LAs to ensure that they are ‘aware of current and likely future demand for such services’ and have regard to sustainability and ‘the need to ensure that sufficient services are available for meeting the needs for care’.<sup>207</sup> Despite the existence of the ‘market shaping duties’, we do think planning by LAs needs to work more effectively and with a long-term focus.
- 8.10 To be effective, LAs’ planning should include forecasting care needs over the next few years (looking 5 to 10 years ahead so that there is an opportunity to take actions to ensure these needs are met). LAs would then need to determine how those needs will be best met (eg through different types of care services), being clear on what care service infrastructure and provision is required in future years, and by taking measures through

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<sup>207</sup> Sections 5(1) and (2) of the Care Act 2014.

commissioning services (or otherwise incentivising and facilitating investment) to get provision to grow and adjust to meet these needs.

- 8.11 Measures need to be in place to assist and guide LAs through the planning process. These measures need to provide them with evidence on care needs and how those needs might be efficiently and effectively met now and in the future. LAs would benefit from technical advice and support, including data and evidence from aggregate forecasts. LAs would also benefit from guidance on how best to develop their plans, as well as better ways of sharing best practice between different LAs.
- 8.12 We have concluded that a single coordinating body should provide this support and advice. It would support LAs in planning by acting as a centre of excellence in developing planning and forecasting tools and facilitating sharing of best practice. It would also provide supporting analysis and data (for example in understanding some of the drivers of future care needs, and understanding the costs and relative efficacy of different means of meeting those needs) as inputs for the local analysis of future needs and how these needs can be met. There would be efficiency benefits in ensuring that analysis relevant to all LAs can be prepared once rather than by many different LAs having to do the same task individually. Responsibility for the development of local plans would remain with LAs. It may be appropriate, at their discretion, for some LAs to cooperate regionally in developing plans, for example if they are individually small, as care services are often delivered across LA boundaries.

### ***Accountability and oversight***

- 8.13 LAs need to be incentivised to plan effectively. As we note in Section 7, there is a risk of LAs deprioritising issues that might arise only in the future. To support and incentivise LAs so that planning processes work effectively, it is important that there is transparency and that LAs are held to account for the decisions they make that affect current and future provision of care. This can be delivered through oversight. This covers how well LAs meet their obligations to meet eligible needs for care, how well they plan, and how well they ensure their plans are met.
- 8.14 We recommend that the oversight function could best be performed by an independent body, ie independent both of LAs, for accountability reasons, and of central government, so that its functions are independent of the government's decisions on funding to be available for adult social care. This body is likely to be the same body as referred to in paragraph 8.12. This independent body would support LAs in carrying out their functions through

providing guidance based on its review of best practice in planning and procurement.

- 8.15 In undertaking an oversight function the independent body would examine, for example:<sup>208</sup>
- that an LA's current delivery of care is meeting its obligations (eg that its processes mean that those who have care needs are being given appropriate care in compliance with their obligations under the Care Act 2014);
  - that future plans are well-informed, quantified, and suitable to provide effectively for future care needs, (and are not in conflict with those of other LAs, eg assuming that they will be able to use a neighbouring LA's capacity, which could interfere with the effective planning and provision of capacity in the neighbouring area);
  - that steps are being taken by LAs to ensure the need for investment in their plans is being met (eg in commissioning so as to secure appropriate investment), and that its actions provide a basis for investors to form positive expectations; and
  - that in practice the investment required is taking place and the provision of care is consistent with the plans.
- 8.16 We expect that increased transparency will result from this process, and that this will better incentivise investors to build new capacity. In particular, LAs should be transparent in publishing their future care plans and explaining how they intend care will be delivered. One specific aspect of this could be for LAs or the independent body to be responsible for publishing details of the extent of price differentiation between LAs and self-funded rates in mixed care homes in the area, both to improve public accountability and to provide transparency to investors as to the extent to which LAs expect to rely on higher self-funded rates in supporting a sustainable industry.

### ***Confidence to investors***

- 8.17 The third element of our recommendation is to provide confidence to investors that the reasonable costs of providing care will be met. Absent this,

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<sup>208</sup> The exact process of oversight would be determined by the body so as to be effective and proportionate, in what it examines and how it is conducted. For example, it could be achieved through the use of LAs reporting their plans and actions to the body supported by occasional in-depth inspections to assess effectiveness. The Department of Health will need to consider what publicity and whether any sanction is required against LAs who fail inspection. There would also need to be processes to ensure that LAs were able to correct and improve plans and delivery of those plans where they are found to be inadequate.

given the track record of LAs paying fees below total cost, we believe that investment will not be forthcoming.

- 8.18 To provide this, the government needs to provide confidence that future funding for social care for the elderly, including care homes, will be based on realistic assessments of the actual costs of providing care. The objective is that there is greater confidence given to funders and providers about the approach taken to funding the state provision of social care. LAs need to be in a funding position which allows them to put in place plans and enter commitments for new capacity which allow providers to cover the full cost of providing that care, including covering the cost of capital necessary for investment. Without this, LAs will be unable to commission the additional capacity needed to meet future care needs.
- 8.19 While it will be for the government to make decisions on public funding, we recommend that there is a formalised process to provide advisory evidence to government. We recommend the government puts in place an ongoing process of independent review of the costs of providing care of different types (including residential care, nursing care domiciliary care and other care options), which it will draw on in deciding on funding plans. There would be benefit in regularly updating this assessment. The independent body may be well placed to do this periodically, in a way which supports its oversight functions. While this does not guarantee certainty, it means reasonable expectations can be formed by investors on the basis of credible commitments that the costs of providing care will be taken into account when prices are agreed.
- 8.20 We recommend that the independent body also provides advice to government on the level of need for different types of care over the foreseeable future, perhaps 5 to 10 years. This assessment could include consideration of all relevant drivers including changes in the acuity of care needs, the impact of demographic developments, and consideration of the appropriate balance of different care approaches (residential, domiciliary and other models of care) to best provide that care.
- 8.21 As noted above, this function would be advisory, with decisions on funding resting with government. However, if it is to be effective it needs to create significantly improved expectations among potential investors in the care home sector that LAs will in future pay rates for care that fully cover costs. This would be achieved through clear principles that future funding will be based on a credible cost of care analysis and with LAs accountable through oversight. There are examples in other sectors where independent bodies provide advice to government, for example the Office of Budget Responsibility, the eight Pay Review Bodies, and the Office of Road and Rail

provides advice to the Department for Transport on state funding required in respect of Network Rail's costs.<sup>209</sup>

## **Our capacity recommendation**

8.22 Our recommendations in this section apply to England and Northern Ireland and comprises two elements:

### ***A sustainable framework for Capacity Planning and oversight***

8.23 We are recommending that the government sets up a new function, independent of government, with the objective of ensuring that planning is of sufficiently good quality to provide confidence that the capacity will be in place to meet needs over a period, specified by government.

8.24 For example, the new function could have the following duties and objectives:

- (a) to review and report on the planning by LAs of all types of social care for the elderly, and whether plans are sufficient to meet the objective of providing care to all those with eligible needs;
- (b) to provide guidance to LAs as to what is required for market planning statements to be effective and to provide information to support LAs in developing plans; and
- (c) to report on where LAs are, based on evidence provided, not planning to a standard required by their duties, or are not taking appropriate actions to ensure that their plans are then met.

### ***Cost assessment and commitment***

8.25 We are recommending that, in England, a process is established to provide independent advice to government, to be updated periodically:

- (a) to provide evidence to government on the expected cost of different forms of care over that period;
- (b) to provide evidence to government on the need for different types of care (including residential care, nursing care, domiciliary care and other options) over the foreseeable future, perhaps 5 to 10 years.

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<sup>209</sup> [ORR letter](#) to Department for Transport, 15 February 2017.

- 8.26 This is not a recommendation to government on levels of funding or that this advice should constrain government's discretion, only that there should be evidence to support decisions on the level of funding for social care. This will help LAs to plan more effectively, for example in commissioning on the basis of multi-year agreements, and it will help potential investors to form positive expectations of prospects.

## **Implementation of our recommendations**

- 8.27 In this section, we explain what would be required for implementation of our recommendations. Our recommendations in this section apply to England and Northern Ireland. The circumstances in Northern Ireland may however require a different implementation process from that in England, and we discuss this in paragraphs 8.42 to 8.45.

### ***Role and identity of an independent body***

- 8.28 The independent body would need access to technical skills, including both knowledge of the sector, and also financial, economic and accounting expertise. This could be done in a number of ways: for example (i) through the creation of a new function within an existing sector body, such as CQC in England, (ii) through the addition of sector skills to a body which has broader oversight experience, such as NAO, (iii) through the appointment by DH of an individual or group which would commission, and oversee independent expert reports, and then report back to government, or (iv) through the creation of a new body with an independent board.
- 8.29 An independent body would need to have suitable skills and knowledge, and there would be some efficiencies if it were possible to accommodate these duties alongside existing functions. If the preferred approach is to identify an existing body for this purpose, our view is that in England, the CQC appears to be the best positioned to operate this function. While this would be a substantial extension to its role, it is highly complementary to other areas of its existing activities. CQC already monitors performance through its market oversight functions, and reviews how LAs integrate health and social care functions. The new functions would be an extension of these functions. CQC also has an independent board with the relevant experience to understand and provide strategic direction on the functions we are recommending.
- 8.30 In Northern Ireland, we have not identified an equivalent body which would be in a comparable position of assuming these responsibilities in a way which overlaps with existing roles and objectives. The identification of a suitable body would need to be considered along with the design of a



targeted approach to delivering on the same objectives as in England, but in the context of a smaller market and nearly all places being state-funded. We discuss this further in 8.42 to 8.44 below.

### ***Actions required in advance of implementation***

- 8.31 The functions above would require amendment to a number of existing statutory provisions (if assigned to an existing body- otherwise a new body would need to be created and duties assigned). New provisions would include:
- (a) new duties for any independent body which takes on the functions;
  - (b) the ability of the independent body to recover the costs of those functions;
  - (c) powers to obtain information and ensure compliance by LAs; and
  - (d) obligations on LAs to have regard to the decisions and reports of the independent body as part of their statutory duties.
- 8.32 Our proposed approach to implementation is discussed further in section 14 on recommendations.

### **Alternative approaches - statutory care pricing**

- 8.33 We have considered whether it would be appropriate to recommend that LAs be required to follow statutory rules on the fees to be paid for care. Various approaches are possible, for example in Scotland there is a cost of care model under development which will be used in fee negotiations (see paragraphs 8.48 to 8.51). Many suppliers told us that it would be extremely helpful to have such a system in the other countries as a means of providing assurance to the industry that their costs will be covered, to provide for the sustainability of care provision and to support investment for the future.
- 8.34 We have decided not to recommend in England and Northern Ireland that LAs be given statutory guidance on how they must calculate the cost of care or the rates which they must pay to providers, nor that there be mandatory national rates LAs must pay. This is because:
- This would be unnecessary if LAs are being held to account on the maintenance of capacity and delivery of investment in their area, whereby LAs would be forced to offer attractive and sustainable contracts to suppliers;

- developing cost of care models for the whole of England covering a wide variety of circumstances, local conditions, different types of care service etc would be extremely complex;
- providing costs of care could reduce the intensity of constructive competition between operators and instead set a focal price with lower incentives to drive efficiency, quality and innovation; and
- a standardised fee rate may not be as effective in promoting quality, as older and lower-quality capacity would potentially be more profitable than the newer capacity which will become necessary to reflect changing care needs.

8.35 While we recognise that care pricing approaches may work well in Scotland and Wales to promote sustainability and investment, in comparison to England these are smaller countries, where there is a greater proportion of LA-funded residents and greater co-ordinated planning than currently exists in England.

8.36 However, we note that LAs and the industry might benefit from some guidance from an independent authority to help them negotiate sustainable rates for care. If LAs are provided with both enhanced guidance and held to account through increased oversight, this should provide increased assurance to investors. For example, this could include resources for LAs setting out:

- (a) the level of a reasonable return on capital and a suitable measure for calculating a return on invested capital through a margin or mark-up on operating costs for providers;
- (b) efficient costs of care, based on analysis of the costs of efficient providers;
- (c) the relative cost of care for different types of care, including nursing care;
- (d) a breakdown of the cost of care into key elements or ratios; and
- (e) analysis of how the cost of care is likely to vary by region or local area, reflecting which elements of the cost of care vary regionally.

8.37 It would make sense for the same body to carry out both the oversight function and the cost of care assessment for two reasons:

- In order to help it present evidence to central government on future costs of providing care as part of its advice on funding requirements; and

- in cases where its oversight finds that suppliers are not investing and maintaining services in line with the LA's local plan, the body would need to examine why this is so - one possibility being that the problem lies with the rates being paid for care.

## **Cost of the recommendation**

8.38 We now consider two costs associated with this recommendation:

- The costs of establishing an independent body to undertake the functions set out in paragraphs 8.24 and 8.25, and
- The costs of funding current and future provision of care home capacity in a sustainable way that will also grow to meet future demand.

### ***Cost of an independent body***

8.39 There are two major costs that will be incurred in setting up and maintaining the independent body. We cannot provide a precise estimate of cost, as exactly how the body performs these functions could take a variety of forms. Even if the numbers quoted are underestimates, the costs will still be very small compared to the scale of LA funding of residential care:

- (a) Cost of providing advice to government on the future costs of providing care, and the cost to the independent body in supporting LA planning. We have considered other specialist analytical bodies with comparable functions and expect that the costs would be moderate given the scale of the sector. Based on other analytical bodies, these tasks might cost around £2m per annum; and
- (b) Oversight of LAs: the oversight function would be more effective if supported by some active monitoring and reviewing of how plans are prepared and implemented, including visits and meetings with LAs and providers. The cost would depend both on whether the body was one which already had similar functions and relationships with LAs, and also the frequency and depth of reviews.

8.40 CQC has provided us with an initial estimate that, based on previous experience, the oversight function would cost at least £11 million per annum, which suggests to us that the oversight and advisory roles together could cost up to £15 million per annum, although, as stated above, the amount of funding of oversight would effectively determine the frequency and detail of reviews undertaken by the oversight body. If the functions were implemented by CQC at this cost, this would be a relatively small increase in CQC's

budget of over £200 million, and should require limited changes to overhead costs. If the costs were consistent with these estimates, the total additional cost would be of the order of 0.2% of state funding of residential care. We expect that the efficiency benefits from enhanced guidance on oversight would outweigh the costs.

- 8.41 We expect that a consequence of our recommendations will be to increase the fees paid by LAs to care homes to a more sustainable level over time, ie to a level which better reflects the cost of care. We have provided estimates of what might be the consequences for LA expenditure in order to achieve this for those LA-funded residents across the UK in paragraph 4.43. We expect the initial effect would be that LAs will need to pay the full costs of care for LA-funded residents in the homes which are most at risk of not covering their total costs, in order to preserve their viability. In paragraph 4.47 we show the consequences for LA expenditure if fees were raised to cover the full costs for all LA-funded residents in these homes.

### **Approaches to capacity planning in Northern Ireland**

- 8.42 We are making a recommendation to the Department of Health in Northern Ireland to put in place planning similar to that described above for England. We have identified the same problems in Northern Ireland as in England. There is evidence that there is insufficient planning, and a significant risk that capacity will not be provided to meet increasing and changing needs, and there are insufficient measures in place to address the risks.
- 8.43 We have outlined a package of measures above, which could address these issues in both England and Northern Ireland. However, the broader context in Northern Ireland may mean that a simpler, more easily implemented approach may be feasible.
- (a) Northern Ireland is smaller, and therefore:
- (i) it is easier for a single body to review planning both in aggregate and in each region;
  - (ii) it is more feasible to co-ordinate plans and to compare the effects of individual plans with the aggregate plans than, for example, in England;
  - (iii) the risks associated with using the same assumptions in planning across all regions are smaller, as there is less dispersion.

(b) In Northern Ireland, there are very few private-funders (ie self-funders who are not contracted through HSC Trusts and therefore may pay higher fees). This has a number of consequences:

(i) there is a direct link between the amount of capacity procured for state-funded residents, and the amount of capacity required in aggregate. This makes planning more straightforward.

(ii) it reduces the risk that existing capacity is diverted from state-funded residents. However, without separate investment in facilities for private funders, it means that if LA-funded care is insufficiently supported the overall provision could be at risk of contraction.

8.44 There are risks to the future provision of adequate care home capacity in Northern Ireland for the same reasons as in England, however we expect that our capacity recommendation can be implemented in a manner which is more straightforward than that required in England. We consider that HSC Trusts should be required to undertake planning for the delivery of care with a longer-term focus, and that there should be oversight of how they are planning and delivering care. However, it may be that not all these functions do not need to be delivered by an independent body, and there may be less need for independent advice to government on funding requirements.

8.45 In summary, in light of our findings, we are recommending to the Department of Health in Northern Ireland that it undertake a review of capacity planning, and a process for independent oversight HSC Trusts' commissioning practices is put in place. This is with a view to provide enhanced planning with accurate and meaningful forecasts of future care needs, oversight to ensure plans will deliver the care that is needed, and measures to provide confidence to investors that they will receive adequate fee rates.

## **Approaches to capacity planning in Scotland and Wales**

8.46 We are not making a recommendation on capacity planning in Scotland and Wales, as we have identified that both of these devolved nations have plans in place to implement measures to address the problems we have identified. We welcome these as they seek to address the need for planning of care provision, and provide improved confidence to potential investors in respect of future returns. In this section, we summarise submissions from stakeholders which describe the approaches being followed to cost of care and capacity planning. These are not necessarily the same as our recommendation for England, but have the same objectives, namely to enhance capacity planning and commitment, to secure investment, and therefore to ensure that the LA-funded sector is sustainable.

8.47 Our diagnoses around the need for planning, funding and delivery of state-funded social care apply in Scotland and Wales. It is important that the delivery of an effective and sustainable social care system is maintained. The impact of these existing initiatives will need to be assessed and further actions may be necessary. We urge both governments to keep this under review and in particular to consider whether improved planning and forecasting to facilitate the long-term development of capacity and provision is required.

### **Scotland**

8.48 In Scotland, there is ongoing reform of the national care home contract and the development of a cost of care calculator. Care home providers (through the CCPS), the Convention of Scottish Local Authorities (COSLA) and Scotland Excel are currently working on the development of a cost of care calculator which has been tested in care home fee negotiations in Scotland.<sup>210</sup>

8.49 The development of the cost of care calculator is widely supported across the sector. Scottish Care told us it thought ‘the process, based as it is on a wider social care legislative emphasis which seeks to enhance choice and control, will serve to improve both care home delivery and quality provision’.<sup>211</sup> COSLA and Scotland Excel, told us there is a ‘shared ambition for a fair and transparent cost of care calculator’. The Scottish government suggested that that the work being carried out through National Care Home Contract (NCHC) reform may lead to commissioning tools being developed which may have potential to be used flexibly across the whole system for purchasing provision .

8.50 Various parties have told us that because of the development of the cost of care calculator there is no need for an independent body in Scotland to provide support and guidance on a fair cost of care at present. Scottish Care said that while there was no independent body in Scotland, there was now a process in place to establish a fair cost of care. COSLA and Scotland Excel said developing a cost of care calculator was preferable to setting up a new independent body because this development was a shared ambition across the sector.

8.51 The development of the cost of care calculator has taken time. In June, Scottish Care reported work had reached the stage of external independent

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<sup>210</sup> [Scotland Excel response to update paper](#), June 2017, p2.

<sup>211</sup> [Scottish Care's response to statement of scope](#), January 2017, p6.

analysis on some aspects and it hoped that this could be completed by the end of 2017.<sup>212</sup>

### *Capacity planning and 'market shaping'*

- 8.52 In Scotland, structures are in place at a regional level to provide for joint commissioning of care homes by health and social care bodies which also provide for forecasting future care needs and planning capacity to meet these needs.
- 8.53 As a result of the Public Bodies (Joint Working) (Scotland) Act 2014, the statutory responsibility for the strategic commissioning of care home provision lies with local integrated health and social care boards.<sup>213</sup> Health and Social Care partnerships are responsible for the planning, funding and delivery of a range of community health and social care, and are governed by IJBs.
- 8.54 Scotland Excel has told us that, in time, the new partnerships and IJBs will help 'shape' care homes markets through market facilitation plans. Scotland Excel anticipates the "market shaping" role will develop over the next few years with partnerships now working with all stakeholders including providers to articulate the use and extent of care homes in future alongside other care models.<sup>214</sup>
- 8.55 Due to the new structures in Scotland, we were told that there is no need for a new independent body to support planning for future needs:
- (a) the Scottish government told us that IJBs are seeking to understand and plan for needs in their localities. In recent years, the focus has been on setting up the new bodies but now they are established, attention is focused on developing models to meet future needs in the next ten to twenty years.
  - (b) Scottish Care, Scotland Excel and COSLA, and the Care Inspectorate have also told us a new body to support local capacity planning is unnecessary because of new responsibilities of IJBs. The Care Inspectorate told us this was in particular due to the national scrutiny and improvement support arrangements set out in the Public Bodies (Joint Working) Act 2014 which commenced in April 2017. However,

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<sup>212</sup> Scottish Care said that in the event the current process was to prove to be unsuccessful it would agree with the principle that the establishment of an independent body to create a transparent cost of care calculator. [Scottish Care's response to update paper](#), June 2017, p7-8.

<sup>213</sup> [Scotland Excel response to statement of scope](#).

<sup>214</sup> Scotland Excel response to update paper, page 9.

Scottish Care has also stated that there needs to be significant improvement in the way in which the IJBs consult, engage and include independent sector care homes or a new body may become necessary. The Care Inspectorate told us IJBs are required to understand what is required in their local areas, have the data they need to plan for future care needs, and direct resources in a strategic way to meet the needs of local populations. The Care Inspectorate and Healthcare Improvement Scotland are jointly responsible for inspecting the effectiveness of this strategic planning and providing improvement support thereto. Scotland Excel and COSLA said IJBs already had a significant amount of data and are in a position to forecast future needs.

### ***Wales – cost of care, capacity planning and ‘market shaping’***

- 8.56 In Wales, structures and processes have been put in place at both a regional and national level to help develop an approach to determining fair costs of care and plan for meeting future care needs.
- 8.57 Under the Social Services and Well Being (Wales) Act 2014, seven Regional Partnership Boards have been established. These are based on Local Health Board footprints and group the 22 LAs in Wales into seven regions. The Regional Partnership Boards are required to develop an integrated approach to the commissioning care home placements through a formal partnership and pooled fund approach from April 2018. The partnerships will also produce ‘area plans’ based on local population assessments undertaken by LAs which will assist with market shaping. These partnerships are producing market position statements in relation to care homes which should provide transparency to the market.
- 8.58 At a national level, the National Commissioning Board, with membership drawn from across the sector including Welsh government, LAs, health boards, providers, Social Care Wales and CSSIW, seeks to promote best practice in commissioning and procurement. The Welsh government has also established a national Care Homes Steering Group, with task groups including on the cost of care.
- 8.59 Over the last year, the Welsh government has commissioned work on cost of care and market analysis as follows:
- (a) the work on cost of care undertaken by Professor John Bolton has initially looked at the problems and different approaches to calculating cost of care. The second stage in the work is focused on developing a methodology for calculating costs of care.



- (b) the market analysis undertaken by the National Commissioning Board describes the state of the care homes market in Wales and seeks to support the development of market position statements at the regional level.
- 8.60 We have been told these developments in Wales mean that there is a distinct Welsh approach underway which will identify whether a new body would be part of the solution in and planning for future needs:
- (a) the Welsh government has said the existing initiatives including cost of care work by Professor Bolton, the development of regional partnership boards and the market analysis means a cost of care and capacity planning related remedy would need to be different in Wales.
- (b) the Welsh Local Government Association (WLGA) suggested that instead of creating a new body, the existing cost of care task group could continue to provide oversight of regional developments. The WLGA also suggested other ways to build on the existing arrangements in Wales including setting up a national commissioning support unit with a market intelligence function and further work with providers on developing new models of care to meet future demand.
- (c) CSSIW has told us about the existing cost of care work but also highlighted the development of regional approaches to commissioning and pooled budgets for health and social care. CSSIW highlighted the ministerial intent to move towards 'bigger platforms' for commissioning of care in future.
- 8.61 While there are developments in Wales, the trade association Care Forum Wales has suggested that future capacity planning is at a very early stage, with only the first iteration of population assessments by regional partnership boards. It suggested there was merit in ensuring a national focus on capacity issues and not leaving this to the regional partnerships.
- 8.62 In September 2017, the Welsh government signalled its continued focus on the social care sector in its 'Prosperity for All' strategy. Its proposed actions include:
- (a) invest in a new innovative care delivery model in the community, building a more diverse sustainable care sector in Wales, working with private and public sector partners;
- (b) assist care providers to create sustainable business operation models in the heart of our communities, including advice and support from Business Wales and the Development Bank of Wales; and

- (c) develop innovative funding models to ensure that funding is available in the future to meet social care needs.<sup>215</sup>

## Summary

- 8.63 We have considered the effectiveness of the measures above in terms of how they will address the problems we have identified in the market.
- 8.64 Our recommendations are designed to move towards a market where there are both incentives for providers to identify needs and invest in capacity, and to act efficiently in respect of both quality and cost. They are also designed to provide an incentive for LAs to take a long-term view, and to seek to ensure a sustainable provision of care that can adapt to changing needs.
- 8.65 Our proposals involve largely retaining the current market structure, and can be implemented promptly and at low cost relative to the size of the sector. We recommend that the proposals are taken forward as part of the current review of the legislation for the sector.
- 8.66 In order to be effective, we have concluded that all the measures of enhanced planning, LA oversight and accountability, and the measures to improve confidence of investors need to be implemented.
- 8.67 If only improved planning is implemented, without oversight, there may be a lack of incentives on LAs to prioritise long term delivery of care to meet future needs. Oversight of LAs could help ensure that LAs are fulfilling their statutory obligations, but on its own is unlikely to provide reassurance to investors. In all cases, there is a need to provide improved confidence to the industry or else investment will not be forthcoming. This requires credibility that LAs will prioritise appropriately, and that the realistic costs of providing care are recognised in agreeing funding of LAs and in the rates that are paid for care home places.
- 8.68 In relation to differential pricing, our recommendations if implemented would increase the fees paid by LAs to care homes to a more sustainable level. Higher LA-fees will not necessarily result in downwards pressure on self-funder rates, but they would reduce the need for care homes to charge higher fees to self-funders. We have recommended that the independent body's role should include disclosure of local fee differentials in order to increase local political accountability on how care is being delivered. In addition, our measures to improve decision making will increase competitive

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<sup>215</sup> Welsh Government (September 2017), *Prosperity for All: The national strategy*, p25. The strategy is to deliver the key commitments laid out in its earlier Programme for Government, Taking Wales Forward.

pressures in relation to self-funders. These measures will reduce existing fee differentials over time.

- 8.69 We recognise that there are risks that if any of the mechanisms above do not work well in some areas, a shortfall in capacity could still emerge. This could occur either regionally or nationally if there is a continuing gap between the funding that is made available by LAs in aggregate and the cost of residential care. This could be for a number of reasons: if there is insufficient funding available, or if there are barriers to effective oversight which mean that some LAs follow a short-term approach to procurement and investment incentives still do not emerge. This reflects that the sector is complex and it is likely that LAs will develop different approaches to reflect local needs and resources, and some will be more effective than others.
- 8.70 We have not recommended a more intrusive approach with directions on the rates LAs should pay for care for the reasons set out in paragraph 8.34. We consider that the measures above provide a more flexible and more proportionate approach. However, if after some time oversight by an independent body is found not to be sufficient to increase LA incentives to take the necessary timely decisions; or if uncertainty about future public funding remains a substantial deterrence to investment, it might be necessary to consider going further. In such circumstances, it would be worth considering the approach taken in Scotland and Wales, where LA fees are determined centrally to provide greater clarity to providers, or to consider mandatory rules on LAs paying care rates that cover the full cost of care (with the requisite funding provided).
- 8.71 Whereas in Scotland and Wales initiatives are in progress for greater co-ordination of health and social services generally and across LAs with improved planning and measures that can help encourage appropriate investment. If the situation persists, this could result in people not getting the care that they need, or care being provided in less efficient and more costly ways, in the future.

## 9. Entering care and choosing a care home

### Introduction

9.1 In this section, we consider the context in which people are making decisions about their care options, how they choose a care home, and the challenges and the barriers that make good decision-making. This section also considers how much people move between homes.

### Context

#### *The decision to move into a care home*

- 9.2 The people moving into a care homes are often over 85 years old and typically have a range of medical and/or mental health needs.<sup>216</sup> The decision to move into a care home is often not made by the individual but by their spouse, relative(s) or friends.<sup>217</sup>
- 9.3 Moving into a care home is one of the biggest and emotionally charged decisions that individuals, their family and representatives will make. Despite this, the CMA consumer research found that people had rarely made preparations for moving into a care home before the need arises.<sup>218</sup>
- 9.4 Some people will be able to foresee the need for care following a period of gradual decline. Some people may already be receiving some form of support and care in their home. Changes in family circumstances (included those of a primary informal carer) may mean that living at home is no longer viable. Often the move into a care home is not expected. It may be subsequent to a short stay in hospital following a fall, illness or accident. In summary, people may know that having to move into a care home is a possibility, but the evidence suggests that few people will have planned or be properly prepared for that eventuality.<sup>219</sup>
- 9.5 The costs of care can be considerable, both in a financial and emotional sense. It is, therefore, in our view, important that the choices that are made about care are the right ones for the individual concerned and their family

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<sup>216</sup> For example, at the time of the last census the ONS found that 172,000 of the 291,000 people in resident care home population in England and Wales were aged over 85 or over. Source: ONS (2014), [Changes in the Older Resident Care Home Population between 2001 and 2011](#).

<sup>217</sup> Which? (2014), *The Care Maze*.

<sup>218</sup> Ipsos MORI, CMA consumer research, p21.

<sup>219</sup> Ipsos MORI, CMA consumer research, p21.

and/or representatives (in terms of environment, their care needs, budget and personal and cultural requirements).

### **Role of LAs**

- 9.6 In England, an LA must: ‘establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers’.<sup>220</sup> The LA has an active and critical role in the provision of information and advice and to fulfil its statutory duty, ‘is likely to need to go further than providing information and advice directly (though direct provision will be important) by working to ensure the coherence, sufficiency, availability and accessibility of information and advice relating to care and support across the local authority area’.<sup>221</sup> Similar obligations apply in Scotland, Wales and Northern Ireland.<sup>222</sup> Importantly, this duty to establish and maintain an information and advice service relates to the whole population of the LA area and not just those who are LA-funded.
- 9.7 People can approach their LA for a care needs assessment. This is usually carried out by a social worker who will assess whether the person has eligible needs and how they would be best met. If the person is eligible for LA funding and the person has eligible needs best met in a care home setting, then a social worker or member of the care management team will advise them on their options and help them find a care home. The CMA consumer research found that people felt that the support and advice provided by LAs can be both variable and limited.<sup>223</sup>

### **Planning for retirement and later life**

- 9.8 While it is generally understood that average life expectancy is increasing, few people think about what this may mean for them individually.<sup>224</sup>
- 9.9 We found that, in contrast to their behaviour in planning for retirement, most people do not prepare or plan for the care they may need when older.<sup>225</sup> An NHS and Social Care Survey conducted in 2014 by Ipsos MORI, found that only 27% of the population had planned how they would fund potential care in later life.<sup>226</sup> Consequently, many people are often surprised by the need to

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<sup>220</sup> The Care Act 2014, [section 4\(1\)](#).

<sup>221</sup> Department of Health (March 2016, as amended), [Care and support statutory guidance](#), paragraph 3.3.

<sup>222</sup> The obligation in Northern Ireland is not based on specific legal obligation. Nevertheless, there is an expectation that the obligation to provide advice, information and support applies as in the other parts of the UK.

<sup>223</sup> Ipsos MORI, CMA consumer research, p35.

<sup>224</sup> Research Works, CMA consumer research p22.

<sup>225</sup> Research Works, CMA consumer research p22.

<sup>226</sup> Ipsos MORI, [Public perceptions of the NHS and social care: winter 2014](#) (July 2015).

pay for their care and are financially unprepared when a need to move into a care home arises.

- 9.10 We found that people typically feel much more positive about care provided in their own home compared to moving into a care home.<sup>227</sup>
- 9.11 Making some financial provision might be more attractive and realistic if there was an option for insurance. However, few providers offer such products at present. Providers told us that this was because of the risks associated with the high costs of care for some people. A cap on fees would make the provision of insurance products a more attractive commercial proposition.

### ***Lack of understanding of the care system***

- 9.12 The CMA consumer research indicated that:
- (a) there was a general lack of understanding of how the care system works, how it is funded, and of people's entitlements to financial support or their eligibility for LA or NHS support;<sup>228</sup>
  - (b) both LA-funded and self-funded people were unlikely to have planned or researched their care options in advance and did not know where to go for advice and support;<sup>229</sup>
  - (c) those who had experience of the social care system had only become aware of how the system worked when an older person they were caring for needed to access social care services urgently;<sup>230</sup>
  - (d) many found the funding system complex and difficult to understand. They felt that there was no one authoritative source of information. Those applying for LA funding described the experience as stressful due to the paperwork and a lack of information;<sup>231</sup> and
  - (e) very few people referred to charities or other organisations for information, advice or support, and many were largely unaware of the existing range of information and support that they could draw on.<sup>232</sup>

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<sup>227</sup> Research Works, CMA consumer research, p28.

<sup>228</sup> Ipsos MORI, CMA consumer research, p57.

<sup>229</sup> Research Works - CMA consumer research, p25.

<sup>230</sup> Research Works - CMA consumer research, p28.

<sup>231</sup> Ipsos MORI, - CMA consumer research, p36.

<sup>232</sup> Ipsos MORI, CMA consumer research, p33.

## Choosing a care home

- 9.13 There are typically two main stages involved in finding a care home. The first involves shortlisting the available care home options in a locality and the second requires making a decision about which care home is most suitable.

### **Shortlisting**

- 9.14 Participants in the CMA consumer research said that they searched for information online, typically by using a search engine to find local care homes.<sup>233</sup> In a survey conducted in England by Independent Age, 29% of people with no prior experience of the care home sector would begin shortlisting homes through search engines (mostly Google), before looking on LA websites (16%), CQC ratings (16%) or NHS Choices (16%), and 22% reported not knowing where to look.<sup>234</sup>
- 9.15 Searching online and using one of the available directories allows future residents, their representatives and families to find lists of care homes in their local area.<sup>235</sup> However, online information about the availability of rooms or beds, prices, and terms and conditions are scarce.<sup>236</sup> It is often the family or friends that are doing the searching and arranging the care rather than the individual requiring care. These people may themselves be older or infirm.<sup>237</sup> Research has found that many older people do not use internet services or are not confident in their ability to do so.<sup>238</sup>
- 9.16 We found that a lot of useful information and advice is available online. For example, organisations, such as NHS Choices, FirstStop and Age UK produce factsheets and checklists of questions to ask providers. There are comparison websites, such as NHS Choices, carehome.co.uk and carehomeadviser.com. In addition, some organisations, for example FirstStop, provide personalised advice to individuals by telephone or email.
- 9.17 Some participants in the CMA consumer research said that they had used care home websites, but that key information, such as, fees rates and other important contractual terms were not available online. A Which? survey of

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<sup>233</sup> Ipsos MORI, CMA consumer research, p39.

<sup>234</sup> Independent Age (2016), *Shining a Light on Care: helping people make better care home choices*, p16.

<sup>235</sup> Examples of online directories include: Which? Carehome.co.uk, NHS Choices, LA directories.

<sup>236</sup> Which? conducted a spot check of UK care home markets in June 2017 and found that only 14 of 100 care home websites provided information about prices and only 3 included terms and conditions. *Which? Response to CMA Update Paper*, dated 10 July 2017.

<sup>237</sup> Financial Conduct Authority (FCA) *Occasional Paper 31: Ageing Population and Financial Services*, p27.

<sup>238</sup> Financial Conduct Authority (FCA) *Occasional Paper 31: Ageing Population and Financial Services*, p20.

100 UK care home websites found that 86 provided no pricing information, 91 offered no detail on any charges made in addition to room rates, and only three made their terms and conditions available online.<sup>239</sup> The CMA consumer research found that information on fees and typically information of vacancies was often only available on calling or visiting the care home.<sup>240</sup>

- 9.18 What was found to be very helpful in terms of identifying potential homes was ‘word of mouth’ recommendations from friends and relatives of care home residents.<sup>241</sup> Participants in the CMA consumer research also liked reading reviews on websites left by others on their experience of a particular care home.<sup>242</sup>
- 9.19 The CMA consumer research found that affordability (and, therefore, fee rates) was an important factor for self-funders in shortlisting care homes.<sup>243</sup> Self-funders mainly identified the price range either from the care home’s website (if available) or by calling the care home, whereas people funded by the LA depended on the LA to provide them with accurate information about their budget and whether top-up payments might be charged.<sup>244</sup> People may not know what fees might be in advance of visiting the home or be taking sufficient account of other up-front charges that may be applicable.
- 9.20 The CMA consumer research found that both self-funded and LA-funded people sometimes received a list from their local social services. LA-funded residents typically felt that they had less choice than self-funders but self-funders felt that they were often left to make their decision on their own, despite the broad scope of the council’s statutory obligation to provide information (see paragraph 9.6).<sup>245</sup> The research also found that many self-funders stopped communicating with LA social services once they realised that they were not eligible for funding (and that they thought social workers stopped communicating with them at this point too).
- 9.21 The CMA consumer research found that many people were unaware of the information and advice that was available to them.<sup>246</sup> Some people were

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<sup>239</sup> Which? Press Release: [Unfair contracts, surprise charges and missing care quality ratings: new Which? research reveals the information that care homes don't share](#), dated 13 July 2017.

<sup>240</sup> Ipsos MORI, CMA consumer research, p30.

<sup>241</sup> Ipsos MORI, CMA consumer research, p31 and Research Works, CMA consumer research, p37.

<sup>242</sup> Ipsos MORI, CMA consumer research, p31.

<sup>243</sup> The price range is often difficult to know because the funding eligibility may be unclear or not understood at the time they are short-listing. Further, not all of the pricing information available on a providers’ website may be sufficiently comprehensive and/or reliable or up-to-date.

<sup>244</sup> Ipsos MORI, CMA consumer research, p49.

<sup>245</sup> Ipsos MORI, CMA consumer research, p40. In Northern Ireland, a short list of care homes is provided by the local HSC Trust. Representatives, both LA and self-funded, then provide their top choices from this short list. The HSC Trust then makes its decision based on needs and availability.

<sup>246</sup> Ipsos MORI, CMA consumer research, p33.



aware of sector regulator inspection reports and considered that they provided some useful information that was helpful to shortlisting candidate care homes.

9.22 The CMA consumer research found that whilst some people may have had an idea that they were self-funders or that they were eligible for support (either from the LA or the NHS), some people had not realised that they would have to pay anything towards the cost of their care (and had become aware only when they started visiting care homes).<sup>247</sup> The research also found that for some people their eligibility for funding had not been fully settled before they moved into a care home. This may mean that people are short-listed and/or looking at care homes that may not be affordable or not able or willing to accept the individual requiring care as a resident.

### ***Support in decision-making***

9.23 The CMA consumer research found that people felt that they had only limited support when it came to making decisions about care options. Many felt they were 'left alone' to make their decision about which care home was best for them.<sup>248</sup>

9.24 Notwithstanding the above, we found that social workers can make a real difference in helping people assess their care options.<sup>249</sup> Social workers, working with the individual and their representatives, can build an understanding of the older person's wishes, explain the care options available to them, and enable them to make better informed choices. Indeed, participants in the CMA consumer research were positive about their experiences of social workers when they had:

- helped them to understand the range of care homes on offer;
- offered advice and recommendations on the different care homes the representative was considering; or
- advised on what kind of care home was needed to take care of their relative's needs.<sup>250</sup>

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<sup>247</sup> Research Works, CMA consumer research, p6.

<sup>248</sup> Ipsos MORI, CMA consumer research, p36.

<sup>249</sup> Social workers are available to help LA-funded clients and often through the NHS where someone is for whatever reason 'in the health system', but self-funders do not have routine access to social workers.

<sup>250</sup> Ipsos MORI, CMA consumer research, p34.

- 9.25 Social workers taking part in the CMA consumer research interviews said that they would not typically provide a recommendation on which care option might be the best fit for the individual requiring care.<sup>251</sup> Further, many of the people participating in the CMA consumer research commented that they felt that social services and care managers could have provided more help than they did.<sup>252</sup> Where a social worker helped representatives to find a home, participants in the CMA consumer research said that they got a sense of urgency from them, particularly if a hospital said it needed to discharge a patient. Many social workers also said that families were not given enough time once they have been notified of discharge to find appropriate care.<sup>253</sup>
- 9.26 During the course of our study, we did find some examples of LAs providing additional support to prospective residents and their representatives. For example, Dementia Advisers have been provided by LAs to support prospective residents with dementia and their representatives.<sup>254</sup>

### **Visiting homes**

- 9.27 Many participants to the CMA research said that they would need to visit a care home before they could make a decision.<sup>255</sup> Choosing a home was a highly personal experience. Many participants said that they prioritised their own perception of the care home being clean, friendly, and homely over other information such as the inspection report from the sector regulator.
- 9.28 The number of care homes visited was largely determined by the individual circumstances, preferences and ease of finding an appropriate home, and the time available for searching.<sup>256</sup> Typically, representatives visited 3 or 4 care homes,<sup>257</sup> depending on the number of nearby homes that could cater for the resident's needs and had availability. The CMA consumer research found that relatives rarely visited more care homes than this before making a

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<sup>251</sup> Ipsos MORI, CMA consumer research, p34.

<sup>252</sup> Ipsos MORI, CMA consumer research, p35.

<sup>253</sup> Ipsos MORI, CMA consumer research, p43.

<sup>254</sup> 'Dementia adviser service' is defined as the provision of a service for those diagnosed with dementia and their families who they can approach for help and advice at any stage of the illness. The role of the dementia adviser will vary, but includes supporting those with dementia from the point of diagnosis by providing a single identifiable point of contact that has knowledge of, and direct access to, the whole range of available local services. They help with advice, signposting and enabling contact with other services if needed'. [Dementia Advisers Survey: Survey of provision of dementia adviser services](#), Ipsos MORI, published in February 2016.

<sup>255</sup> Ipsos MORI, CMA consumer research, p42.

<sup>256</sup> Ipsos MORI, CMA consumer research, p42.

<sup>257</sup> Independent Age (2016), [Shining a light on care: helping people make better care home choices](#), and supported by Ipsos MORI, CMA consumer research, p44.

choice. Those that did visit more felt that they had more time in which to make their decision.<sup>258</sup>

9.29 Those who looked at only one care home did this either because they had managed to find a home they liked at the beginning of the search process or because they did not have a choice of more than one care home to look at. Residents in respite care may choose to stay in the home in which they have been receiving care. It could also be that a word of mouth recommendation was enough for them. It might also be because there was only a limited number of care homes to choose between because social services only had a limited range they could offer.<sup>259</sup>

### ***What matters to people***

9.30 Participants in the CMA consumer research told us that they wanted the care home to:

- be located close to their family and/or friends;
- have a good look and feel;
- be clean and tidy;
- have staff with a good attitude; and
- have appropriate facilities.<sup>260</sup>

9.31 This and previous consumer research found location to be the most important factor for residents and their representatives in choosing a care home.<sup>261</sup> The prospective resident typically wants to be in the same care home as their partner and/or friends, and/or close to their old home, friends and relatives.

9.32 The CMA consumer research found that people wanted to have a choice between a small number of suitable care homes that are easily accessible and in a familiar location.<sup>262</sup> Often the deciding factor in choosing between suitable homes would be the ‘feel’ of the home.<sup>263</sup>

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<sup>258</sup> Ipsos MORI, CMA consumer research p43.

<sup>259</sup> Ipsos MORI, CMA consumer research, p43.

<sup>260</sup> Citizens Advice found that people juggle a wide range of factors when selecting a home including cleanliness, friendliness of staff, quality of rooms and/or facilities and activities. Citizens Advice (2016), *Taking greater care*.

<sup>261</sup> For example, Independent Age (2016), *Shining a light on care: helping people make better care home choices* and OFT (2011), *Evaluating the impact of the 2005 OFT study into care homes for older people*.

<sup>262</sup> Research Works, CMA consumer research, p34.

<sup>263</sup> Ipsos MORI, CMA consumer research, p46.

## *Assessing quality*

- 9.33 The CMA consumer research found that some people looked at inspection reports produced by sector regulators, but many respondents did not. Those who did, used these in their initial search, but did not then place much weight on them in making their final decision. This was because many did not feel that the ratings matched their own experiences on visiting a care home.<sup>264</sup> Furthermore, the inspection report may not be recent enough to be relied on.<sup>265</sup> Independent Age said that inspection reports capture some aspects of quality, but may not be sufficient by themselves.<sup>266</sup>
- 9.34 Participants in the CMA consumer research did not find care home provider websites or their glossy brochures to be very helpful because they did not reflect their experience of the care homes when they visited them.<sup>267</sup> They considered these to be primarily sales and marketing tools for the care homes.
- 9.35 The CMA consumer research found that people had low expectations and, as a result, had settled for a care home that they felt to be ‘good enough’. Participants in the CMA consumer research told us that they felt lucky to have found a space in an acceptable home.<sup>268</sup> This willingness to accept ‘good enough’ was exacerbated by the pressure on them to make a quick decision (see paragraphs 9.41 and 9.42). People were concerned that they could miss out on a vacancy at a home that was acceptable and did not have high expectations of finding a vacancy somewhere better).

## *Fees, top-ups and other charges*

- 9.36 Where the resident could fund their own care, representatives told us that they did not feel that the level of the fee should restrict choice, since the money funding the care was not their own. However, long term affordability was more likely to be considered if the representatives themselves were contributing to the cost of care.<sup>269</sup>
- 9.37 The CMA consumer research found that representatives of residents eligible for LA-funding were often unaware that they could make top-up payments,

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<sup>264</sup> Which? research published on 13 July 2017 found that 27% of English care homes that they surveyed did not display their CQC rating online or did so poorly. *Which? Response to CMA Update Paper*, dated 10 July 2017.

<sup>265</sup> Ipsos MORI, CMA consumer research, p31.

<sup>266</sup> Independent Age UK (2016), *Shining a light on care: helping people make better care home choices*.

<sup>267</sup> In England, an LA must: ‘establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers’. Similar obligations apply in Scotland, Wales and Northern Ireland.

<sup>268</sup> Ipsos MORI, CMA consumer research, p9.

<sup>269</sup> Ipsos MORI, CMA consumer research, p67.

which is consistent with other findings on the confusion and misunderstanding around funding.<sup>270</sup> Providers told us that in some cases LAs actively discouraged the use of top-ups.

## Barriers to good decision making

### *Difficulty in having conversations about care*

- 9.38 Research carried out by Independent Age found that while nearly four out of five people believed conversations about future care needs to be important, nearly two thirds of people aged 65 and over had not actually had them with their family members.<sup>271</sup> The reasons they gave for avoiding these conversations included: not wanting to upset family members; not wanting to face up to the issue of getting old and/or developing poor health; and simply not knowing how to start the conversation. Even where people were trying to have these conversations, the older person's views were often entrenched or automatically dismissive of the very idea of being cared for in a care home.<sup>272</sup> This was the case even if it was no longer practicable or feasible for the person concerned to maintain their independence (ie continue to live in their own home).<sup>273</sup> The CMA consumer research is consistent with Independent Age's findings that many older individuals often actively resist the option of moving into a care home and that families are reluctant to initiate discussions about care homes.<sup>274</sup>
- 9.39 The main communication challenge representatives faced was convincing their relative that that they needed more assistance and support and could no longer be cared for at their own home.<sup>275</sup> This might be because their care needs had increased to the point where they could no longer be met safely in their home.
- 9.40 Family members may also be experiencing feelings of guilt about not being able to look after a family member.<sup>276</sup> When facing such issues, people dealing with this situation can feel overwhelmed and unsupported, particularly if there is no family consensus on how to address the care needs

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<sup>270</sup> '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 LA 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' Department of Health (March 2016, as amended), *Care and support statutory guidance* and Ipsos MORI, CMA consumer research, p63.

<sup>271</sup> Independent Age (2016), *We need to talk about caring: dealing with difficult conversations*.

<sup>272</sup> Research Works, CMA consumer research, p53.

<sup>273</sup> Ipsos MORI, CMA consumer research, p24.

<sup>274</sup> Ipsos MORI, CMA consumer research, p21-24.

<sup>275</sup> Ipsos MORI, CMA consumer research, p24.

<sup>276</sup> Ipsos MORI, CMA consumer research, p24.

of the older person. In such circumstances, support from ‘trusted’ professionals, such as doctors, social services and hospital staff, can be crucial in helping the family come to terms with the decision that a relative requires full-time care in a care home.<sup>277</sup>

### ***The urgency of the decision to move into a care home***

- 9.41 Once the need for the individual to go into a care home is realised, the individual or their representatives are faced with the need to understand rapidly a large volume of information and navigate an unfamiliar (and complex) care system.<sup>278</sup> The decision to move into a care home is often made under time pressure.
- 9.42 The CMA consumer research found that participants in the process, both self-funded and LA-funded, felt rushed into making their decisions.<sup>279</sup> The CMA consumer research found that this urgency was partly a consequence of pressure from hospitals to free up bed space, but was also related to the limited number of care home vacancies (placements must be taken quickly when they are available), and the need to settle the resident quickly into their new care home. There may often be concerns about the individual’s safety if they were previously living at home alone and this adds to the urgency of finding a suitable care home.

### ***Limitations on choice from vacancies and local availability***

- 9.43 The CMA consumer research found, whether the participant was self-funded or LA-funded, that choice was often quite limited, either because there were few suitable care homes or because they did not currently have a vacancy. There were examples of participants in all four nations feeling they had a choice, but largely the research participants said that their choice was limited.<sup>280</sup>
- 9.44 Care homes also gave people relatively short time scales in which to make a decision. This was either because of a limited number of care homes in the area (ie rural areas), or many care homes not having capacity. Homes and social services also gave people relatively short-time frames, sometimes as

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<sup>277</sup> Ipsos MORI, CMA consumer research, p25.

<sup>278</sup> Ipsos MORI, CMA consumer research, p6.

<sup>279</sup> Ipsos MORI, CMA consumer research, p6 and 43.

<sup>280</sup> Ipsos MORI, CMA consumer research, p52.

little as a day, to decide before the room would be offered to someone else.<sup>281</sup>

- 9.45 Families therefore have to be prepared to make quick decisions. This may mean they end up opting for a care home that would not have been their first choice if they had more time to look or wait for a vacancy.<sup>282</sup>

### ***Lack of trust in the care sector***

- 9.46 The CMA consumer research found that people have low expectations about the quality of the care and environment in care homes.<sup>283</sup> As discussed above (see paragraph 9.35), this is contributing to people's willingness to accept care homes that are 'good enough' as they have no expectation that they could, with more time, find somewhere better. We consider that this lack of trust is making the decision to move someone into a care home even more stressful and worrying. It also means that people are less likely to be getting the care in an environment that best suits their needs.
- 9.47 The CMA is supportive of initiatives, such as Quality Matters.<sup>284</sup> Quality Matters is an ongoing programme of work involving the CQC and organisations across the adult social care sector that aims to support and promote best quality experiences and outcomes and more generally encourage quality improvements across the sector.

### ***Difficulties judging quality***

- 9.48 Judging certain aspects of quality is difficult. People are often unsure what questions they should be asking and how to evaluate their options. We found that participants in the CMA consumer research were making decisions based on look and feel.<sup>285</sup> They said that they found performance measures hard to find, hard to interpret and did not trust them.<sup>286</sup> Many respondents said that they felt ill-qualified to judge the care homes available to them.<sup>287</sup>

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<sup>281</sup> Ipsos MORI, CMA consumer research, p48.

<sup>282</sup> Ipsos MORI, CMA consumer research, p49.

<sup>283</sup> Ipsos MORI, CMA consumer research, p50.

<sup>284</sup> [Quality Matters](#).

<sup>285</sup> Ipsos MORI, CMA consumer research, p37.

<sup>286</sup> Ipsos MORI, CMA consumer research, p31.

<sup>287</sup> Ipsos MORI, CMA consumer research, p9.



### ***Difficulties comparing fees and terms and conditions***

- 9.49 For people to gauge affordability and compare different care homes they need to know what care home fees are and what those fees cover. However, such information is not always available on provider websites. People will often only find out what the fees are and what they cover when they visit the care home. This may mean that they visit homes that are not affordable or do not consider others that may be more suitable.
- 9.50 Terms and conditions and contractual arrangements were often not considered in any detail in advance of someone moving into a care home. The emphasis is on getting people out of hospital (or an unsuitable home environment) and settled into their new care home as quickly as possible.<sup>288</sup> The contractual terms were rarely available on provider websites or set out in full in provider brochures (some did contain a summary of the main terms and conditions and services provided). This means that people typically do not compare terms and conditions when assessing the relative merits of competing care homes. Section 12 considers these issues in more detail.

### ***Limitations in advice services provided by social workers***

- 9.51 The relationship with the social worker is less significant for those who will be funding care themselves. However, many people who are just above the means test threshold will need a close relationship with the social worker to make sure the LA will continue to support them in the same care home when their financial assets fall below the relevant financial threshold.
- 9.52 In addition to the assigned social worker, many LAs provide some intermediary support to users, such as Dementia Advisers, often through a third-party intermediary such as the Alzheimer's Society or Age UK. The role of such intermediary advisers varies between LA areas, but typically includes supporting people by providing a single identifiable point of contact that has knowledge of, and direct access to, the whole range of available local services. They can also help with advice, signposting and enabling contact with other services if needed.
- 9.53 The CMA consumer research found that for residents whose care was being funded, at least in part, by the LA, there were challenges around convincing social workers that their relative needed a care home rather than a care package to support them in their own home. Some of these participants commented that they felt that social services could be obstructive when they

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<sup>288</sup> Ipsos MORI, CMA consumer research, p70.



did not agree with the family that someone needed to be cared for in a care home. Other times, there was a sense that social services only stepped in to help them once a doctor had agreed with the family that a care home was needed. Participants were concerned that social services stalled on decisions or recommended care at home to delay the need to fund the more expensive care home option.<sup>289</sup>

## Moving between care homes

- 9.54 The CMA consumer research found that moving a resident was normally a last resort due to practical reasons beyond the resident's or representative's control, such as changes in care needs following a reassessment that could not then be met in their original home.<sup>290</sup> This finding is supported by a 2016 Citizens Advice survey that found that nearly a quarter of residents had moved care home but mostly did so only in circumstances where they did not have a choice.<sup>291</sup> Over three-quarters of those who had moved care homes in the Citizens Advice research did so for reasons 'outside of their control', for example because of changing care needs or a closing care home.
- 9.55 The CMA consumer research found that moving between care homes was initially considered to be an option before the resident moved into the home, particularly in cases where the move was urgent. However, once settled, family members and friends of residents were reluctant to go through the process of finding and moving to another care home, even if they were unhappy or dissatisfied with the care home, unless they felt the resident was at risk.<sup>292</sup>
- 9.56 Participants in the CMA consumer research were particularly concerned about:
- (a) potentially unsettling the resident;
  - (b) struggling to find an alternative care home;
  - (c) low expectations about the quality of other care homes available; and
  - (d) fear of the risk of maltreatment of the resident at a new care home.

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<sup>289</sup> Ipsos MORI, CMA consumer research, p25.

<sup>290</sup> Ipsos MORI, CMA consumer research, p96.

<sup>291</sup> Citizens Advice (2016), *Taking greater care*.

<sup>292</sup> Ipsos MORI, CMA consumer research, p97.

- 9.57 There is consensus in the view across the sector 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, particularly when they are moving between nursing homes.
- 9.58 Where people were unhappy or had concerns about the care home, the CMA consumer research found that people would try to resolve these issues within their current care home, rather than moving.<sup>293</sup> 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.<sup>294</sup> Where these concerns were not resolved, those who felt they could not move also expressed a feeling of powerlessness in these discussions, as they felt they had no option other than to accept the situation.<sup>295</sup>
- 9.59 The CMA consumer research found that media reports of poor care (including abuse) meant that people were less likely to contemplate moving a resident.<sup>296</sup>
- 9.60 Where respondents did have experience of moving residents, moving was described as 'a difficult process', even if the practicalities of the move and the associated administration went smoothly. Having settled somewhere, people generally remained resistant to the idea of moving again.<sup>297</sup>

## Conclusions

- 9.61 We have found that there are many inherent barriers to people making well-informed decisions in this market. Choosing a care home is often an extremely difficult decision for people to make at a point in their lives when they are particularly vulnerable. Our consumer research found that there is often very little prior consideration of care needs and options by individuals and their families. People do not, for a variety of reasons, wish to discuss their later life care needs and can be dismissive of the need to do so. Often decisions about care are made following a sudden illness, injury or loss of a carer, meaning they are often made with urgency under distressing circumstances.
- 9.62 Prior to this point, most people do not have a good understanding about the care system or how it is funded. While the information and guidance

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<sup>293</sup> Ipsos MORI, CMA consumer research, p99.

<sup>294</sup> Citizens Advice (2016), *Taking greater care*.

<sup>295</sup> Ipsos MORI, CMA consumer research, p99.

<sup>296</sup> Ipsos MORI, CMA consumer research, p98.

<sup>297</sup> Ipsos MORI, CMA consumer research, p100.

available can be very good, many people do not know it is available or where to look. Because the care system and its funding is complex it can be confusing. Further, providers often do not clearly provide all the key information people need to make well-informed choices, such as: fee levels; up front charges; how many vacancies they have; contractual terms, etc. The level of support provided by LAs can be very variable. Often people felt unsupported and left alone to make these very important decisions about which care option is right for the prospective resident, their family and representatives.

- 9.63 Once settled in a care home, it is very difficult for residents to correct a poor choice, as moving to a different home can adversely impact on the residents' health.

## 10. Recommendations to support individuals' decision-making

### Introduction

- 10.1 We have found substantial barriers to people making good choices about their care in older age (see section nine). We consider that removing these barriers could mean better outcomes for all residents and their friends and families and not only people who are eligible for LA-funding. This is because:
- (a) if people plan ahead they can take steps that may allow them to live independently for longer;<sup>298</sup>
  - (b) if people are better informed, the experience of choosing and moving into a care home can be less stressful and pressured, and they are more likely to choose the care home that is best for them; and
  - (c) if people can make better informed choices, this could promote competition between care homes on the things that matter most to residents and their friends and families.
- 10.2 In this section, we set out why we think the barriers to informed decision-making should be addressed and our recommendations for achieving these outcomes.

### Benefits

- 10.3 The investment that LAs are making in services to support people in their own homes (see Section 2) is strong evidence of the potential for more people, if they think and plan ahead, to live independently for longer. For example, some LAs' initiatives focus on preventing events and accidents, such as falls in the house, that can lead to people moving into a care home. Some of these preventative measures, (such as moving to a more suitable house or making modifications to a home), are things people can do for themselves.
- 10.4 CMA consumer research found that people were often under pressure to make decisions quickly and because of this, they often visited a small

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<sup>298</sup> Department of Health (March 2016, as amended), [Care and support statutory guidance](#), paragraph 1.20, states that 'wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible.'

number of homes.<sup>299</sup> Perceptions of care homes were often a ‘gut feel’ based on impressions around cleanliness, friendliness, and homeliness.<sup>300</sup> The research also found that residents and their representatives were often making decisions without understanding what kind of care home was appropriate for them, and that residents and their representatives had little recall of the detail of the contracts they had signed.<sup>301</sup> More generally, the CMA consumer research found that residents and their representatives felt powerless to take control of their situation, and that low expectations created a willingness to accept a ‘good enough’ care home (see paragraph 9.35).

- 10.5 We consider that in these circumstances, there is a real risk of poor outcomes for people. The process of finding and choosing a care home is often stressful. In addition, people cannot be confident about the choices they make and this can add to their distress or sense of guilt. We consider that helping people to make better informed decisions would give them a sense of control and improve their well-being. In addition, people would be more likely to choose a care home that suits them.
- 10.6 We recognise that the regulation of care homes provides some assurance for residents and their friends and families.<sup>302</sup> However, sector regulators have rated a significant number of care homes as ‘requiring improvement’ or ‘poor’ (see section two). Moreover, we have identified number of consumer protection concerns, some of which have the potential to breach consumer law (see Section 11). This is further evidence of the risk of poor outcomes.
- 10.7 In addition, the CMA consumer research found that choosing a home is a highly personal experience.<sup>303</sup> The regulatory inspection reports provide useful information on how care homes have performed against fundamental standards and other requirements relating to safety and quality that all providers of regulated activities must meet. However, people cannot rely on inspection reports in making a decision on the best care home for them, because the information is not personalised. The CMA consumer research also found that many people were not aware of the regulatory inspection reports and others noted that reports were often out-of-date.<sup>304</sup>
- 10.8 Finally, our findings suggest that there could be substantial benefits from more intense competition between providers. As set out in Section four, we

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<sup>299</sup> Ipsos MORI, CMA consumer research, p34.

<sup>300</sup> Ipsos MORI, CMA consumer research, p46.

<sup>301</sup> Ipsos MORI, CMA consumer research, p70.

<sup>302</sup> Each nation has registration requirements that all providers must meet in order to operate, and regulations that set out on-going requirements relating to matters such as safety and quality.

<sup>303</sup> Ipsos MORI, CMA consumer research, p7.

<sup>304</sup> Ipsos MORI, CMA consumer research, p31.

have found that, on average, fee rates paid by self-funding residents exceed average costs. Greater competition should have the effect of reducing the amounts self-funders pay.

## Approach

- 10.9 We commissioned Research Works<sup>305</sup> and the Behavioural Insights Team (BIT)<sup>306</sup> to carry out research that would help us to identify possible measures for promoting better decision-making.
- 10.10 Using this research, we have developed a package of recommendations that, working together, would help to achieve better outcomes for prospective residents by:
- (a) providing them with useful and timely support when they are making life-changing decisions about care;
  - (b) helping them quickly and easily identify the care options that are available to them; and
  - (c) encouraging and helping them to prepare for future care needs.
- 10.11 We are recommending to the four national governments to convene a joint Remedies Programme Working Group (working group) comprising sector regulators, local government, care providers and public sector websites such as NHS Choices to take forward this package of recommendations.
- 10.12 We recognise that these bodies are already providing information, advice and support to people. LAs in England have a duty to establish and maintain information and advice services to all people in their area (ie both LA and self-funded).<sup>307</sup> There are similar arrangements in place across the devolved nations. What we are recommending is that the working group builds on these existing activities to deliver better and more accessible services. We would also expect these organisations to work closely with charities, consumer groups and community networks in both the design and implementation of the recommendations.
- 10.13 In the remainder of this section we describe each of these recommendations in more detail including why we think these would be effective in addressing our concerns and how these might be implemented.

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<sup>305</sup> [Research Works](#)

<sup>306</sup> [Behavioural Insights Team](#)

<sup>307</sup> Care Act 2014, [section 4\(1\)](#).

## Supported decision-making

10.14 We are recommending that the working group develops and agrees a substantial plan for improving the provision of supported decision-making services in the UK.

### ***Effectiveness***

10.15 We recognise that supported decision-making services already exist such as those provided by Dementia Advisers, care managers, and care navigators (see section 9). However, the CMA consumer research found that, in many instances, people thought that they received limited support from, for example, LAs and social workers. Participants also told us that they felt more confident in their decision-making when they had spoken to someone with either professional knowledge of the system, or first-hand experience of choosing a local care home.<sup>308</sup>

10.16 The aim of the recommendation is that people have ready access to the support they need (which will vary from person-to-person) in order to:

- understand what they can do to prevent or delay the need for care in a care home in older age (for example, by carrying out adjustments to their own home) and in preparing themselves and their relatives for the possibility that they may need care;
- understand, at the time they need care, their options, and to allow them to come to an informed decision on the care that best meets their needs and budget; and
- empower care home residents by ensuring that they understand the feedback and complaints and redress systems available to them if they are unhappy with the care (see section 13).

10.17 We consider that supporting people to prepare and plan for later life and empowering them to make decisions about how they would like to be cared for in later life would help to reduce the burdens on the care systems resulting from sub-optimal decisions about care options.

### ***Remedy implementation***

10.18 We would expect these services to be delivered through multiple channels (including online, telephone and face to face) and multiple providers

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<sup>308</sup> Ipsos MORI, CMA consumer research, p31.

(including LA, charities, consumer and community groups, and at GP surgeries and hospital discharge units) to promote awareness and ensure accessibility. The services could include:

- online resources including well-researched checklists and clear guidance, and links to the location of detailed information such as Age UK's 'Finding a care home';<sup>309</sup>
- telephone advice and web chat services;
- dedicated support to an individual and their representatives (perhaps time limited with an option to pay for additional support);<sup>310</sup>
- a social worker with dedicated responsibility to support older people with developing care needs;<sup>311</sup> and
- volunteers for some roles (for example, supporting people once settled in their new care home, gathering feedback from residents).

10.19 The support would not necessarily need to be provided by a 'specialist' or dedicated social worker. However, we found that people must have trust in the organisation or the individual providing information, advice and support for these services to be effective.<sup>312</sup> Specialist organisations and charities were perceived as more trustworthy than providers. Providers were the least trusted of the options, as they were perceived to be acting directly in the interests of their own business and/or prioritising profit over everything else.<sup>313</sup>

10.20 The implementation costs would vary depending on existing service provision in an area. However, our intention is to build on existing services working closely with community networks including charities, consumer groups, community groups and volunteers. In this regard, the main age-related charities (Independent Age, Age UK, Alzheimer's Society, etc) already play a role in this area.

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<sup>309</sup> Age UK, [Finding a care home](#).

<sup>310</sup> Care brokers can provide support to people of various disabilities and health conditions and long-term illnesses, supporting them to remain as independent as possible and empowering people to make better informed decisions about their care options.

<sup>311</sup> Gerontological social workers' specialist skills and knowledge include understanding of: the ageing process and models of ageing; health conditions in later life; end of life issues; family carers' needs; the policy and legal frameworks relating to older people and carers; effective management of loss, change and transitions; and the evidence base for interventions in work with older people. Source: [Social work with older people: a vision for the future](#).

<sup>312</sup> Research Works, CMA consumer research, p44.

<sup>313</sup> Research Works, CMA consumer research, p46.



10.21 The Dementia Advisers survey carried out by the Department of Health in 2016, estimated that the average annual salary of Dementia Advisers was £25,000–£34,999 per adviser, but also noted that this could be less (£15,000–£24,999).<sup>314</sup> Set against the average fee level for a resident receiving residential care of £588 per week<sup>315</sup> (roughly, £30,000 a year),<sup>316</sup> the potential benefits from providing improved support, in terms of better outcomes for residents, their families and the LA, do not appear to be disproportionate.

## **Better information about local care options**

10.22 We are recommending that the working group develops and agrees:

- (a) a set of standards for the provision of information provided on care home or other websites, with the aim of supporting the development of online comparison services and making it easier for people to compare care providers.
- (b) guidelines for all LAs in providing people with better information on: how the care system works and how to engage with the LA; on care homes in their areas; and advice on choosing a care home (for example the questions to ask when visiting homes).

10.23 We propose that these standards build on the CARE principles developed by the CMA for digital comparison tools,<sup>317</sup> the guidelines referred to in (b) above and the proposals made by the BIT in the research they carried out for this study, and subsequent user testing.

10.24 We think that particular consideration should be given to the provision of up-to-date information on vacancies and the obligations on providers to facilitate this. In addition, we are specifically recommending that the existing sector-specific regulations are amended to require registered care homes to give indicative fee information for self-funders on their websites (if they have one) (see Section 12).

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<sup>314</sup> [Dementia advisers survey: survey of provision of dementia adviser services](#), published on 4 April 2016.

<sup>315</sup> The figures in this paragraph are average mid-points derived from CMA analysis of care home fee data collected from self-selecting samples of care home from LaingBuisson and Caredata.co.uk, see Section 2, paragraph 2.26. Further details about our data and methodology are provided in Appendix C.

<sup>316</sup> Fees for nursing care are higher averaging £741 per week, ie approximately £38,000 a year, see Section 2, paragraph 2.26.

<sup>317</sup> The CARE principles are to treat people fairly by being Clear, Accurate, Responsible and Easy to use, in order to help digital comparison tool (DCT) websites to comply with consumer law and to support consumer trust.

## **Effectiveness**

- 10.25 This recommendation would help to address some of our concerns by making searching for a suitable care home easier, thereby alleviating some of the time pressures and associated stress, and increasing the likelihood of people making the right choices for them.
- 10.26 We consider that the working group will need to put in place a means of ensuring that care homes publish key information (such as indicative fees, terms and conditions and current vacancies) on a consistent basis (ie in accordance with the agreed standards) and make these available to providers of online search tools. Reporting of this information to the relevant national sector regulators (such as the CQC in England and the Care Inspectorate in Scotland) would need to be mandatory.

## **Remedy implementation**

- 10.27 There are already some comparison sites that can help people to shortlist care homes in local areas provided by government, commercial bodies and charities.<sup>318</sup> For example, carehome.co.uk and the LaingBuisson site, carehomeadviser.com. However, participants in the CMA consumer research said that they would like more information than is currently available on these sites at an earlier stage in the process (ie before they visited any care homes).<sup>319</sup> They specifically mentioned that they would like access to a more comprehensive list of care homes along with information on fee rates; the care they offer; staff turnover;<sup>320</sup> activities offered; and food menus.<sup>321</sup> They also said that they would like access to reviews of the care homes from other residents, families or friends, or the ability to talk to peers about their experiences.<sup>322</sup>
- 10.28 Websites such as NHS Choices and carehome.co.uk have also told us that people would value additional information on fees. The majority of provider websites do not provide fee information. Where providers set out fee information (either on their websites or on enquiry over the telephone or in person) it can be unclear what costs the fee covers. Although people base their final decision on a wide range of other factors, affordability is an important consideration in shortlisting.

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<sup>318</sup> See [carehomeadviser.com](https://www.carehomeadviser.com).

<sup>319</sup> Ipsos MORI, CMA consumer research, page 45.

<sup>320</sup> Familiarity and continuity of staff is important for residents with conditions such as dementia. Staff turnover may also serve as a proxy for how committed and happy the care home staff are.

<sup>321</sup> Ipsos MORI, CMA consumer research, page 45.

<sup>322</sup> Ipsos MORI, CMA consumer research, page 45.

- 10.29 Some key information is already provided to sectoral regulators (for example, staffing information is required information in the CQC's annual Provider Information Return). We consider that once the information format and frequency of returns has been agreed, the costs to care homes of providing the information should not be significant. There would be regulatory costs associated with the initial set-up of infrastructure systems and ongoing costs related to monitoring compliance.
- 10.30 We are recommending that the existing sector-specific regulations in each nation are amended to require registered care homes to give indicative fee information for self-funders on their websites (if they have one). See Section 12 for more detail.

### **Helping people to consider and plan for their longer-term care needs**

- 10.31 We are recommending that the working group develops and agrees a programme of sustained and coordinated communications to promote awareness of the care system, and to encourage people to plan ahead for possible care needs in later life.
- 10.32 We recognise that the barriers to be overcome are substantial and that our recommendation is, therefore, unlikely to result in material changes in behaviour in the short term. However, the potential benefits of getting people to think ahead about their prospective care needs are potentially large, not least because more people would have control over what care they receive, and when, in later life.
- 10.33 Financial planning under the current system is difficult because of the uncertainty about care costs. By creating certainty over the financial risk, for example through a financial cap,<sup>323</sup> it would be possible for the financial services industry to create products, such as annuities that would increase should a care need arise, life time mortgages and other related insurance products. This would help to encourage more people to think about and make financial provision for later life.
- 10.34 The working group should take account of our consumer research and seek to work in partnership with relevant organisations with a recognisable brand

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<sup>323</sup> The Dilnot *Commission on Funding of Care and Support* (July 2011) proposed a financial cap on care costs to protect people against the potentially 'catastrophic costs of care' that can affect some individuals under the current system.

name. Potential prompts should be trialled, before any widespread implementation, to achieve maximum impact.

### ***Effectiveness***

10.35 Planning ahead can help take much of the stress and complexity out of making decisions about care and can keep options open, such as the possibility of living in one's own home for longer. We consider that it would also help to remove some of the 'fear' and uncertainty that currently exists that makes some people resistant to discussing their care needs and the idea of moving into a care home. Also, by addressing some of the commonly held misconceptions about how the care system is funded, this would encourage people to take positive steps to plan and make better financial provision for later life.

### ***Remedy implementation***

10.36 The findings of the CMA consumer research strongly suggest that in order to support and normalise the process of earlier engagement, broader messages and prompts about the implications of changing social structures for care are needed.

10.37 Broader messaging about changing social demographics and their implications for life in older age could be disseminated through: housing information; magazine; noticeboards; posters; leaflets in GP surgeries; scheduled events such as Carers Week; and open days at care homes. The CMA consumer research found that these were all potentially useful channels. Messaging around experiences could take the form of case studies and 'hints and tips'.<sup>324</sup>

10.38 As well as broader messaging, CMA consumer research indicated that there are moments in people's lives when they are receptive to being prompted to thinking about their later life. Typically, this would be when people are in their 50s or older. Arranging care for an older relative can be a salient moment. Other moments include when people are will-writing, taking (or giving) power of attorney, buying financial products, pension planning, arranging for more support in the own home, health check-ups and making

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<sup>324</sup> Research Works, CMA consumer research, page 52. Research Works asked respondents to consider whether case studies about life in residential care would be a useful way of challenging negative perceptions. The response was positive, particularly in terms of reassuring respondents that the future and meeting their care needs.

home adaptations.<sup>325</sup> The CMA consumer research also found that when people's children moved out of the family home and when approaching retirement, respondents became more open to thinking about housing options and their changing lifestyle.

- 10.39 Choosing the right messenger to deliver the prompt is crucial for ensuring it is effective. The level of trust and perceived authority of messengers has been found in the CMA consumer research to be highly influential in determining how much weight people assign to the messages they receive.<sup>326</sup> GPs and other authoritative health staff and related support intermediaries are well placed to identify when a person might need to consider a care home and are highly trusted by the public.<sup>327</sup> While some people were positive about their experiences in dealing with LAs, others were afraid of engaging with social workers out of the fear that 'they might put them in a care home'.<sup>328</sup> Relatives also expressed some concerns that social workers may have hidden agendas.<sup>329</sup>

## Summary

- 10.40 We are calling on the four national governments to work with the NHS, LAs, care home providers and the third sector to deliver a sustained and coordinated programme of actions to help people make good decisions about their care needs. This work should focus on the following three areas:
- (a) providing people with good quality, relevant and timely support when they are making life-changing decisions about care;
  - (b) helping people quickly and easily identify the relevant, local care options that are available to them; and
  - (c) encouraging and helping people to prepare and plan for future care needs.
- 10.41 We consider that such actions would help people make better choices, potentially live independently for longer, reduce the stress associated with

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<sup>325</sup> Research Works, CMA consumer research, pages 51 and 52. Research Works found that people were open to considering bungalows and other options that would allow them to remain independent. Some participants in the CMA consumer research found that some people had experience of creating an annex within their house for a relative; others were open to this idea (to save money and retain control of their care). Housing adaptations were a popular option for people looking after older relatives (to avoid care fees, to prevent relatives having to go into a care home) and provided a personal learning experience that they could then use themselves later in life.

<sup>326</sup> Ipsos MORI, CMA consumer research, p39.

<sup>327</sup> Research Works, CMA consumer research, p37.

<sup>328</sup> Behavioural Insights Team, CMA consumer research, p27 and 28. According to a social worker interviewed by the behaviour insights team in the work we commissioned from them.

<sup>329</sup> Ipsos MORI, CMA consumer research, p36.

going into a care home and place greater competitive pressure on providers. We also consider that it could reduce the burden on councils providing care for older people.

# 11. Consumer protection and empowerment

## Introduction

- 11.1 All care home residents are entitled to strong protections against unfair contracts and business practices, so that they know they are getting a fair deal. Consumer law, together with other consumer protections such as sector rules, are especially important in this market given the vulnerability of people, the harm that may arise from residents being treated unfairly, and the importance of social care as a service.
- 11.2 It is important to recognise that the circumstances in which prospective residents choose a care home can be difficult, with pressure to make a decision quickly and with no previous experience. Once in the care home the vulnerability of residents can manifest itself in other ways. In most markets it would be normal for someone who is unhappy with the service they receive to move to a different provider, but it is relatively unusual for residents to move between care homes once they have settled in a particular home. This means residents are potentially susceptible to price rises and changes in service once they have lived in a home for some time, and are less able to do anything in response. There may also be less willingness to challenge the care home over potentially unfair contracts and practices. The personal impact on residents if a care home asks them to leave can also be much greater than in other markets because of the stress and potential health effects on them.
- 11.3 We have identified a number of consumer protection concerns,<sup>330</sup> some of which have the potential to breach consumer law.<sup>331</sup> Although consumer law can apply to the contracts that LAs (and other funding bodies) have with residents, most of our concerns relate to the contract terms and associated practices used by some care homes in their dealings with self-funded residents. In part, this reflects the weak bargaining position many self-funders find themselves in when choosing a care home. However, our concerns around some care homes' terms and practices when asking residents to leave

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<sup>330</sup> This is based on a review of submissions by stakeholders including national charities and consumer groups, experiences reported to us by members of the public, our review of a sample of UK care home provider contracts, sales materials and other documentation, and an online provider questionnaire. See a [summary of individual responses](#) on the full range of consumer issues that have been reported to us by members of the public.

<sup>331</sup> The CMA has powers to enforce a range of consumer laws, including Part 2 of the Consumer Rights Act 2015 (which protect consumers against unfair contract terms) and the Consumer Protection from Unfair Trading Regulations 2008 (which protect consumers from unfair business practices).

(or imposing visitor bans) apply to all residents regardless of how their care is being funded.

- 11.4 The main consumer protection concerns we have found are outlined below and set out in the order of a typical resident journey. Further details and supporting evidence can be found in Appendix E.

## **Consumer protection issues**

### ***Lack of indicative prices on websites***

- 11.5 We have found a lack of indicative pricing information on many provider and care home directory websites. Most of the provider websites we have looked at do not contain any indication of the weekly fees typically charged to self-funders. A Which? review of 100 UK care home websites also found that 86 provided no pricing information.<sup>332</sup>
- 11.6 We are concerned that this increases the time and effort involved for residents and their families 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 and emotional distress. It may also make residents more vulnerable when fees (and other costs) are gradually disclosed during their decision making, as they may already become ‘committed’ to a particular care home.
- 11.7 In the instances where we have found indicative fees are being displayed on websites, it is not always clear whether those fees apply to self-funders or LA-funded residents, which could potentially confuse or mislead people.
- 11.8 We consider that care homes are more likely to be complying with consumer law where they give accurate indicative fee information on their websites.

### ***Resident Deposits***

- 11.9 Some providers ask for a substantial deposit in advance from self-funding residents,<sup>333</sup> which is refundable when the resident leaves or dies provided that no outstanding fees are owed to the care home.<sup>334</sup> The deposit can typically be the equivalent of two weeks’ or four weeks’ fees<sup>335</sup> and we have seen examples where this can amount to £4,000 to £5,000.

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<sup>332</sup> [Which? research, July 2017.](#)

<sup>333</sup> We understand that similar deposits are not required from state funded residents.

<sup>334</sup> This is distinct from a ‘reservation’ deposit which may be taken in order to hold a room for a resident.

<sup>335</sup> Some providers have told us they require a deposit of more than four weeks’ fees.



- 11.10 We have been made aware of some providers holding large sums in residents' deposits at any one time, in a few instances several million pounds. We are concerned that unlike the private rented sector, there is currently no specific regulatory requirement for deposits to be safeguarded in full against the risk of insolvency.
- 11.11 While a few providers have told us they already safeguard deposits against the risk of insolvency (or are actively taking steps to do so), others say they don't.<sup>336</sup> This means that if a care home provider were to become insolvent there is a risk that residents, as unsecured creditors, would not get their deposit back in full.
- 11.12 We consider that where care homes fail to tell prospective residents that their deposit will not be protected (so they are not made aware of the risks their money is being exposed to before they make the decision to choose the home), or use money taken as a deposit to fund general running expenses, this could infringe consumer law.
- 11.13 We also have concerns that some providers give themselves a wide discretion to withhold or retain deposits, and more generally that the use of deposits to offset any outstanding fees or charges can discourage or prevent residents or their representatives effectively challenging disputed bills or invoices. This may be unfair under consumer law.

### ***Other substantial upfront payments***

- 11.14 Some providers require residents to pay substantial upfront charges when or before they move into a care home. These can include administration charges, or one-off 'management' type fees.
- 11.15 We have concerns that some of these one-off charges may come as an unwelcome surprise to people because they are not always transparent. They may only be mentioned for the first time when visiting the care home or before signing the contract. The purpose of the charge and the nature of the services being provided in return may also be opaque or not clearly or even misleadingly explained.
- 11.16 The element of surprise may be exacerbated by the fact that these types of one-off charges do not appear to be common across the sector, as most

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<sup>336</sup> For example, of the 20 providers who said they charged a deposit and responded to a question in a CMA online questionnaire asking if resident's deposits were protected in full against the risk of insolvency, 14 said resident deposits were not protected.

providers incorporate administrative and other business costs associated with running a care home within their overall weekly fees.

11.17 The lack of transparency around the charging of these fees may mean that residents and their representatives are less able to compare the true costs of homes, and may end up paying sums which they would not have had they been fully informed. This is likely to be unfair under consumer law.

### ***'Hidden' extra charges***

11.18 The key services that are included within the weekly fees can vary between providers. Providers sometimes make extra charges for a range of additional services and items, including things such as chiropody, hairdressing, refreshments for visitors, accompanied visits to medical appointments, medical supplies, toiletries, 'surcharges' for processing payments and telephone charges.

11.19 Charities and consumer groups have highlighted concerns that there may sometimes be a lack of clarity and visibility about what extra charges are payable (for example, because they are often not included in care home brochures or websites),<sup>337</sup> whether these are mandatory or optional, and how much these might be.

11.20 We are concerned that the point at which any additional charges do become clear may then be too late, as residents are already committed or in the home. This can result in residents receiving large unexpected bills for additional services or goods that they may have thought would be included in their weekly fee. We consider that not clearly explaining this kind of important information is likely to be a breach of consumer law.

### ***Not providing contract terms to prospective residents in a clear and timely way***

11.21 Entering a contract with a care home is a major decision which can have significant implications for residents and their families, having on-going effects on the older person's quality of life and in many instances a large financial commitment.

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<sup>337</sup> [Which? analysed 100 UK care home websites](#) and reported that 91 offered no detail on any charges made in addition to room rates. Citizens Advice research also reported that key charges, such as carer assistance, are often hard to discover as they are frequently not included in care home brochures and websites and can be very expensive - for example, a weekly trip to the hospital, requiring two hours of carer time, could end up costing as much as £5,200 a year

- 11.22 We are concerned that some care homes are not giving prospective residents and their representatives sufficient time to read the contract before being asked to sign it, and in some instances only giving them the contract after they have moved in or failing to let them have sight of it at all.<sup>338</sup>
- 11.23 Care homes who do this risk breaking consumer law (as well as sector-specific rules) as people should always have a real opportunity to read and understand contracts before becoming bound by them. Further, terms which have not been communicated to residents before they enter into the contract may not be incorporated into the contract at all, meaning that the care home may not be able to rely on or enforce those terms.
- 11.24 More generally, some care homes are not providing prospective residents with copies of contracts or information on important terms at an early stage of their decision making, such as when searching for a home or in response to an initial enquiry.<sup>339</sup>
- 11.25 Care home contracts also vary greatly in how user-friendly and easy to understand they are in the language used, length and layout. Some contracts we have seen may fall below the standards of transparency required under consumer law.

### ***Need to ‘guarantee’ the payment of care home fees***

- 11.26 Some providers require self-funding residents or their representatives to ‘guarantee’ that they can continue to pay their fees for a minimum period of time, which can range from 12 months to three years.<sup>340</sup>
- 11.27 We are concerned that where a provider’s contract terms or policies prohibit or deter self-funding residents from approaching their LA should they become eligible for state funding within a certain period, such a requirement is likely to be unfair under consumer law. For example, Age UK highlighted a care home contract that asked residents to guarantee to fund their own care for two years and not to approach the LA in that time.

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<sup>338</sup> For example, [Independent Age](#) has highlighted that a lack of time to look at the contract is a major issue in the calls it takes on its helpline. [Citizens Advice research](#) in England also found that 25% of people surveyed said they were only given a copy of the contract after the resident had moved in.

<sup>339</sup> For example, a Which? review of 100 UK care home websites found that only three care home providers made their terms and conditions available online. Which? also contacted 50 care homes by telephone to request additional information, including contracts, but only 17 sent further information.

<sup>340</sup> Some providers have told us that the primary purpose of these requirements is to safeguard them financially against admitting self-funded residents who do not have sufficient funds to pay for the likely duration of their stay, ensuring that they have some certainty over the mix of private and LA funded residents at the home.

11.28 Some providers may ask an individual to co-sign the contract as a ‘guarantor’, agreeing to be liable for the fees in the event the self-funding resident is unable to continue to pay<sup>341</sup>. We have seen contracts where the guarantor’s role and the circumstances in which they will be liable are not clearly set out or explained, so they may not always be in a position to understand their potential liability for covering (unknown) future costs. We consider that not clearly, accurately and prominently explaining this kind of important information may be a breach of consumer law.

### ***Fee increase terms***

11.29 Concerns have been raised with us by some relatives of care home residents about the frequency and amount of fee increases. This is in the context of a sector where most residents are unlikely to move care home because of the stress and inconvenience involved.

11.30 The self-funder contracts we have reviewed give providers a potentially wide discretion to increase resident’s fees. Although most contracts say 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 (for example, some merely refer to ‘increased costs’) or may include vague and non-cost related factors such as ‘local market conditions’. Many contracts we have seen also reserve the right for the provider to increase fees at other times for a wide range of reasons, including for example due to increased operating costs arising from regulatory or legislative changes, or other factors not foreseen at the time of the annual review.

11.31 Consumer law requires that residents must be able to foresee when entering the contract how the fees may change during their time in the care home and the reasons for those changes, and understand the implications for them. We therefore consider that terms in contracts which permit a care home to increase fees arbitrarily, without reference to clear and objective criteria, are likely to be unfair. Such terms may also be open to misuse, since residents will be unable to determine if fee increases are reasonable.

11.32 Generally speaking, a right to give notice to end a contract and leave without penalty would normally enable consumers to avoid an unwanted fee increase (even though this may not make the term fair), but the possibility of moving provider is often not a desirable or practical option for older people in care

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<sup>341</sup> We have been told by some providers that this is not usually linked to any minimum funding period.

homes.<sup>342</sup> We consider that unfairness arising from a lack of transparency and foreseeability in fee increase terms cannot be cured simply because residents are given reasonable notice of an increase and a right to terminate in response (even though these remain important protections for those who are able to take action to avoid the increase).

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

11.33 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. Over 79,000 care home residents in England are eligible for FNC.<sup>343</sup>

11.34 We have found there is considerable uncertainty amongst some self-funded residents in England about how NHS FNC payments affect their own contribution to their overall care home fees, particularly when the payments are changed. In particular, concerns have been reported to us by a number of relatives following the 40% increase<sup>344</sup> in the FNC rate in England announced by the government in July 2016.

11.35 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](#). The existing practice guidance could be interpreted as meaning that for self-funders the relationship between their residential care fees and the FNC payment is dependent on the terms in their contract with the care home. This leaves considerable scope for different (and not necessarily all fair) contractual approaches to be taken by care homes in how they deal with any changes in the amount of FNC payments (which is reflected in our own review of care home contracts), resulting in a lack of price transparency.

11.36 We are also concerned that, in some instances, the contracts we have seen (both the terms dealing with the treatment of the FNC contribution, and general fee variation terms which give an overly broad discretion to increase

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<sup>342</sup> CMA research suggests that people feel 'disempowered' to do anything about increasing fees because of the likely stress and inconvenience involved in finding another care home. Research Works, CMA consumer research, p64.

<sup>343</sup> The total number of people eligible for NHS-funded Nursing Care was 79,378 as at the last day of Q1 2017/18. See Statistical Press Notice NHS Continuing Healthcare And NHS-funded Nursing Care data Q1 1718.

<sup>344</sup> The standard FNC rate was increased by £44 a week to £156.25.

self-funders fees when the FNC rate goes up) may be unfair under consumer law.

### ***Termination clauses: residents being asked to leave the home***

- 11.37 Although care homes may have legitimate reasons for asking someone to leave (for example, because their condition has worsened and they cannot be looked after anymore), it is important that this is always done in a transparent and fair way given the significant effect it can have on a resident's wellbeing.
- 11.38 From our review of care home contracts, most care home residents seem to be treated as contractual licensees and have certain basic legal protections against being evicted<sup>345</sup>. However, charities including Age UK and Citizens Advice have raised concerns that care home provider's rights to evict are too broad, making the position of care home residents more vulnerable.
- 11.39 Many of the care home contracts we have looked at give the provider a potentially wide discretion to end the contract, sometimes at short notice, for reasons which the resident may find difficult to question or challenge. Such terms might be unfair under consumer law.
- 11.40 Serious concerns have also been raised that some care homes may be relying on widely drafted termination clauses to unfairly evict residents by way of reprisal for their families or relatives making complaints (as well as imposing other measures such as visitor restrictions or bans). Although we have received a number of reports and case studies alleging these kinds of reprisals, it is difficult to ascertain how often such instances may be happening.
- 11.41 Many care homes' contracts also include provisions that allow them to terminate the agreement at very short notice.<sup>346</sup> We are concerned that such terms may give the impression that residents can be evicted without a court order, where this would otherwise be required by legislation such as the Protection from Eviction Act 1977 in England and Wales, and have the potential to be misused. Even where an eviction may be justified for good reasons, we would be concerned about residents being given notice that is too short for them to be able to make other arrangements for their accommodation and care.

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<sup>345</sup> For example, we understand that under the Protection from Eviction Act 1977 in England and Wales there are certain basic legal protections in place for licensees against eviction.

<sup>346</sup> For instance, when the care home considers that they can no longer meet the care needs of the resident or if the behaviour of the resident becomes a threat to them or other residents.

- 11.42 More generally, the provider contracts we have reviewed do not set out the process and procedures that will be followed by the care home when asking someone to leave, including the evidential basis upon which any decision will be made and the opportunities for the resident or their representatives to challenge or appeal the decision or involve an advocate on their behalf.
- 11.43 Concerns have been raised that some care homes may be unfairly banning or restricting family members and relatives from visiting a resident in reprisal for having raised complaints or feedback. Doing so is highly likely to be unfair under consumer law, in relation to both the use of unfair terms and unfair and aggressive business practices.

### ***Fees charged after death***

- 11.44 Fees are sometimes being charged by care homes for extended periods of up to 4 weeks 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. In addition, we have seen contracts that make no provision for a pro-rata refund of these fees even where the room is re-let to a new resident during this period.
- 11.45 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 FNC contribution of £155 a week which we understand typically stops within a short time after death).
- 11.46 In contrast, the examples of LA 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.<sup>347</sup>
- 11.47 Following the death of a care home resident, that resident clearly no longer needs, and the provider can no longer provide, the care home services they were receiving when alive. We understand that a care home provider has a legitimate interest in ensuring swift recovery of the deceased resident's room, so that they can get on with the business of finding a new resident. We also accept that the resident's relatives will need to have access to the room after death, for example to remove the deceased's possessions. But we are concerned that including a term which obliges the payment of fees for an extended period after death, regardless of the circumstances, goes beyond

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<sup>347</sup> For example, the Scottish National Care Home Contract states that the LA'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.

what is necessary and proportionate to protect the legitimate interests of both parties (and distorts the balance of the contract significantly to the disadvantage of the resident and their estate).

### ***Other consumer protection concerns impacting on state funded residents***

11.48 We have also identified some consumer protection concerns that are specific to state funded residents and their families.

#### ***Third party top up arrangements***

11.49 Where a person is eligible for LA funding but would like to move to a care home that costs more than the council will pay or secure a better room in the same care home, their family or friends (a 'third party') can pay a 'top-up fee' to make up the difference. We have concerns that some third parties are not benefiting from the protections against paying unnecessary or unfair top-ups that should be afforded to them when an LA is involved in the arrangement.<sup>348</sup>

#### ***Top up fees agreed privately between a third party and the care home***

11.50 Care homes should only ask for a top-up payment if an arrangement has been agreed with the third party and the LA. However, we have been told by charities such as Age UK of instances where care homes have approached relatives directly to demand top-ups without the agreement of the LA.<sup>349</sup> As well as meaning the third party will not benefit from the protections when an LA is involved in the arrangement, we consider the care home is also potentially breaching consumer law.

#### ***Third parties being asked to pay top up fees directly to the care home***

11.51 Some providers have told us that a significant proportion of the third party top-up payments they receive in their English care homes are paid directly by the third party to the care home, based on what they say has been agreed with the LA<sup>350</sup>. This means that the third party will typically sign a contract with the

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<sup>348</sup> For example, under the Care Act in England LAs should be party to the funding agreement, enter into a written agreement with the person paying the top-up, and monitor how third parties are managing their payment.

<sup>349</sup> Concerns have also been raised over the way in which some LAs in England are meeting their duties under the Care Act in relation to managing third party top up arrangements.

<sup>350</sup> Under the statutory guidance to the Care Act in England, where an LA is meeting someone's needs by arranging a care home, it is responsible for contracting with the provider and for paying the full amount, including where a third party 'top-up' fee is being paid. Although the guidance says that where all parties are agreed the LA may choose to allow the third party to pay the provider directly for the 'top-up', it does not recommend this and makes clear that LAs should deter such arrangements because '*multiple contracts risk confusion*' and the LA may be unable to assure itself that it is meeting its responsibilities.



care home for payment of the top-up fee in addition to the written agreement they have with the LA, as well as there being a contract between the LA and provider in relation to the placement and funding of the resident.<sup>351</sup>

11.52 We are concerned that there is a real risk of confusion to third parties from signing multiple agreements, in particular where the care home's terms and conditions are not consistent, or are in conflict, with those of the LA (even if not enforced). Although most providers we have spoken to have told us that their policy is to only enforce their contract with the third party in line with the terms of the placement agreement they have with the LA, we are aware of some instances where third parties appear to have been subjected to more onerous terms (specifically where the care home requires payment of the top up fee for a longer period after the death of the resident than would have been the case under the LA agreement). This raises potential concerns under consumer law.

### *NHS Continuing Healthcare (CHC) funding and top-up payments*

11.53 NHS Continuing Healthcare ('CHC') describes a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and who have complex ongoing healthcare needs.<sup>352</sup>

11.54 We have received reports of some care homes asking residents in receipt of CHC or their families to make top-up payments towards the cost of their agreed care package, ostensibly to cover a 'shortfall' in funding of the basic costs. We understand that this is not permissible under NHS rules.<sup>353</sup> Where care homes are making such charges this may therefore involve misleading or otherwise unfair practices under consumer law.

11.55 Generally speaking, a CHC package can only be 'topped up' if the resident or their family agrees to pay for additional discretionary services<sup>354</sup> (on top of the services they get from the NHS) which the NHS would not normally fund as they are not clinically necessary.<sup>355</sup> However, we think there is currently some uncertainty around the types of additional private services that are permissible under NHS rules, for example in relation to top ups for better rooms. This is

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<sup>351</sup> We understand that where a third party is paying the top up to the LA instead, the provider may not have sight of the third party and will often simply have an agreement with the LA.

<sup>352</sup> The total number of people eligible for NHS CHC in England was 57,165 as at the last day of Q1 2017/18. See Statistical Press Notice NHS Continuing Healthcare And NHS-funded Nursing Care data Q1 1718.

<sup>353</sup> NHS services must be provided free of charge and fee sharing is not permissible for core NHS services.

<sup>354</sup> This is not a top up in the same sense as third party top ups to LA fees, but payment for additional optional services.

<sup>355</sup> Under current Department of Health guidance in England, 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).

reflected in the different approaches some CCGs in England appear to take over the extent to which they allow top ups for additional services.

- 11.56 We are concerned this lack of consistency, coupled with a general lack of awareness amongst CHC residents and their families about the rules on top ups and who 'enforces' them, may mean that they do not benefit from all of the protections they are entitled to against unforeseen or unfair additional costs.

## **Complaints**

- 11.57 Given the difficulties associated with moving between care homes, 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, is not acting consistently with residents' rights and expectations, or is not providing services or facilities of an appropriate quality. This is both for the benefit of the complainant, and to drive care homes to address general problems and offer care of a high standard overall.
- 11.58 Reflecting views from consumer groups, ombudsman, LAs and providers across all four nations, and findings in CMA consumer research,<sup>356</sup> below we set out some of the barriers which make it difficult for care home residents and their representatives to raise a complaint within the care home or escalate it externally. We also provide a brief overview of the process for making a complaint and the role of the regulator in reviewing complaints systems.

### ***What do we mean by complaints?***

- 11.59 We use the term 'complaints' in its everyday sense, to mean any statement that a service or member of staff has not met the standard people would expect. A complaint in this context can cover anything from: the specifics of a contractual term (eg fee increases); dissatisfaction with the general facilities in a care home (eg cleanliness of the room); the quality of the care itself; or a safeguarding issue (eg instances of abuse).<sup>357</sup>
- 11.60 We also use the term broadly so that it covers 'concerns'. People may have concerns about their care home which never become formal complaints. It is important to make sure that people feel confident that there is a vehicle through which their concerns can be voiced and addressed.

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<sup>356</sup> Ipsos MORI, CMA consumer research, pp85-93; and Research Works, CMA consumer research pp 58-65.

<sup>357</sup> We have not looked at processes relating to safeguarding procedures in this market study.

11.61 While our study has focussed on complaints systems in care homes, in England the NHS has its own complaints systems which may be available to residents and relatives in certain circumstances (eg where the complaint relates to the CCG's handling of CHC payments).

### **Overview of complaints processes**

11.62 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. Complaints processes within care homes will vary, but in general, concerns will be raised with a care worker or registered manager in the first instance and then escalated to a more senior person within the care home if unresolved. Complaints might be raised by residents, relatives or other parties, including social workers or GPs visiting the home.

11.63 The route to escalating complaints beyond the home will vary depending on whether the resident is publicly funded and who arranged their placement. For example, in England, publicly funded care home residents might approach their LA or Clinical Commissioning Group. In each nation, the Ombudsman is the ultimate and final stage in the complaints resolution process<sup>358</sup> (although in Scotland, Scottish Public Services Ombudsman (SPSO)'s role is narrowly defined).<sup>359</sup>

11.64 There are several types of third party who can potentially help someone in a care home understand how and where to direct their complaint. This includes advocates (who are generally independent of the home and can represent complainants), third sector organisations (who often provide general advice, support or information), in-house advice, professionals linked with the home (eg social workers or GPs), or intermediaries between residents and the home.

11.65 See Appendix F for an overview of complaints processes in each nation, including an explanation of different types of support available.

### **Barrier to complaints - findings**

11.66 Residents or their representatives are often reluctant to complain to a care home for a variety of reasons, including fear of repercussions following a

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<sup>358</sup> An exception exists for private funders in Northern Ireland who do not have access to NIPSO.

<sup>359</sup> In Scotland, the Care Inspectorate can hear complaints. SPSO would normally only investigate complaints that are not under the Care Inspectorate's jurisdiction (e.g. social work assessments), or where there is alleged maladministration on the part of the Care Inspectorate. It cannot consider the substance of the decision by the Care Inspectorate. Aside from this, SPSO can also consider unresolved complaints that relate to a decision by the LA.

complaint, vulnerability of the individuals involved, lack of experience with the care homes sector, a weak feedback culture within the home, or lack of support for complainants.

### *Reluctance to complain*

11.67 Stakeholders broadly agreed that residents and their representatives may be reluctant to complain about concerns in a care home setting, or to complain too often. The CMA consumer research found that reluctance could stem from a fear of negative ramifications following a complaint (eg eviction, visitor restrictions, or reduced quality of care), not wanting to offend the staff, or where it was felt that staff would not be receptive to complaints (eg where registered managers are not visible, discouraged complaints, or there is a high turnover of staff).<sup>360</sup> Ultimately, the nature of a care home environment as the complainant's home has the potential to act as a deterrent to complaints, particularly if the complaint is with the care home manager. To mitigate these concerns, some providers have introduced avenues for providing feedback anonymously or directly to corporate management.<sup>361</sup>

### *Vulnerability of residents*

11.68 Many residents in care homes are particularly vulnerable, for example if experiencing dementia or other frailties, and this can affect their ability to raise concerns or pursue a complaint. For these residents, representatives such as family or advocates will be integral to progressing complaints on the resident's behalf.<sup>362</sup> Difficulties can arise where representatives are unable to support residents with their complaints (eg are themselves vulnerable or do not have the time or energy to pursue complaints), where they are unaware of concerns (eg where the resident has not made them aware or is unable to communicate their concerns), or where the resident's frailty (eg dementia) make it more difficult to know if there is a genuine cause for concern.<sup>363</sup> In the case of advocates, the person concerned may not know how to access this support or the local advocacy service may not have capacity to help.

### *Lack of experience or low expectations of care homes*

11.69 A lack of experience with the sector or confidence that a complaint will lead to change within the home can also impact on residents' or their representatives' ability to complain. Not knowing what 'good care looks like' or warning signs

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<sup>360</sup> Ipsos MORI, CMA consumer research, pp 85-93.

<sup>361</sup> For example, see response to update paper from MHA.

<sup>362</sup> In certain circumstances, the person concerned may have a legal right to support from an advocate.

<sup>363</sup> Ipsos MORI, CMA consumer research, p91; and Research Works CMA consumer research p 58.

for poor care can mean potential complainants are unaware of issues until they become more serious (eg resident is hospitalised), or that their confidence to complain is undermined. The CMA consumer research noted that when facing institutional concerns such as fee increases, representatives assumed the same issues would arise in other care homes or were quite small in comparison to the wider issue of the resident's care.<sup>364,365</sup>

### *Processes for complaining*

- 11.70 Providers told us that they make residents aware of their complaints process in different ways, eg posting on notice boards or as part of a welcome pack. Regulators have also explained that they check complaints processes are in place.<sup>366</sup> Nevertheless, CMA consumer research found that representatives were generally unaware of the process which they should follow if they needed to raise a complaint within the home, although they felt confident that they could find this information if needed.<sup>367</sup>
- 11.71 In terms of the process itself, we have seen that providers take quite varied approaches.<sup>368</sup> Beyond internal care home processes, CMA consumer research found that some representatives did not know to whom or how to escalate complaints.<sup>369</sup> Furthermore, end-to-end processes (ie from raising a complaint with the care home to a decision by the Ombudsman) have the potential to be quite lengthy. This could act as a deterrent for complainants or affect the redress available, particularly those with limited life expectancy.
- 11.72 In England, CQC encourage care homes to sign post residents to the Local Government and Social Care Ombudsman (LGSCO). In Northern Ireland, Scotland and Wales, there is a specific legal requirement for care homes to do so.<sup>370</sup> The Northern Ireland Public Services Ombudsman (NIPSO) and Public Services Ombudsman for Wales (PSOW) have told us that they experience low levels of complaints in this sector, the reasons for which are

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<sup>364</sup> See [Ipsos MORI](#), CMA consumer research, p86.

<sup>365</sup> Research Works, CMA consumer research, p63.

<sup>366</sup> The Care Inspectorate has told us that it also checks whether complaints processes are working effectively.

<sup>367</sup> See [Ipsos MORI](#), CMA consumer research, p92.

<sup>368</sup> SPSO has published model complaints handling procedures for most other public services. There is a legislative requirement for these organisations to comply with the model, which promotes the early resolution of simple and straightforward complaints and the thorough, robust investigation of more complex complaints through a two stage model process.

<sup>369</sup> Research Works, CMA consumer research, p59.

<sup>370</sup> In Scotland, all providers are required to signpost to the Care Inspectorate who can hear individual complaints. In Northern Ireland, this requirement was introduced by the Public Services Ombudsman Act (NI) 2016. In Wales, this requirement is in section 33(8) of the Public Services Ombudsman (Wales) Act 2005.

unclear. Similarly, the CMA consumer research identified a low awareness of the role of the Ombudsman by those interviewed.<sup>371</sup>

- 11.73 As illustrated by the diagrams in Appendix F there is no one route for escalating complaints and the processes will depend on your funding stream (LA, NHS, self-funder) and the type of complaint you wish to raise (eg safeguarding, breach of national standards, health care etc). This could be a source of potential confusion if someone isn't clear about how their complaint should be categorised.
- 11.74 Further, the onus is on the complainant to actively pursue each step in the process and there is no automatic shifting to the next stage. Combined with the vulnerability of the resident, there is a risk that residents or representatives do not pursue complaints after becoming lost or fatigued by the process.
- 11.75 We understand that Healthwatch England and the LGSCO, as part of the Quality Matters commitment, are developing a single statement to ensure that all the bodies involved in handling complaints about adult social care have a shared understanding of the correct processes, and a public-facing online tool that will give people tailored, consistent, and accurate information if they want to make a complaint. We believe this will help to improve residents and relatives' awareness and understanding of the role of the Ombudsman in England.

### *Feedback culture*

- 11.76 CMA consumer research found that representatives who had positive relationships with staff in the care home and felt staff were receptive to feedback were more willing to raise their concerns,<sup>372</sup> which may often prevent these from escalating to formal complaints. In the responses to our update paper, providers also emphasised their view that willingness to complain increases where homes foster a culture of openness to feedback and learning.<sup>373</sup> It also provides valuable information to continually improve and deliver services that their users want and need.
- 11.77 To achieve this organisational culture, some providers use residents and relatives' meetings, anonymous surveys, comment books and staff training to

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<sup>371</sup> Many interviewees assumed there was an Ombudsman for social care, as in other sectors (eg health). In England, some of the interviewees assumed CQC had a complaints function. See Research Works, CMA consumer research, p59.

<sup>372</sup> Ipsos MORI, CMA consumer research, p88.

<sup>373</sup> For example, see response to the update paper from [Barchester](#) (August 2017).

encourage compliments, comments and complaints.<sup>374</sup> Some have also used technology to allow ‘real-time feedback’ e.g. through tablets.<sup>375</sup> In addition to collecting feedback, providers and consumer groups highlighted the importance of governance processes in place to generate a ‘feedback loop’ where comments, compliments or complaints are regularly reviewed by management, with trends analysed and acted upon.

11.78 The CMA consumer research and responses to the update paper often confirmed that the role of the registered manager and, in larger providers, corporate management, is also significant in generating this type of culture.<sup>376</sup> Providers have told us that they are alive to this issue for example one provider has specific training for registered managers including complaints handling.<sup>377</sup> Both providers and residents’ families and friends have indicated that building a 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.<sup>378</sup>

#### *Availability of advocacy services*

11.79 Consumer groups and ombudsmen have told us that advocacy services can assist residents or representatives to raise complaints. This can include understanding the complainant’s rights, articulating their concerns and navigating different bodies who may be able to resolve the complaint at different stages.

11.80 The actual coverage and availability of advocacy services for care home residents is not clear. We note that a report by the Older People’s Commissioner for Wales has shed more light on this issue in Wales.<sup>379</sup> In England, LAs can choose to commission social care advocacy beyond their statutory duty under the Care Act, but Healthwatch England has told us that there is evidence to suggest this kind of coverage is ‘patchy’.<sup>380</sup> In Scotland, research into funding and provision of advocacy in Scotland identified dementia as a gap in provision, amongst other services.<sup>381</sup> We consider that

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<sup>374</sup> For example, see response to the update paper from [Home of Comfort for Invalids](#) (August 2017).

<sup>375</sup> For example, see response to the update paper from [HC-One](#) and [FourSeasons Healthcare](#) (August 2017 respectively).

<sup>376</sup> For example, see response to the update paper from [College Fields Nursing Home](#) (August 2017).

<sup>377</sup> See response to the update paper from [MHA](#) (August 2017).

<sup>378</sup> See Ipsos MORI, [CMA consumer research](#), p88.

<sup>379</sup> The report predated the [Regulation and Inspection of Social Care \(Wales\) Act 2016](#) and CSSIW’s new role in relation to advocacy services.

<sup>380</sup> A Freedom of Information request in 2014 by Healthwatch England found that only one in five of LA respondents offered a dedicated complaints service for people who use social care services. See: Healthwatch England (March 2015) [Patchy complaints support is putting vulnerable people at risk](#).

<sup>381</sup> The Scottish Independent Advocacy Alliance (September 2017), [A Map of Advocacy across Scotland 2015–2016 edition](#), pp11-12.

greater investigation of the availability of both statutory and non-statutory advocacy services could therefore be useful.

### *Inspecting the complaints procedures in a care home*

11.81 Oversight of providers' complaints processes usually takes the form of reporting the number and outcomes of complaints to the quality regulator and/or LA. In addition, regulators will consider complaints as part of their inspection processes. For example, CQC use an assessment framework when they inspect an individual care home which queries issues, such as learning from complaints. However, in light of the barriers identified above and drawing from the recommendations of the Older People's Commissioner for Wales, we found that there are opportunities to expand the factors which the regulators examine when they assess the effectiveness of the complaints procedures in an individual care home. These are covered in more detail in section 13.

## **Conclusion**

11.82 All care home residents are entitled to strong protections against unfair contracts and business practices where these occur. But we have found that some care homes may not be treating their residents fairly, in part reflecting the weak bargaining position many self-funders find themselves in when choosing a care home. We set out in section 12 a number of recommendations, and actions for the CMA to take, to enhance consumer protections across the sector.

11.83 We also found that there are various barriers which affect the ability of residents and their relatives to raise and escalate a complaint about a care home. These can include: a fear of repercussions following a complaint; the vulnerability of the individuals involved; limited experience with the care homes sector; lack of awareness or difficulties in engaging with complaints processes; and a weak feedback culture within the home. In addition to these barriers, consumer groups we spoke to highlighted the need for greater support for residents in making a complaint, or in some cases, better awareness of existing services that could assist, including advocacy. Recommendations relating to complaints are set out in section 13.



## 12. Measures to enhance consumer protection

### Introduction

- 12.1 This section explains our recommendations, and actions for the CMA to take, to ensure care homes are treating their residents fairly. Most of our recommendations apply to all four nations, but we also make some specific recommendations in relation to England.
- 12.2 As set out in section 11, we have found that some care homes may not be treating their residents fairly. All care home residents are entitled to strong protections against unfair contracts and business practices where these occur.
- 12.3 Consumer protections are especially important in this market given the vulnerability of many residents. They matter for care homes as well as residents in maintaining public confidence and the standards and reputation of the care home sector, as well as in supporting competition.
- 12.4 With this in mind, we have developed a package of remedies aimed at ensuring:
- (a) **that care homes are treating their residents fairly and complying with their consumer law obligations** - by taking enforcement action where we suspect breaches of the law, publishing guidance to help care homes understand and comply with their legal obligations, and working in partnership with compliance partners such as Trading Standards Services, to drive up standards across the sector;
  - (b) **that existing consumer law works well within the context of the care homes market** - by making recommendations to give sector regulators a greater role in helping to 'embed' a culture of consumer law compliance across the sector;
  - (c) **that sector-specific rules are strengthened to reduce the risk of residents being treated unfairly** - by making recommendations that improve consumer protections by building on and strengthening existing regulatory requirements.
- 12.5 In the remainder of this section we describe the actions that the CMA is taking, and our recommendations to others, in more detail including why we think these would be effective in addressing our concerns and how these might be implemented.

## Ensuring care homes are complying with consumer law

- 12.6 Consumer law has a very important role to play in ensuring that care homes' terms and conditions, and the way in which they deal with residents and their representatives, are transparent and fair. In particular, it sets out minimum requirements that care homes must follow to ensure residents get the information they need when deciding which care home to choose, get fair treatment once there, and can make and progress complaints should they be dissatisfied.

### Actions for the CMA to take

- 12.7 Ensuring that care home residents are treated fairly and openly depends not only on consumer law being in place, but also on care homes understanding and complying with the law and on the effective enforcement of it. Enforcement is also important in helping care homes who respect consumer law and ensure a level playing field by stopping competitors who do not play by the rules from gaining an unfair advantage.
- 12.8 We are therefore using the full range of the CMA's consumer powers to ensure that care homes across the market are meeting their obligations under consumer law. Specifically, we are:
- (a) taking enforcement action;
  - (b) publishing guidance for care homes; and
  - (c) working with our compliance partners to ensure care homes are held to account.

### ***CMA consumer enforcement action***

- 12.9 The CMA has powers to enforce a range of consumer protection laws<sup>382</sup>, which it shares with LA Trading Standards Services<sup>383</sup> and the Department for the Economy (DfE) in Northern Ireland. We can deal with infringements of consumer law using a number of different powers, and can bring civil proceedings or criminal prosecutions against certain breaches. Where appropriate, we can also seek compensation or other remedies for consumers (such as the right to cancel the contract) where consumers have

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<sup>382</sup> Typically, the CMA will take enforcement action where breaches of law point to systemic failures in a market; where changing the behaviour of one business would set a precedent or have other market-wide implications; where there is an opportunity to set an important legal precedent; or where there is a strong need for deterrence.

<sup>383</sup> Trading Standards Services are the lead enforcers of consumer law.

suffered loss as a result of the unfair terms or practices giving rise to the enforcement action.

- 12.10 The key pieces of consumer law relevant to the CMA's current enforcement action are Part 2 of the Consumer Rights Act 2015 (CRA) and the Consumer Protection from Unfair Trading Regulations 2008 (CPRs). The CRA aims to protect consumers against unfair contract terms - this means that care homes' terms need to be fair and transparent, striking a fair balance between the care home's rights and obligations and those of the resident. The CPRs protect consumers from unfair business practices – this means that care homes who mislead, behave aggressively or otherwise act unfairly towards residents or their representatives are likely to be in breach of the CPRs.

#### *CMA's enforcement action*

- 12.11 The CMA is taking enforcement action and raising concerns with care homes to ensure they are complying with consumer law. We have prioritised action so far on the following two issues where we identified clear, specific concerns that some care homes are engaging in egregious practices that we consider to be unfair under consumer law and can be most effectively addressed through enforcement:

- (a) the charging of large upfront fees that are not fair or transparent;
- (b) charging families for extended periods of up to 4 weeks after a resident has died.

- 12.12 Our investigation into these matters continues, and we have raised our concerns with a number of care home providers.<sup>384385</sup>

- 12.13 Because of the widespread public concerns that were raised during our market study about fees charged after death, and the varying practices we have identified in the sector, we will also be issuing an enforcement statement in early 2018, setting out in what circumstances charges made after the death of a resident are more likely to be fair. We will expect all care homes to review, and where necessary change, these terms in accordance with the finalised guidance, or risk further action.

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<sup>384</sup> For legal reasons, we cannot give details of the providers concerned until our enforcement action is complete.

<sup>385</sup> If necessary, the CMA can take action through the courts to enforce consumer law and bring an end to infringements. It can also accept undertakings from providers in lieu of going to court.

## ***CMA consumer law guidance***<sup>386</sup>

- 12.14 In addition to taking targeted enforcement action now on some issues which we have prioritised, we are also addressing the other concerns identified during the market study (as set out in section 11). We will be publishing comprehensive guidance for care homes on the range of issues we have found, so they can ensure their practices and terms are in line with consumer law. There has been strong support from many stakeholders, including from within the industry and amongst consumer groups and charities<sup>387</sup>, for the CMA to publish such compliance guidance for care homes. We therefore intend to consult on the guidance in Spring 2018 and publish a final version in the summer.
- 12.15 Care homes should already be complying with consumer law. In light of the concerns set out in our market study, we expect providers to begin reviewing their practices and terms to check they are compliant now, as well as doing so in light of our full guidance. We are continuing to monitor complaints and other intelligence. If we identify serious breaches of consumer law we may decide to open further investigations against other providers or on other issues.

### *Significant changes to consumer law and market practices since the OFT guidance*

- 12.16 It has been nearly 15 years since the Office of Fair Trading (the CMA's predecessor) published its care homes guidance on unfair terms in 2003. Since then both the market and consumer law have moved on considerably.<sup>388</sup> There have also been a lot of court decisions which have clarified the law on numerous issues which were less certain in 2003. New business practices have also emerged amongst some care homes. Further, the old OFT guidance has since been formally withdrawn by the CMA.
- 12.17 We will be consulting on and publishing comprehensive guidance. We intend to address many of the concerns we have identified during our market study through the guidance. It is likely to include setting out our views on what care

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<sup>386</sup> The CMA and the Chartered Trading Standards Institute share the role of providing guidance to businesses to drive up standards through clarifying their legal obligations. The CMA generally focusses on sector-specific issues that have emerged as a result of a market study or other in-depth analysis of business practices in a particular market.

<sup>387</sup> Citizens Advice publicly called on the CMA to update the Office of Fair Trading's unfair terms guidance, which was formally withdrawn by the CMA.

<sup>388</sup> For example, the CPRs came into force in 2008 (prohibiting unfair commercial practices) and the CRA (covering unfair terms) in 2015.

homes need to do to ensure their terms and practices are fair and transparent in relation to issues such as:

- the taking of resident deposits;
- the requirement for self-funding residents to guarantee payment of their fees for a minimum period;
- fee increases;
- ending the contract and asking residents to leave;
- complaint handling.

12.18 Previous OFT commissioned research<sup>389</sup> from 2011 suggested that a significant minority of care homes (46%) were not aware of unfair terms law, which may be a reflection that there are a large number of smaller providers in the sector with potentially limited knowledge of consumer law, and that many care homes previously contracted with LAs and were not involved in consumer contracts<sup>390</sup>. This is further supported by more general research commissioned by the CMA<sup>391</sup> which found that perceived knowledge around the rules on unfair contract terms increased with size of business.<sup>392</sup>

12.19 As part of our compliance strategy around consulting and publishing on the guidance we will seek to ensure that we reach smaller providers, for example by working through trade associations, and that our guidance is accessible to them.

12.20 New CMA guidance will also help to drive compliance through its wider use as a reference tool by different stakeholders in tackling terms and practices which are likely to be unfair, including:

- other consumer enforcers such as local Trading Standards Services;
- sector regulators, in helping to hold care homes to account;
- consumer advice bodies such as Citizens Advice and charities representing older people;

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<sup>389</sup> Evaluating the impact of the 2005 OFT study into care homes for older people, May 2011.

<sup>390</sup> See, for example, the response from Hampshire Trading Standards Service to the CMA's Update Paper.

<sup>391</sup> [Unfair Contract Terms research, CMA, October 2016](#)

<sup>392</sup> Just over half of small (52%) and medium sized businesses (56%) reported knowing the rules well, compared to close to seven in ten (69%) large businesses. Small businesses were also least likely to have reviewed their terms and conditions.

- the Local Government and Social Care Ombudsman.
- 12.21 It has also been suggested by some stakeholders in Scotland that the terms and conditions of the National Care Home Contract (NCHC) could be reviewed in the light of the new CMA guidance.
- 12.22 Alongside the guidance for care homes, we also intend to produce some short advice for residents and their families about their consumer rights.
- 12.23 We will continue to review complaints and other intelligence we receive before and after publication of the guidance and will carry out a compliance review to assess what progress has been made. If we were to identify serious infringements either through our intelligence monitoring or during the course of our compliance review, we or another consumer enforcer such as Trading Standards may decide to take action.

#### *Working with compliance partners*

- 12.24 Working in partnership with other bodies having consumer enforcement functions (as well as the sector regulators) is a key element of the CMA's consumer law compliance strategy. This will include working with LA Trading Standards Services (as the primary enforcers of consumer law) and the DfE in Northern Ireland.
- 12.25 We intend to work closely with Trading Standards Services across the UK in monitoring compliance at a local level.<sup>393</sup> We will explore what support Trading Standards might find helpful in assisting them with compliance work, which might include the CMA producing a 'toolkit' for enforcers and giving training seminars.

#### **Working with sector regulators to help 'embed' a culture of consumer law compliance across the sector**

- 12.26 We are recommending to government that sector regulators take a greater role in helping to embed a culture of consumer law compliance within the care home sector. We think this will further raise industry standards and drive a 'culture of expectation' amongst residents about the quality of service and fair treatment they are entitled to expect from care homes.

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<sup>393</sup> For example, the Society of Chief Officers of Trading Standards in Scotland is considering how a risk based programme of checks and advice in the care homes sector could be co-ordinated across Scotland, possibly in the form of a fair-trading project in 2018/19.

## *Effectiveness*

- 12.27 Sector regulators in each of the nations already have, within their general remit, the ability to deal with some consumer protection issues - for example in relation to the provision of upfront information to prospective residents about their fees and contract terms, and complaint handling. Therefore, some of the practices we have identified as likely to be unfair under consumer law will also come within the ambit of sector regulators. We need to work with the sector regulators to avoid duplication in effort, ensure consistency as far as possible, and maximise the impact of interventions for residents (as 'consumers').
- 12.28 Given the large number of providers in the care home sector, many of whom are relatively small, general enforcers of consumer law such as the CMA (and Trading Standards) will not be able to act on every instance of a potential breach.<sup>394</sup> We think sector regulators are in a better position, given their existing relationships with providers, inspection/evaluation frameworks, and intelligence mechanisms, to ensure consistent compliance across the sector.

## *Remedy implementation*

- 12.29 We think that the sector regulators' functions and objectives are likely to be sufficiently broad to allow them to take on a stronger role in embedding consumer law compliance.
- 12.30 Where possible, we recommend that specific requirements (as reflected in the CMA's consumer law guidance) are incorporated within the sector regulations and standards. This is likely to be most suited to requirements that are more straightforward to interpret, such as for example around minimum notice periods. This would have the benefit of giving certainty to providers.
- 12.31 We also recommend that sector regulators amend their own guidance for care homes (as part of their inspection/evaluation frameworks) to make it clear that they will also require providers to demonstrate a reasonable understanding of the implications of consumer law for their residents, and have in place policies and procedures to maximise the prospects of compliance with consumer law. Where a regulator identifies very clear instances of non-compliance with consumer law, it could take action to improve consumer protection (although the regulator would not be making a

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<sup>394</sup> The CMA prioritises its work in line with its published prioritisation principles.

finding that consumer law itself had been breached).<sup>395</sup> Regulators could also cross-reference the CMA's consumer law guidance.<sup>396</sup>

- 12.32 An alternative approach would be to give sector regulators the power to enforce a range of consumer laws under Part 8 of the Enterprise Act 2002 (EA02).<sup>397</sup> However, such an approach would require the sector regulators to develop new in-house consumer law expertise, which could have cost implications. We are therefore not minded at this stage to recommend this.
- 12.33 Arrangements, such as Memoranda of Understanding, would also need to be put in place to enable the mutual exchange of intelligence between the CMA/Trading Standards Services and sector regulators to determine who might be best placed to act on specific consumer protection concerns about a provider.
- 12.34 While this would involve some cost in ensuring regulators' staff are trained sufficiently to identify problems, we consider these likely costs to be necessary and proportionate in comparison to the scale of the problems in the sector.

### **Industry to develop model contracts for use with self-funders**

- 12.35 We are recommending that the industry takes steps to develop model contracts that could be recommended for use by care home providers with self-funding residents.

#### *Effectiveness*

- 12.36 Our recommendation would help to address the variability we have seen in the user-friendliness and intelligibility of care home contracts for self-funders, aiding the understanding of residents and their representatives about their contractual rights and obligations.
- 12.37 Model contracts (together with the model pre-contract information template we are recommending sector regulators develop, see paragraph 12.58 below) would also have benefits in encouraging best practice across the

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<sup>395</sup> There is already a precedent for this in the proposed regulatory approach for the Higher Education sector in England (in the context of the creation of the Office for Students).

<sup>396</sup> Some sector regulators have told us that they already require care homes to have regard to relevant guidance produced by other external organisations, so in principle the CMA's compliance guidance could be specifically referenced in this way.

<sup>397</sup> The CMA already shares its civil consumer enforcement powers with many regulators in other sectors. These regulators are able to tackle consumer protection related concerns either through enforcing their own sector rules or through general consumer law under the Enterprise Act 2002.



sector, and in easing the workload of care home providers in designing, preparing and updating their individual contracts. This is especially so in a sector where there are a significant number of smaller providers who may have less knowledge of unfair terms law.<sup>398</sup>

### *Remedy implementation*

- 12.38 We think trade associations representing care home providers should take steps to develop model contracts for use with self-funders, that could be recommended to their members. It would be for individual care home providers to decide whether or not to use the model contract.
- 12.39 In Scotland, the development of model self-funder contracts might need to take into account the relevant provisions of the National Care Home Contract.
- 12.40 The CMA has no specific powers to ‘approve’ or ‘endorse model contract terms. However, following publication of our consumer law guidance, we would be willing to offer appropriate support to assist the industry in taking forward our recommendation.
- 12.41 Notwithstanding any industry initiative to develop model contracts, it is important that all care home providers review and where necessary revise their existing contracts to ensure they are compliant with consumer law, in light of our market study findings and the compliance guidance we will be publishing.

### **Additional sector protections for residents and their families**

- 12.42 In recognition of the vulnerability of care home residents, consumer law sits alongside specific sector regulations and standards that registered care homes must also follow. Where we have identified gaps in the adequacy of existing sector-specific rules in protecting residents, we are recommending additional protections that will build on and enhance current regulatory requirements.<sup>399</sup>

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<sup>398</sup> Previous OFT commissioned research from 2011 suggested that a significant minority of care homes (46%) were not aware of unfair terms law.

<sup>399</sup> Many of these gaps may potentially be filled by consumer law. However consistent compliance across the sector is likely to be better achieved by amendment to the sectoral rules, and the scope for care homes to be confused about their obligations reduced, if the sectoral rules set out clearly some of the most important requirements of consumer law.

## *Displaying indicative fees on websites*

- 12.43 We are recommending to government that sector-specific regulations are strengthened to require registered care homes to publish indicative fee information for self-funders on their websites (if they have one) as well as any directory website they might appear on, together with information on what is included and excluded from the weekly fees and any additional upfront fees that are payable. Where a care home does not have a website, this information should be provided in any information packs sent to enquirers and in marketing materials.

## *Effectiveness*

- 12.44 There is currently a lack of indicative pricing information on many care home provider websites (and care home directory websites). This increases the time and effort involved for people to identify different care homes that may fall within their budget, often in circumstances when a decision has to be made under significant time pressure and emotional distress.
- 12.45 CMA consumer research suggests that self-funders tried to exclude homes that were too expensive for their budget from the outset of their search, and that people would value additional information on indicative fees on websites.<sup>400</sup> Therefore, disclosure of indicative fees is important, so that people can take efficient decisions and make informed choices.
- 12.46 Where indicative fees are already being displayed on websites, we have found it is not always clear whether the fees shown apply to self-funders or LA-funded residents (some providers have told us it could be a mixture of both), which could potentially confuse or mislead people. Introducing a new requirement will help to ensure greater consistency in how such fee information is displayed and reduce the risks that people are misled.
- 12.47 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 and the type of room or facilities chosen. Concerns have also been expressed that a prescriptive requirement to display indicative fees in a standardised way could inhibit innovative pricing models such as unbundled fees, and that there are resource costs of keeping websites regularly updated. We do not consider these to be significant barriers to ensuring greater price transparency.

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<sup>400</sup> Ipsos MORI, CMA consumer research, page 48.

- 12.48 Whilst we accept that a care home cannot necessarily know the exact fee that will be charged without detailed individual information, we think it is feasible to give an indication of the fees as some care homes already do. This could take the form, for instance, of giving the range of fees charged (for example: 'nursing £1,000 to £1,200 per week depending on the services required and individual circumstances') or, where it is reasonably representative a 'from' price (for example: 'residential fees from £900 a week').
- 12.49 Although the range of fees could in some instances be wide (particularly for nursing homes where residents may have complex care needs), this would still give prospective residents an indication of affordability. It should be made clear that the exact fee charged would be subject to a care needs assessment and the facilities and services chosen.
- 12.50 We also think this kind of pricing information should already be to hand if a potential resident makes an initial enquiry about fees over the phone or during an initial visit to the care home (some care homes have also told us they include indicative fee information in marketing materials such as brochures). We therefore think the resource implications for care homes are likely to be limited.
- 12.51 We understand that if care home providers were to display indicative fees on their own websites, it would encourage and make it easier for them to display this information on care home directory websites. This would enhance the benefits arising from our recommendation. For example, the operator of carehome.co.uk has told us care home directory/review websites (such as carehome.co.uk) could offer providers an Application Programming Interface (API) to integrate with so that when a provider makes a change to the fees info on their own website it automatically updates the third-party website.
- 12.52 Given the concerns we have also identified around 'hidden' extra charges and the lack of transparency of large upfront payments, we are also recommending that there should be a requirement for care homes to clearly and prominently disclose on their websites information about what services are included and excluded from the weekly fees, and any additional fees they charge (where these are otherwise lawful).

## *Remedy implementation*

- 12.53 There are already existing sector regulations requiring care homes to give people timely and accurate information about the costs of their care<sup>401</sup>, so this recommendation would build on this. In England, there is also a precedent for a website specific regulation, which requires all providers who have received a CQC performance assessment to display the most recent rating conspicuously and legibly at each location delivering a regulated service and on their website (if they have one).
- 12.54 An addition to the regulations would make it a requirement for registered care homes to display indicative fee information for self-funders on their website, together with information on what is included and excluded from the weekly fees and any additional upfront fees that are payable. Where a care home does not have a website, this information should be provided in any information packs sent to enquirers and in marketing materials.
- 12.55 We think the requirement should apply only to self-funder fee rates, not rates charged by care homes to LAs. We think self-funders are more reliant on accessing fee information from care home websites at an early stage than LAs.

## **Providing contracts (and a summary of important terms and conditions) on care home websites**

- 12.56 We are recommending to government that existing sector-specific regulations are strengthened to require registered care homes to provide a copy of their standard (self-funder) contract, and a summary of important terms and conditions, on their websites. Where a care home does not have a website, the contract and summary could be included in any marketing materials or information packs.
- 12.57 We are also recommending that sector regulators should review and, where necessary, strengthen their existing guidance to make clear that a copy of the contract and a summary of the most important terms and conditions should be given to prospective residents and their representatives at an early stage of their decision-making process, and explained to them in a timely way.

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<sup>401</sup> For example, CQC guidance in England states that providers must give people a written estimate of the costs of the care, treatment or support if a fixed price cannot be given (and this should include details of any likely additional costs).

- 12.58 We are further recommending that to help facilitate the provision of clear pre-contract information to prospective residents and their representatives in a more consistent way, sector-specific regulations should be strengthened to require registered care home providers to use a model template in summarising their most important terms and conditions clearly and prominently.

### *Effectiveness*

- 12.59 Entering a contract with a care home is a major decision which can have significant implications for residents and their families. But some care homes are not giving people sufficient time to read the contract before being asked to sign it, which raises concerns about fairness as well as about whether the terms are incorporated into the contract at all. And many do not make their terms and conditions available online.
- 12.60 There are already existing sector-specific regulations and standards requiring care homes to give prospective residents a copy of the contract prior to the start of the service. Although the intention behind these regulations is to ensure that prospective residents can make informed choices, there are no specific timescales within which this must be done (or in most instances any clear, specific requirement to do so at an early stage of engagement).
- 12.61 Requiring care home providers to put copies of their contracts and a summary of the most important terms and conditions on their websites would help to ensure that prospective residents and their families, who often have limited time to make their choice of care home, have the opportunity to read the contract at the start of their decision-making process and have easy access to it at any point. It would also help mitigate some of the risks of people not being given sufficient time to read the contract (although it would not be a substitute for care home staff going through the contract and explaining the important terms in a timely way).
- 12.62 Having terms and conditions online would also allow people to more easily compare key differences between care homes. A clear requirement such as this would also be relatively straightforward for sector regulators to enforce (through monitoring and inspection).
- 12.63 There would be some initial administrative costs to care homes in ensuring copies of contracts were prominently placed on their websites. We think these costs are likely to be low, particularly as we understand from speaking to providers that changes to their standard contracts do not happen

regularly. There would also be some costs to sector regulators in scrutinising providers' compliance with the regulations.

- 12.64 There is a potential risk that such a requirement could be seen by some care homes as an alternative (rather than an addition) to the need to provide and explain contractual information in good time before the resident moves in. It is not, and failing to do this is likely to be unfair under consumer law. We think this risk can be mitigated by sector regulators clearly setting out expectations in supporting guidance that a copy of the contract and a summary of the most important terms should be given to prospective residents and their representatives at an early stage of their decision-making process, and explained to them in a timely way. This will be further reinforced by the CMA's own consumer law guidance.
- 12.65 The development of a model template to summarise the most important terms and conditions would help to address the variability we have seen in the user-friendliness and intelligibility of care home contracts. A template would also reduce the time and costs incurred by smaller providers in producing a summary of their important terms. It could build upon some good examples we have come across of care homes including this type of summary information on websites or information packs.

#### *Remedy implementation*

- 12.66 An addition to the existing sector regulations would make it a requirement for registered care homes to prominently display their terms and conditions (contract) or standard residency agreement on their website. Where a care home does not have a website the terms and conditions could be included in any marketing materials or information packs, as well as being made available on request.
- 12.67 There would also be an additional requirement for care homes to use a model template to explain or summarise their key terms and conditions clearly and prominently. The CMA could provide support in helping to design and develop such a template.
- 12.68 These requirements could potentially be limited to contracts for those people who self-fund their own care. State funded residents are placed in a care home under a contract between the LA or NHS and the provider - however, the residency agreement signed by a publicly funded resident with the care home would still include important terms such as about any additional charges, notice periods, and reasons for asking someone to leave.

## ***Protecting residents' deposits from the risk of insolvency***

12.69 We are recommending to government that existing sector-specific regulations are strengthened to require registered care homes to protect residents' deposits in full against the risk of insolvency.

### ***Effectiveness***

12.70 Unlike the private rented sector, there is currently no specific regulatory requirement for deposits to be safeguarded in full against the risk of insolvency. This means that if a care home provider were to become insolvent there is a risk that residents, as unsecured creditors, would not get their deposit back in full.

12.71 We consider that the harm to individual residents if they were to lose their deposits could be significant: deposits can typically be the equivalent of two weeks' or four weeks' residential care fees, which can amount to up to £4,000 to £5,000 in some instances. We have been made aware of some providers holding large sums in residents' deposits at any one time, in a few instances several million pounds.

12.72 While a few providers have told us they already safeguard deposits or are actively taking steps to do so, others say they don't. A voluntary approach is unlikely to persuade all providers to take measures to safeguard their deposits given it may involve some additional cost or mean they cannot use the monies as working capital.

12.73 There is already existing sector legislation, as well as regulations and standards, which require registered providers to ensure that residents' money is safeguarded against misappropriation. Our recommendation would make it a requirement for registered care homes to also protect residents' deposits in full against risk of insolvency. This would safeguard residents in full against the risk of losing their deposits should the care home provider cease trading.

12.74 The requirement would apply to care homes who take deposits in advance from residents, which are then refundable when the resident leaves or dies provided that no outstanding fees are owed to the care home<sup>402</sup>. It is possible that the requirement could be specifically linked to the size of the deposits taken (and hence to the potential impact on individual residents).

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<sup>402</sup> In principle, it could also apply to reservation deposits which may be taken in order to hold a room for a resident and are typically off-set against the first month's fees when the resident moves in, but we think the risks are lower here.

- 12.75 We are not proposing that the requirement applies to other pre-payments such as residential fees paid monthly in advance given these are likely to be used as working capital and so any requirement to ring fence would have a significant impact on a care home's cash flow.
- 12.76 We understand there are a number of potential ways in which deposits could be safeguarded, such as by:
- ring-fencing them and keeping in a trust account: this would have the benefit of protecting residents' deposits and would allow residents to be reimbursed quickly, and in full, should the care home enter a formal insolvency procedure;
  - taking out a protection bond: a care home provider could purchase a protection bond, which would honour deposits in the event of insolvency.
- 12.77 There are likely to be some associated costs to providers in introducing deposit protections, such as purchasing a bond or ensuring resident deposit accounts are separated. These costs are unlikely to be industry wide as we understand that many providers do not ask self-funding residents for deposits.
- 12.78 The remedy should not impact on the normal day-to-day running of the care home unless they had been using deposits as working capital or for cash flow purposes, which we do not think would in any event be appropriate.
- 12.79 Even though there may not be an imminent risk of the care homes sector collapsing and the levels of insolvencies have been very low (see section 4), the structural problem of the potential loss of deposits remains in the case of the failure of a provider. A requirement to safeguard deposits will help to increase public confidence in the care home sector at a time when concerns have been expressed about the financial position of certain providers, and mitigate against the future risk (and associated adverse publicity) of a provider going into insolvency and residents losing their deposits.

### *Remedy implementation*

- 12.80 Governments would introduce a new regulation, enforced by each sector regulator, to make it a requirement for any registered care home that takes resident deposits to ensure they are protected.



### ***Requiring care homes to notify the sector regulator when they ask a resident to leave or impose a visitor ban***

- 12.81 We are recommending to government that it strengthens sector-specific regulations to require care homes to notify the regulator if they ask a resident to leave a home or impose a visitor ban.
- 12.82 We are also recommending to sector regulators that they should develop specific guidance for registered care homes on high quality practice to be used when asking residents to leave and when imposing visitor bans or restrictions, to ensure such processes are fair and transparent. Sector regulators should be able to consider the way such guidance is used in their inspection and scrutiny activities, where necessary.

### ***Effectiveness***

- 12.83 Although care homes may have legitimate reasons for asking someone to leave (for example, because their condition has worsened and they cannot be looked after anymore) and for banning visitors (for example, because of disruptive or abusive behaviour), it is important that this is always done in a transparent and fair way. Our recommendations would broaden and strengthen current sector regulations and supporting guidance to make them more effective.<sup>403</sup>
- 12.84 It is currently very hard to get evidence about how often care homes are asking residents to leave, and about the extent of concerns that have been raised around unfair evictions because:
- some care homes do not routinely record such information;
  - complaints by residents and their families are likely to be under-reported given the general barriers to complaining;
  - in some instances, residents may agree to leave without the care home having issued a written notice.
- 12.85 There are already existing sector regulations which require care homes to notify the regulator of certain things ('notifiable incidents'), for example where they affect the health, safety and welfare of residents. Regulators can

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<sup>403</sup> In England, although providers are not currently asked about instances in which they have asked a resident to leave the care home in the current Provider Information Return (PIR), the new PIR which will be rolled out in a phased approach is expected to include a question asking providers for information about people who have been asked to leave the service in the last 12 months. Inspectors will take this intelligence into account in their inspections.

take action if a provider fails to submit a notification<sup>404</sup>. But these do not specifically include incidents where residents have been asked to leave<sup>405</sup>, or visitors have been banned, even though it could adversely affect the resident's wellbeing.

- 12.86 Our recommendation would make it a requirement for care homes to notify the regulator in a timely way where they ask a resident to leave, giving the reasons for doing so, the notice period that was given (including reasons if it was less than 28 days), and any other relevant information to allow a regulator who had concerns about a particular home to see whether the move was made in the best interests of the person.
- 12.87 We think the duty to notify should cover every instance where a resident was asked to leave the home; it should not be limited to circumstances where a care home gives formal written notice to leave, as this might exclude situations where the care home says that a resident agreed to leave or where no written notice was served. We also think that the requirement should be extended to include visitor bans.
- 12.88 The statutory notification process would be used as a reporting and intelligence function for sector regulators, so that, where needed, they could take follow-up action if there had been a breach of relevant regulations or standards. It is not intended that it should be an appeal mechanism for individual residents, where there might be an expectation that the regulator could act as an adjudicator.
- 12.89 Such a reporting function would allow regulators to get better and more timely intelligence about how often residents were being asked to leave or evicted and the reasons. From a risk perspective, it would allow them to act in a more pro-active and timely way where potential concerns were identified about a care home's behaviour (or a pattern of behaviour). It would also give regulators an insight into the culture of evictions and hold care homes more to account to ensure they always acted fairly and openly when asking residents to leave.
- 12.90 Alongside this, sector regulators should publish guidance for registered care homes on good practice to be used when asking residents to leave and when imposing visitor bans or restrictions, to ensure such processes are fair

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<sup>404</sup> For example, the CQC can prosecute or take other regulatory action for a breach of the Regulation.

<sup>405</sup> However, in Northern Ireland there are specific regulations which require a registered care or nursing home not to terminate 'the arrangement for the accommodation of a patient' without giving reasonable notice (28 days), and to notify the regulator (RQIA) if less than 28 days' notice is given to explain the circumstances which made it impracticable to comply with the requirement. There is also a requirement that the individual themselves, their next of kin and the Trust are notified of the termination.

and transparent. Sector regulators would be able to consider the way such guidance was used as part of their inspection activities. This could cover things such as prior consultation with the resident and their representatives, the right to resident representation and advocacy (for example involvement of third parties such as GPs or an advice service), notice periods and the exceptional circumstances in which shorter notice may be appropriate, and appeal processes if someone wishes to challenge the initial decision.

- 12.91 There would be some administrative and regulatory costs to providers in having to notify the sector regulator each time they had asked a resident to leave a care home or imposed a visitor ban, particularly if they did not already have their own internal systems in place to record such events. If, as some providers have asserted to us, asking residents to leave does not happen very often, the costs should be relatively low. Further, given the seriousness of this step, it is important that providers do have robust systems in place to ensure that eviction (or a visitor ban) is a last resort, so these costs are appropriate in all the circumstances. There would also be costs to sector regulators in reviewing notifications, but in the context of enhancing their intelligence gathering capabilities and risk-based inspection processes.
- 12.92 Statutory notifications, together with sector guidance on best practice when asking residents to leave or imposing visitor bans, would help to provide reassurance to residents and their families that there are strong safeguards in place to ensure they are treated fairly. Even more importantly, these measures are likely to protect some individuals from unwarranted eviction, by raising the bar for this as an outcome. This would sit alongside, and reinforce, relevant parts of the CMA's consumer law compliance guidance dealing with contract terminations.
- 12.93 More generally, a better understanding of how often residents are being evicted or visitors banned and for what reasons will give a more robust evidence base to decide whether additional stronger protections are needed.

### *Remedy implementation*

- 12.94 Governments would amend existing regulations, enforced by each sector regulator, to make it a requirement for a registered care home to notify the regulator within a specified time period when it has asked a resident to leave or banned a visitor. Sector regulators would also develop guidance for care homes on best practice.

## **Clarifying existing sector guidance**

- 12.95 We are also recommending that some of the existing sector-specific guidance in England is reviewed and clarified to ensure that there is:
- (a) Stronger protection and clearer policy and guidance on the payment of third party top-up fees;
  - (b) clearer guidance on the relationship between NHS Funded Nursing Care payments and self-funding resident's own contribution to their fees;
  - (c) clearer guidance on the circumstances in which top ups are permitted for NHS Continuing Healthcare Funded residents, greater consistency in how CCGs interpret the rules, and clarity about how the rules on top ups are enforced.

## **Stronger protection and clearer policy and guidance on third party top-up fees for LA funded residents**

- 12.96 We have some concerns about the way in which third party top-ups are being applied in practice in England. In summary, it appears that some third parties are not benefiting from the protections against paying unnecessary or unfair top-ups that should be afforded to them when an LA is involved in the arrangement.
- 12.97 Our recommendations are not intended to change the legislation and principles which underpin the role of top-ups. They are, however, intended to reinforce the role of the LA in ensuring that people are adequately protected. Although the value of third party top-ups as a percentage of care home providers' total revenue may be relatively small, they can amount to very significant sums for the people making the payments.
- 12.98 We have only received limited evidence of similar problems arising in Wales, Scotland and Northern Ireland. However, we think that Governments in those nations keep these issues under review.

### ***Top-up fees agreed privately between a care home and third party***

- 12.99 We are recommending that LAs actively discourage state funded residents and their representatives from entering any agreement with a provider for a top-up without the agreement of the LA. Specifically, we recommend that the Department of Health in England consider updating the Care Act statutory guidance so that it is clear that LAs must explain to prospective care home residents and their families and people arranging their care that:

- care home providers should not approach them or their representatives such as relatives directly to demand a top-up, or without the involvement of the LA; and
- there are significant benefits in arranging a top-up through the LA.

### *Effectiveness*

12.100 This is intended to address concerns about care homes approaching residents and third parties to demand a top-up, or without the involvement of the LA, with the result that:

- (a) the LA may not be aware of the arrangement and true cost of care; and
- (b) the third party does not have the protections they would have if the top up had been arranged through the LA;<sup>406</sup> and
- (c) there is scope for the care home to impose more onerous terms and conditions on the third party than if the LA is involved in the arrangement.

12.101 The recommendation is intended to increase awareness that a third party has better protection if the top up agreement is arranged with the involvement of the LA.

12.102 There could be some additional resource and cost implications for LAs in making sure that people understand the risks of not involving an LA in a third party top-up arrangement. But it is in line with the duties on an LA to make sure that the person paying the top-up understands the implications of the top-up and their liabilities.<sup>407</sup> Our recommendation would help LAs fulfil their existing obligations under the Care Act.

### *Remedy implementation*

12.103 We envisage that the Care Act statutory guidance would be updated so that it explicitly states that LAs must make residents and their families or representatives aware of the LA's duties around third party top ups and recommends that people do not make private agreements with a provider as

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<sup>406</sup> For example, the LA being liable for the top up until it can recover costs or make alternative arrangements and remaining under the duty to meet the eligible needs of a care home resident if, for whatever reason, a third party cannot continue paying a top-up.

<sup>407</sup> These include: the consequences of not making payments; the effect of increases in the fees; and the effect of changes in the payer's financial circumstances (Regulation 5 of SI 2014/2670)

they will lose the benefits of arranging it through the LA. Those benefits should also be made clear.

### ***Third parties being asked by LAs to pay top-up fees directly to the care home***

- 12.104 We are recommending that that the Department of Health in England consider making it a requirement that when an LA arranges the preferred accommodation with a third party top-up, the provider agrees with the LA that its payment and other conditions will be the same, irrespective of whether the third party contribution is paid to the provider via the LA or directly by the third party.
- 12.105 We also recommend that the Department of Health in England consider updating the Care Act statutory guidance to make it clear that where it is agreed with the third party and provider for a top up to be paid directly to the care home, the LA will include a provision in its contract with the provider to ensure that the third party will not be subject to less advantageous terms and conditions than if they had paid the top up through the LA.

### ***Effectiveness***

- 12.106 Our recommendation would address concerns about third parties (such as relatives of residents) agreeing to make top up payments directly to care homes on potentially more onerous terms than if they had paid them through the LA - such as, for example, being required under the care home contract to pay the top up fee for a longer period after the death of the resident. It would also help mitigate some of the risks of confusion arising from third parties signing multiple contracts when paying the top up directly to the care home.
- 12.107 We think LA contracts with care homes should clearly stipulate that where a third party agrees to pay a top up directly to the care home, the payment conditions must be the same as when the payment is made through the LA. Our recommendation should not have a significant cost or resource implication for the LA.
- 12.108 There could be resource implications for the LA in clarifying the terms of this condition to the third party responsible for making the payment. However, we do not consider that this will add significantly to the burdens on the LA given that it already has an obligation to make sure that the person paying the top-up understands the implications of the top-up and their liabilities.<sup>408</sup>

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<sup>408</sup> Regulation 5 of SI 2014/2670.

12.109 Given that some providers have told us a significant proportion of third party top ups they receive are paid directly to them (based on what they say has been agreed with the LA), and the potential vulnerability of the people concerned, we consider that the benefits outweigh the relatively low costs involved.

### *Remedy implementation*

12.110 We envisage that the Choice of Accommodation Regulations would be amended to include the additional condition described above. The Care Act statutory guidance would also need to be updated and expanded upon. It states that '*multiple contracts risk confusion*'. It should also expand on this and explain that the terms of any direct payments should have been agreed by the LA who will explain the implications of those terms to the third party.

### **Clearer guidance on the relationship between NHS Funded Nursing Care (FNC) payments and a self-funding resident's own contribution to their fees (in England)**

12.111 We are recommending to the Department of Health in England that it revises the 'National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care' and practice guidance to clarify how the FNC payment affects self-funding residents' fees.

12.112 We also think that the Welsh Government should consider whether there is a need to review its existing 'NHS Funded Nursing Care in care homes guidance 2004' in light of the concerns we have identified in England.

### *Effectiveness*

12.113 We have found there is considerable uncertainty amongst some self-funded residents about how NHS FNC payments affect their own contribution to their overall care home fees, particularly when the payments are changed.

12.114 The existing practice guidance appears to suggest that for self-funders the relationship between their residential care fees and the FNC payment is dependent on the terms in their contract with the care home. This leaves considerable scope for different contractual approaches to be taken by care homes in how they deal with any changes in the amount of FNC payments.

12.115 We think the revised National Framework and practice guidance should clarify how the FNC payment affects self-funder's fees, in a way which ensures that residents and care homes understand how the FNC payment should impact upon the resident's contribution, particularly when the

resident's FNC contribution ceases (for example, if they go into hospital or when they die) and when there is a change in the rate of the FNC paid. In part, this requires clarifying whether FNC is meant to be a payment made to care homes to i) meet the costs of providing registered nursing care that they might otherwise charge to the self-funding resident or ii) to reduce the financial burden on the self-funding resident (or those funding the care) of paying for the cost of registered nursing care.

12.116 Clearer guidance, which would be reflected in care homes' contract terms with self-funders, would provide much greater price transparency for residents.

### *Remedy implementation*

12.117 The Department of Health is currently undertaking a wider review of the National Framework (including the practice guidance) and as part of its stakeholder engagement process we have shared our findings and recommendation to help inform the review. We understand that the Department of Health intends to publish an updated version in early 2018.

### **Clearer guidance on the permissibility of top up payments for NHS CHC residents**

12.118 We are recommending to the Department of Health in England that it revises the 'National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care' and practice guidance to further clarify, in the context of CHC residents:

a) the types of additional, private services that may permissibly be 'topped up' via private payments to a care home under NHS rules; and

b) how the Department of Health and NHS rules on top up payments are monitored, applied to, and enforced against CCGs and providers.

12.119 We also think that the Welsh government should consider whether there is a need to review its existing guidance ('Continuing NHS Healthcare: The National Framework for implementation in Wales') in light of the issues we have identified in England.

### *Effectiveness*

12.120 We consider there to be some ambiguity and uncertainty about the types of additional services that may be funded privately by CHC residents under



NHS rules (for example, whether there are circumstances in which ‘top up’ payments for a better room within the care home are permissible).

- 12.121 We also think there is a general lack of awareness about the ‘top up’ rules as they relate to CHC residents, which organisations are bound to take them into account (including how the National Framework applies to care home providers and their contractual arrangements with individual residents), and how and by whom they are monitored and enforced in the event of breaches or non-compliance by providers or CCGs.
- 12.122 Clearer guidance would help to ensure that CHC residents benefit from all of the protections they are entitled to against unfair additional costs.

### *Remedy implementation*

- 12.123 The Department of Health in England is currently undertaking a wider review of the National Framework (including the practice guidance) and as part of its stakeholder engagement process we have shared our findings and recommendation to help inform the review. We understand that the Department of Health intends to publish an updated version in early 2018.
- 12.124 Alongside this, we are also aware that in April 2017 NHS England started a programme<sup>409</sup> to look at how Continuing Healthcare (CHC) services can be improved, including setting national standards of practice and outcome expectations. The programme is called the NHS Continuing Healthcare Strategic Improvement Programme and it will run for two years.

### **Other potential ways to enhance consumer protections: codes of practice**

- 12.125 During the course of our market study some stakeholders have highlighted the potential role that self-regulatory Codes of Practice and trader approval schemes can play in building on the consumer protections already afforded to residents through consumer law and sector-specific rules.
- 12.126 In particular, the Consumer Codes Approval Board (‘CCAB’) and Age UK highlighted the role that an Approved Consumer Code might have in helping to address some of the consumer protection concerns we have found, including around information provision, fair contracts, and complaint handling. The codes approval scheme is open to any eligible code of practice

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<sup>409</sup> See NHS England’s [NHS CHC Strategic Improvement Programme](#).

that meets its core criteria and has obtained CTSI approval. There are already trade associations and other code sponsors operating approved consumer codes in a number of other markets.<sup>410</sup>

12.127 An approved consumer code in the care homes sector could potentially bring a number of benefits – for example, through:

- the provision of a low-cost, speedy, responsive, accessible and user-friendly alternate dispute resolution (ADR) for consumer-related disputes;
- the protection of deposits;
- potentially recommending the use by members of a model contract or key model contract terms.

12.128 If an approved consumer code or other type of trader approval scheme<sup>411</sup> is developed, it could potentially play an important role - alongside consumer law and sector-specific rules - in raising consumer protection standards. But we think there are likely to be some challenges in the short-term to developing and implementing such a code across the sector. The care home market is fragmented with a large number of providers (many of whom are small) and a number of different trade associations representing the industry across the UK, so finding a suitable code sponsor<sup>412</sup> and setting up a code that has widespread coverage may be harder. Care home providers will need to see the benefits to them of signing up to a code scheme, there will need to be sufficient clarity about how such a code adds value (beyond care homes' existing obligations under consumer law and sector-specific rules), and the public will need to see clear benefits in choosing a care home that is a code member.

12.129 Although a mandatory Code of Practice (which all care homes would be required to sign up to as a condition of their registration) could address the issue around industry-wide coverage, we think the better way to raise standards at this time is through a combination of changes to sector-rules and giving sector regulators a greater role in helping to embed consumer law compliance.

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<sup>410</sup> See [Chartered Trading Standards Institute – code sponsors](#).

<sup>411</sup> For example, there is a 'Buy with Confidence +Care' scheme run through the cooperation of Adult Social Services Departments with Trading Standards Services, which currently operates in Hampshire and Bath & North East Somerset. In order to become a Buy With Confidence +Care member, a business must apply to join the scheme, pass a set of background checks and a face to face audit. Applicants must agree to abide by the scheme's code of conduct. The scheme has concentrated on the domiciliary care sector to date but plans to extend to other care services (including residential care) over time.

<sup>412</sup> If a suitable code sponsor cannot be found, then CCAB would consider alternative methods of consumer code delivery, through a strategic partner for example.

12.130 The CMA would be willing to work with the industry and CCAB if an approved consumer code is developed and taken forward, but we do not think this should delay the implementation of the recommendations we are making to strengthen sector-specific rules and to embed consumer law, as these will help immediately to address the concerns we have identified.

## **13. Measures to enhance complaints and redress systems**

### **Introduction**

- 13.1 This section explains our recommendations to enhance complaints and redress systems. Most of our recommendations apply to all four nations, but we also make specific recommendations in relation to the Ombudsmen in England and Northern Ireland.
- 13.2 As set out in section 11, there are various barriers which affect the ability of residents and their relatives to raise and escalate a complaint about a care home. These can include: a fear of repercussions following a complaint; the vulnerability of the individuals involved; limited experience with the care homes sector; lack of awareness of, or difficulties in engaging with, complaints processes; and a weak feedback culture within the home.
- 13.3 With these barriers in mind, we have developed recommendations which are aimed at ensuring that:
- (a) Residents and relatives are aware of and able to access support to raise their concerns. This could be in the form of advocacy services, or general advice and support.
  - (b) Providers generate a feedback culture within their homes where compliments, comments and concerns can be raised, both openly or anonymously, and where they are effectively addressed.
- 13.4 We also make recommendations to the sector regulators in each nation about the way they review the complaint systems of individual care homes. These are intended to embed improvements, particularly in the way care homes help their residents access advice and support.

### **Accessing support for concerns**

#### ***Review of advocacy services***

- 13.5 We recommend that central government in England, the Scottish government and Northern Ireland Executive undertake, in consultation with relevant bodies, a review of the coverage of advocacy services for residents of care homes with a view to ensuring that all residents have access to adequate services which are sufficiently targeted at care home residents.

- 13.6 This recommendation does not apply in Wales where we understand that CSSIW is planning to consider advocacy services as part of its new role to regulate these services and where the Older People's Commissioner for Wales has already completed a review.<sup>413</sup> In Northern Ireland, DHNI has indicated that this could form part of a wider review of adult social care.<sup>414</sup>
- 13.7 As set out in our findings in section 11, a common theme in both the CMA consumer research and the consumer groups we spoke to, is the need for greater support for residents in making a complaint, or in some cases, better awareness of existing services that could assist.<sup>415</sup> Support in the form of advocacy services can help residents who find the complaints process complex or overwhelming, or who do not have the time, energy or health to actively pursue complaints. Given the vulnerability of the residents involved, access to representation is an important mechanism for ensuring that complaints systems work well.
- 13.8 Consumer groups we spoke to raised concerns that there are insufficient advocacy services available to support complainants, particularly in an environment of strained budgets. The Older People's Commissioner for Wales made similar findings in its review of advocacy services in Wales and has indicated that a further report about independent advocacy in Wales will be published in 2018.<sup>416</sup> Our study has not attempted to measure the amount of advocacy support currently available to care home residents. A review would reveal whether these services are sufficiently available and, if not, how these services could be targeted for the benefit of care home residents.
- 13.9 In terms of scope, we recommend that the review consider the availability of both statutory and non-statutory advocacy services, including those provided by LAs. Further details on types of advocacy are set out in Appendix F, paragraph 7.
- 13.10 Findings of this review should be published and include an explanation of how any shortfall will be addressed. As part of this exercise, central government should explore the need for additional funding for LAs or other

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<sup>413</sup> Part 1 of the [Regulation and Inspection of Social Care \(Wales\) Act](#). Older People's Commissioner for Wales (September 2012), [Voice, Choice and Control: Recommendations relation to the provision of independent advocacy in Wales](#).

<sup>414</sup> On its [website](#), DHNI explains that it is taking forward a process to reform adult care and support (including residential and nursing home care) and has commissioned an Expert Advisory Panel and Call for Evidence to develop proposals for change.

<sup>415</sup> For example, Research Works, CMA consumer research, page 60, sets out that when prompted, residents and relatives interviewed by Research Works raised these concerns.

<sup>416</sup> See Older People's Commissioner for Wales (September 2012), [Voice, Choice and Control: Recommendations relation to the provision of independent advocacy in Wales](#).

bodies to provide advocacy services and whether this funding should be ring fenced for adult social care and specifically targeted at residents in care homes.

- 13.11 We see value in central government working jointly with or commissioning certain organisations for this review. In England, Healthwatch England or CQC could be well placed to partner with Department of Health.<sup>417</sup> In Northern Ireland, the Patient Client Council (PCC) could assist, given its expertise in complaints. In Scotland, the Care Inspectorate could have a role.<sup>418</sup>
- 13.12 We are aware that there will be a cost to central government and bodies in undertaking this review. In addressing any shortfall found, there could also be cost implications for LAs or other bodies. The review should consider these costs in its recommendations and how to make best use of the existing resources and services.

## **Sector regulators' role in improving feedback and advocacy services**

- 13.13 We recommend that the sector regulators include in their inspections an assessment of a) the effectiveness of feedback processes within the home, including whether a feedback champion is required, so that a culture of listening to and acting on feedback prevails within care homes; and b) the level of awareness of and access to advocacy services.

### ***Encouraging feedback culture***

- 13.14 Effective complaints systems are vital in ensuring that people can seek and obtain redress. However, given the vulnerability of the people concerned in this sector and the difficulties identified in section 11 (paragraph 11.71) with lengthy or complicated complaints processes, it is often more important to resolve issues quickly so that they do not need to be escalated into more formal complaints. Encouraging and acting upon feedback are therefore key to a successful complaints system.

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<sup>417</sup> Building on reports such as Healthwatch England (August 2017) *What it is like to live in a care home?: Findings from the Healthwatch network*, or CQC (July 2017) *CQC annual report and account 2016/17*. We understand that if CQC were involved, its focus would be on whether people in care homes have access to advocacy services.

<sup>418</sup> Building on reports such as Care Inspectorate (November 2016) *Complaints about care services in Scotland, 2011/12 to 2015/16, A statistical bulletin*.

### *The inspection regime*

- 13.15 Sector regulators ensure that their inspections assess whether and how effectively the provider is embedding a feedback culture in the home. We suggest that they should look at factors such as how internal governance processes encourage feedback, whether a feedback champion is in place and examples of where the home has applied learning from feedback.
- 13.16 This recommendation would strengthen incentives on providers to facilitate feedback culture and could build on existing efforts by providers to create this environment, as well as promoting consistency across providers. Sector regulators could also consider ways of promoting best practice sharing amongst industry or support for providers such as specific training. This would build on existing requirements around feedback in inspection frameworks.<sup>419</sup>

### *Feedback champions*

- 13.17 When assessing feedback culture, sector regulators should also consider whether the provider would benefit from having a feedback champion in place, for example where the home is struggling to encourage a feedback culture. These champions would be a person independent of the home, who can provide a conduit between the residents and/or relatives, and care home staff including corporate management. The champion should visit the home regularly to provide advice and assistance to individuals and to report to management on any themes emerging and to champion changes where needed.
- 13.18 As someone independent of the home, feedback champions could help to address concerns around complaining directly to the home (eg for fear of recrimination).<sup>420</sup> They can also help bridge communication gaps between residents and representatives, and their care home. Importantly, champions could be available for staff who may not feel confident to raise concerns directly with corporate management.
- 13.19 When requiring providers to have feedback champions in place, we recommend that sector regulators consider the merits of having a local feedback champion who visits several homes in a particular area to reduce costs and implementing a network of support for champions to support to

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<sup>419</sup> For example, CQC has told us that its inspection framework considers, amongst other factors, “what are the arrangements to encourage relatives and friends to provide feedback?”. CSSIW inspects whether there are ‘robust, transparent systems in place to assess the quality of the service in relation to outcomes for people which includes feedback from people using the service and their representatives’.

<sup>420</sup> See [IPSOS Mori](#), CMA consumer research, p86 and Research Works, CMA consumer research, p57.

ensure champions do not become isolated within a home or lack sufficient visibility to generate change.

### **Advocacy support**

- 13.20 Sector regulators should carry out their inspections so as to include a qualitative assessment of how providers make residents and relatives aware of services that could support them in complaints. At a minimum, this assessment should consider: appropriateness and availability of material used for signposting residents to services (both advocates and complaints functions), staff training on services available, and examples of where advocacy services have been accessed by residents and/or relatives.
- 13.21 This recommendation would place a greater onus on providers to ensure that residents and relatives are aware of services that could support them. This could assist with concerns raised by consumer groups that there is a lack of awareness by residents of services that are available and how and in what circumstances they might access it.<sup>421</sup>
- 13.22 Some providers have told us that they already signpost to consumer groups and/or advocacy services, for example using leaflets or notices. This recommendation would build on these existing efforts and ensure they are effective, as well as promoting consistency across providers.

### **Impact of amending inspection regime**

- 13.23 The qualitative assessment of the effectiveness of feedback processes and the level of awareness and access to feedback champions will have some resource implications for both sector regulators and providers. We consider these would be minimal as this requirement would enhance existing inspection rules eg CSSIW's inspection framework already considers documentation around whether advocacy arrangements exist and how independent those arrangements are.<sup>422,423</sup>

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<sup>421</sup> A similar finding was reached by the Older People's Commissioner Wales in its report on advocacy services. See Older People's Commissioner for Wales (September 2012), [Voice, Choice and Control: Recommendations relation to the provision of independent advocacy in Wales](#).

<sup>422</sup> See CSSIW (April 2017), [Framework: Older Adults](#).

<sup>423</sup> Similar requirements exist for other sector regulators e.g. CQC explained many of its Next Phase Key Lines Of Enquiry (KLOEs) and sources of evidence cover advocacy eg Caring 2.2 (information given to people including about advocates).” In Northern Ireland, [standards](#) specify that “residents must, where appropriate, be made aware of the role of independent advocacy services and be assisted to access the support they need to articulate their concerns and successfully navigate the system. Homes facilitate arrangements for residents to speak to their advocates in private.” The [Health and Social Care Standards](#) in Scotland state that “I am supported to use independent advocacy if I want or need this.”



## **Improving awareness of and access to the Ombudsman**

13.24 These recommendations are aimed at ensuring residents and relatives are aware of and able to access bodies to whom they can escalate their concerns. This includes statutory signposting to the LGSCO in England and extending the remit of NIPSO in Northern Ireland to hear complaints from private funders.

### ***Statutory signposting to the LGSCO in England***

13.25 Recommendation to central government in England to introduce a statutory requirement for providers to signpost to the LGSCO.

13.26 This recommendation would strengthen the onus on providers to ensure that residents are aware of the LGSCO and how it can assist. While many providers have told us that they already signpost to the LGSCO, CMA consumer research found that residents and relatives were largely unaware of bodies outside the home who could assist with or hear their complaint.<sup>424</sup> Many interviewees assume that there is a 'social care ombudsman' based on their knowledge of other sectors, but were unaware of its name. Signposting could therefore raise the profile of the LGSCO in this area.

13.27 Introducing statutory signposting would align England with the statutory requirements in Wales and Northern Ireland (note that in Scotland, the Care Inspectorate has this obligation). It would also place the onus for ensuring that residents are aware of the role of the LGSCO squarely on providers. At present, signposting to the LGSCO is only a good practice requirement by the CQC. A good practice requirement means that there is a risk that only some providers will signpost to the LGSCO. This recommendation would provide consistency across all providers.

13.28 This recommendation supports the Quality Matters initiative which will develop standardised information explaining the role of the LGSCO in relation to adult social care and how it can assist complainants in care homes. Therefore, we think that this requirement will work best if combined with the Quality Matters work to ensure signposting is clear and effective.

### ***Extend remit of the NIPSO to consider complaints from private funders***

13.29 Recommendation to the Northern Ireland Executive to extend the remit of NIPSO so it can investigate complaints from private funders.

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<sup>424</sup> Research Works, CMA consumer research, p92.

- 13.30 This recommendation would allow care home residents in Northern Ireland who are privately funded to raise complaints with NIPSO. At present, in Northern Ireland, these residents would have to pursue complaints that are not resolved at the home level through other means such as contract law and court proceedings.
- 13.31 This recommendation would remove one of the complexities of the complaints system. As demonstrated by the flow charts in Appendix F, avenues for escalating a complaint will vary depending on the type of funding stream, which has the potential to be confusing for complainants.
- 13.32 This recommendation will also give NIPSO greater sight of the type of complaints raised with a care home. This information can then inform its oversight role in the complaints sector, such in the use of own initiative powers<sup>425</sup> to produce reports on systemic issues.
- 13.33 Care homes residents, including private funders, are a vulnerable group who could benefit from support from NIPSO. This would align the position in Northern Ireland with other nations where those who fund their own care can access the Ombudsman, and could be considered as part of a wider programme of reform for adult social care in Northern Ireland.
- 13.34 This remedy could require additional resources for NIPSO in order to investigate complaints from this group. We anticipate that the resource implications would be minor as we have been told that an estimated 5% of residents are privately funded in Northern Ireland (ie arrange care their own care without going through the HSC Trust) and not all of these residents will need to approach the Ombudsman.<sup>426</sup>
- 13.35 This recommendation touches on a wider debate around the appropriateness of the public purse being used for those who have means. Stakeholders have queried whether extension of NIPSO's remit could lead to an 'opening of the floodgates' for other sectors. We consider that the vulnerability of residents in care homes, regardless of funding stream, arguably distinguishes them from other cases such as private schools.
- 13.36 For the reasons set out in the paragraphs above, we believe risks highlighted above will be outweighed by the ability of this group of residents

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<sup>425</sup> Section 8 of the [Public Services Ombudsman Act \(Northern Ireland\) 2016](#) provides that the Ombudsman may investigate a matter in respect of which no complaint has been made, where certain requirements are met.

<sup>426</sup> For example, response to update paper by the [Commissioner for Older People Northern Ireland](#) (August 2017).

to access NIPSO, minimal resource requirements, availability of better information for NIPSO and wider streamlining of complaints processes.

## **14. Recommendations**

- 14.1 This section explains the recommendations we are making. We also describe the intended outcomes and timing of the interventions we are proposing, and explain how we expect our proposals to act together to improve outcomes for people using care homes.
- 14.2 Our recommendations are targeted at improving outcomes in the care homes sector in two priority areas:
- (a) Protecting and supporting older people and their families and representatives as they make decisions about care, and whilst using care homes. We are recommending enhancements to consumer protection and consumer-facing interventions to help people find the information and support they need to find care that is right for them; and
  - (b) Delivery of sufficient capacity to meet the needs of current and future older people, particularly those funded by LAs, including making sure there is enough capital investment in the right types of care to meet future needs so that care home places are available for people when they need them.
- 14.3 We have 20 recommendations, all of which have been explained in detail elsewhere in this report. These recommendations can be grouped as
- (a) Capacity recommendations;
  - (b) Consumer protection recommendations; and
  - (c) Consumer decision-making recommendations -Helping people make decisions about care.
- 14.4 Our recommendations are summarised in paragraphs 14.5 to 14.12 and explained in more detail in paragraphs 14.27 to 14.43. All recommendations apply in all nations except where stated.

### **Summary of recommendations**

#### ***Capacity recommendations***

- 14.5 Our primary recommendation in respect of capacity is to enhance the effectiveness of capacity planning in England and Northern Ireland (see paragraphs 8.23 to 8.26). We recommend:

- (a) that the government sets up a new function, independent of government, with the objective of ensuring that planning is of sufficiently good quality to provide confidence that the capacity will be in place to meet needs over a period, specified by government. For example, the new function could have the following duties and objectives:
  - (i) to review and report on the planning by LAs of all types of social care for the elderly, and whether plans are sufficient to meet the objectives of providing care to all those with eligible needs;
  - (ii) to provide guidance to LAs as to what is required for market planning statements to be effective and to provide information to support LAs in developing plans; and
  - (iii) to report on where LAs are, based on evidence provided, not planning to a standard required by their duties, or are not taking appropriate actions to ensure that the plans are then met.
- (b) in England, a process is established to provide independent advice to government, to be updated periodically:
  - (i) to provide evidence to government on the expected cost of different forms of care over a specified period;
  - (ii) to provide evidence to government on the need for different types of care (including residential care, nursing care, domiciliary care and other options) over the foreseeable future, perhaps 5 to 10 years.

14.6 We also recommend the introduction of enhanced market oversight for UK-based care home groups, and of mechanisms for the sharing of critical information and market intelligence among the relevant national regulators to facilitate continuity of care for residents (see paragraphs 5.9 to 5.14).

### ***Consumer protection recommendations***

14.7 Alongside the actions we are taking to ensure care homes are meeting their consumer law obligations (including enforcement and new guidance - see paragraphs 12.9 to 12.25), we recommend that sector regulators play a greater role in helping to 'embed' consumer law compliance across the sector - both to further raise industry standards and drive a 'culture of expectation' amongst residents about the quality of service and fair treatment they are entitled to expect from care homes.

14.8 As follow up to our guidance, we would be prepared to work with industry bodies who wish to develop model contracts that they will recommend care

homes to use with self-funders which would help address the variability we have seen in the user-friendliness and intelligibility of contracts and encourage best practice across the sector. (see paragraphs 12.35 to 12.41)

- 14.9 In order to improve compliance and ensure consumers are better protected, we are also recommending that sector rules are updated to require care homes to:
- (a) publish indicative fee information for self-funders (see paragraphs 12.43 to 12.55).
  - (b) publish a copy of their standard (self-funder) contract, and a standard summary of important terms and conditions (using a model template), as well as to provide these to prospective residents at an early stage in the decision-making process (see paragraphs 12.56 to 12.68);
  - (c) protect residents' deposits in full against the risk of insolvency (see paragraphs 12.69 to 12.80).
  - (d) notify the sector regulator if they ask a resident to leave a home or impose a visitor ban (see paragraphs 12.81 to 12.94); and
  - (e) follow new guidance from sector regulators on high quality practice to be followed when asking residents to leave and when imposing visitor bans or restrictions, to ensure such processes are fair and transparent (see paragraphs 12.81 to 12.94).
- 14.10 In order to achieve these changes, regulators will need to work together with industry to develop the standard practices and templates necessary.
- 14.11 In order to ensure that residents have sufficient clarity about their rights, we recommend that some sector-specific guidance in England is reviewed and clarified and sector rules are updated so that:
- (a) LA funded residents and those helping to fund their care are not misled or otherwise confused about their rights when making third party top up payments (see paragraphs 12.99 to 12.103)
  - (b) where people have agreed with the LA to make third party top up payments directly to the care home, they do not face contract terms that are more onerous than those used in the contract between the care home and the LA (see paragraphs 12.104 to 12.110)
  - (c) it is much clearer how the FNC payment affects self-funders' fees (see paragraphs 12.111 to 12.117)

(d) It is much clearer what additional private services may be paid for where an individual is receiving NHS Continuing Healthcare funding (See paragraphs 12.118 to 12.124)

14.12 Further, in order to ensure that residents can resolve problems they encounter after they have moved in, we are recommending that:

- (a) steps are taken to ensure that all residents have access to adequate advocacy services which are sufficiently targeted at care home residents, starting with a review of the coverage of these services (England, Scotland and Northern Ireland only) (see paragraphs 13.5 to 13.12);<sup>427</sup>
- (b) sector regulators encourage a culture of feedback in care homes by including in inspections an assessment of the effectiveness of a) feedback processes within the home, including whether feedback champions are required; and b) awareness of and access to advocacy services (see paragraphs 13.13 to 13.23); and
- (c) there is a statutory requirement to signpost to the LGSCO (England only) (see paragraphs 13.25 to 13.28), and that the remit of NIPSO is extended to hear complaints from private funders (Northern Ireland only) (see paragraphs 13.29 to 13.36).

### ***Consumer decision-making recommendations - Helping people make decisions about care***

14.13 We are recommending that the national governments take forward the evidence of our work on consumer decision-making in order to improve the way in which people interact with care homes, whether acting for themselves or their families. We recommend that a working group is established to develop and agree a plan for substantially improving the provision of supported decision-making services in the UK (see paragraphs 10.14 to 10.21). This group should:

- (a) develop and implement an approach to give people access to better information on care homes and other services in their local area (paragraphs 10.22 to 10.30); and

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<sup>427</sup> See Appendix F paragraph 7 for a description of advocacy services.

- (b) develop and implement measures with the objective of encouraging and helping people to think and plan ahead for care they may need in later life (paragraphs 10.31 to 10.37).

## **How our recommendations work together**

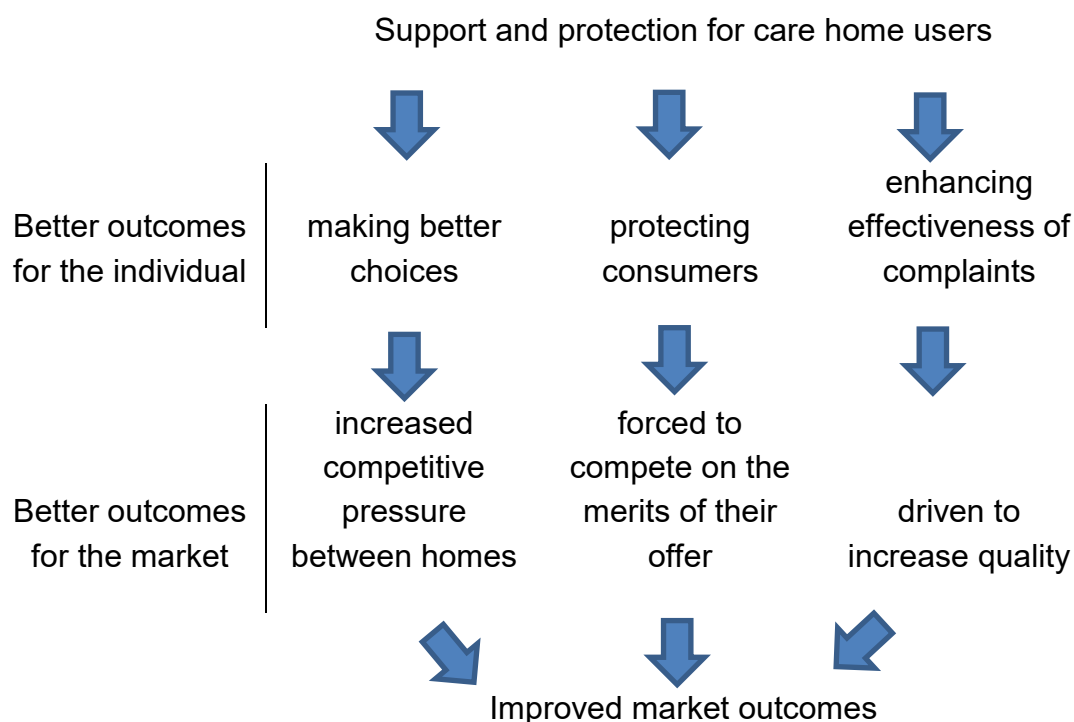
- 14.14 Our recommendations work together as a package. Elderly people and their loved ones need support and information to help them make good choices, and for realistic choices to exist it is also essential that sufficient capacity is put in place. Even having made good choices, once older people are in residential care, they will need additional protection after going into care. The human cost of failing to act in the best interests of residents can be very high, and we are making a number of recommendations which are intended to reduce the risk of this happening in practice. We summarise below how these should work together, starting with how we propose to help people make informed decisions about residential care.

### ***Greater support and protection for those requiring care***

- 14.15 People currently make life changing decisions under pressure, at the last minute, using whatever information is available at that point. Our recommendations have the objective of encouraging people to think about care earlier. This can keep options open, reduce the stress of the final decision, and help people find the right care home for them.
- 14.16 The final decision will always need to be made nearer the time, and some people will still have to make quick decisions. However, better informed consumers, well placed to make better decisions, should drive improved market outcomes as care homes will need to compete with rivals on the services they offer, their quality and value, in order to attract residents. This will apply to both self-funded and state-funded residents.
- 14.17 We recognise that many of the barriers people face to acting as well-informed consumers in this market are deeply ingrained and can only be mitigated, particularly once a resident has settled in a care home.
- 14.18 This is why we consider it essential that residents receive the benefits of consumer protection against potential unfair treatment and adverse outcomes, through consumer law and sector regulation, and why we have recommended measures to support complaints and feedback processes. With these protections in place, and with care homes being held accountable for the services they deliver, we would expect that they will be motivated to compete actively and transparently on the quality and value of care they provide. This is illustrated in figure 14.1.



**Figure 14.1: Interaction of recommendations for greater support and protection**



Source: CMA.

### ***State-funded care and capacity***

14.19 We have identified several contributing factors leading to a risk that it will not be possible to meet future care needs for state-funded residents without decisive interventions.

14.20 The different elements of this recommendation are all important:

- (a) without careful planning in relation to needs and capacity, LAs will not know what needs to be delivered and will not be able to demonstrate their commitment to deliver credibly enough to encourage the required level of private investment;
- (b) such plans will need to be supported by funding in order to be realised;
- (c) oversight and accountability provide the incentives to deliver what is needed, and to be able to take a long-term view as well as concentrating on delivering services today.

14.21 We have concluded that an independent body will help enable LAs to deliver services efficiently, and its independence will help ensure planning is driven by need.

### *Alternative approaches*

- 14.22 Our recommendations are based around the current policy approach to the provision of social care for the elderly, ie it is largely provided by the private sector with individuals responsible for the costs of care above a relatively low asset threshold.
- 14.23 We have considered whether recommendations for greater regulation (such as price capping or centralised procurement) in the sector would be appropriate. There is a great variety of types of care, types of care home and local circumstances. There is also a risk that, at least in some areas, further regulation could reduce competitive incentives for efficiency and improved services and instead focus the sector's priorities on the regulated price. We have also not found indications of the industry overall making excessive profits; there is some competition between care homes for residents (including the possibility of new entry in many local areas); the market consists of a very large number of providers, many of whom are very small;
- 14.24 We expect that the measures we have recommended will be sufficient to ensure that capacity is there in the future for the increased numbers of people who will need it. If, however, oversight by an independent body is not sufficient to increase LA incentives to take the necessary timely decisions, or if uncertainty about future public funding remained a substantial deterrence to investment, it might be necessary to consider going further. In such circumstances, it may be worth considering the approach taken in Scotland and Wales, where LA fees are determined centrally to provide greater clarity to providers, or to consider mandatory rules on LAs paying care rates that cover the full cost of care (with the requisite funding provided).

### *Fee differentials*

- 14.25 We have considered whether recommendations should be made to require that fees charged to self-funders are set at the same level charged to LAs in any specific home. We have not made such a recommendation, for two major reasons. First, to do so would impose an immediate and very substantial public funding cost. Second, such a measure would be likely to cause the market to split in two as those care homes which could concentrate on self-funders (particularly those who are well placed and with attractive facilities to meet areas of high local demand) might want to stop serving LA-funded residents altogether.
- 14.26 However, we expect that a consequence of our recommendations will be to increase the fees paid by LAs to care homes to a more sustainable level over time. Higher LA-fees will not necessarily result in downwards pressure

on self-funder rates, but they would reduce the need for care homes to charge higher fees to self-funders. We have recommended that the independent body's role should include disclosure of local fee differentials in order to increase local political accountability on how care is being delivered. In addition, our measures to improve decision making will increase competitive pressures in relation to self-funders. These measures will reduce existing fee differentials over time.

## **Implementation of our recommendations**

- 14.27 In this section, we explain our recommendations in more detail, setting out who they are directed to, together with a summary of how we expect the recommendations, if accepted, to be taken forward by the CMA and the bodies to whom we are making recommendations. We have a strong package of recommendations that tackles some of the underlying causes of problems which we have identified in the care home sector. The CMA stands ready to work with governments and other stakeholders to put these changes into place, and make a real difference to older people and their families and representatives.
- 14.28 We have presented our remedies in the three sections described above:
- (a) capacity recommendations;
  - (b) consumer protection recommendations; and
  - (c) consumer decision-making recommendations - Helping people make decisions about care.

### ***Capacity recommendations***

- 14.29 In section eight, we explained that we are recommending that there is a change to the approach of planning and funding capacity in the sector, targeted at LAs and the planning of capacity by LAs.
- 14.30 We are making recommendations to the Department of Health in England and Northern Ireland that they develop policies and practices to deliver adult social care for the elderly in a way that addresses these concerns. There are three elements to our recommendation, reflecting our assessment of the causes of the problem:
- (a) enhanced planning at local level, so LAs can make accurate and meaningful forecasts of future needs, and plan how best to meet them;

- (b) oversight of LAs commissioning practices to ensure LAs are supported in drawing up their plans, and that these plans are drawn up and carried out; and
  - (c) there is greater assurance at national level about future funding levels, by establishing evidence-based funding principles, in order to provide confidence to investors.
- 14.31 We expect that the consequence of our recommendations is that there will need to be changes to the level of funding for the enhanced planning and oversight to be effective, for the reasons explained in sections 4 and 8.
- 14.32 We summarise our recommendation below. We expect that the next step for implementation would be as part of the broader review of adult social care provision which is underway, and being led by the Cabinet Office. We are recommending that the capacity remedies are implemented as part of that process.
- 14.33 We are making a more general recommendation in Northern Ireland, where capacity is almost all procured under the contracts agreed by the state-funded sector. We are recommending to the Department of Health in Northern Ireland that it undertake a review of capacity planning, and a process for independent oversight HSC Trusts' commissioning practices is put in place. This is with a view to provide enhanced planning with accurate and meaningful forecasts of future care needs, oversight to ensure plans will deliver the care that is needed, and measures to provide confidence to investors that they will receive adequate fee rates.

**Table 14.1: Our capacity recommendations**

<b>Recommendation</b>	<p>In England, that the government sets up a new function, independent of government, with the objective of ensuring that planning is of sufficiently good quality to provide confidence that the capacity will be in place to meet needs over a period, specified by government. For example, the new function could have the following duties and objectives:</p> <ul style="list-style-type: none"> <li>• to review and report on the planning by LAs of all types of social care for the elderly, and whether plans are sufficient to meet the objectives of providing care to all those with eligible needs;</li> <li>• to provide guidance to LAs as to what is required for market planning statements to be effective and to provide information to support LAs in developing plans; and</li> <li>• to report on where LAs are, based on evidence provided, not planning to a standard required by their duties, or are not taking appropriate actions to ensure that the plans are then met.</li> </ul>
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	<p>In England, a process is established to provide independent advice to government, to be updated periodically:</p> <ul style="list-style-type: none"> <li>• To provide evidence to government on the expected cost of different forms of care over that period;</li> <li>• To provide evidence to government on the need for different types of care (including residential care, nursing care, domiciliary care and other options) over the foreseeable future, perhaps 5 to 10 years.</li> </ul> <p>In Northern Ireland, the Executive identifies a suitable body along with the design of a targeted approach to delivering on the same objectives as in England, and reflecting the different circumstances of Northern Ireland.</p>
<b>Countries applicable</b>	England, Northern Ireland
<b>Body directed to</b>	DH, England, and DH, Northern Ireland
<b>How recommendation might be implemented</b>	<p>In England, we are recommending that either a new body or existing bodies, are given an enhanced remit for the new function, independent of government.</p> <p>In Northern Ireland, we recommend that the Executive identifies a proportionate approach to managing risks to future capacity, drawing on the approaches being taken in the other nations.</p>
<b>Next steps</b>	In England, we are recommending that the government considers the recommendation of the changes to the oversight framework as part of the ongoing review of adult social care.

Source: CMA.

14.34 Related to this, we are recommending that in order to provide sustainable capacity, in respect of market oversight, all governments and regulators consider a better approach to reviewing the financial position of UK care home groups, as the current approach of reviewing the financial position of homes in individual nations only, is hard to measure and will not properly reflect the overall financial position of those providers. We expect this recommendation to be taken forward directly by the relevant bodies.

### ***Consumer protection recommendations***

14.35 In sections 12 and 13 we explained that as well as the CMA taking actions itself to ensure that care homes are meeting their consumer law obligations, we are making a number of recommendations designed to ensure that existing consumer law works well within the context of the care homes market and that, where appropriate, sector rules are strengthened.

14.36 Some of our findings are being addressed by the CMA separately to our recommendations in this market study. We are already taking forward enforcement action against a number of providers who we think have been unfairly charging large upfront fees, and charging fees for extended periods

after a resident has died. Given the widespread use by care homes of contract terms charging fees after death, we will be putting out a compliance statement on these fees in early 2018, which we will expect all providers to comply with, or risk facing court action. We will be following this up with comprehensive Guidance on the standards of behaviour we think all care homes should be meeting to avoid infringing consumer law across the full range of concerns we have identified. We intend to consult on the guidance in Spring 2018 and publish a final version in the summer.

- 14.37 The majority of our recommendations relate to consumer protections for self-funders, who pay for their own residential care and have contracts with care homes on that basis. We think all our recommendations to sector regulators can be incorporated as part of their inspection and evaluation frameworks and current ways of working (for example, they will not impose new obligations to deal with individual complaints). We are recommending that sector regulators have a greater role in ensuring that providers are consistently complying with consumer law across the sector. We are not recommending that regulators have direct powers to enforce consumer law but we are recommending that certain specific consumer protection requirements are incorporated into sector rules and that sector regulators require providers to show a reasonable understanding of the implications of consumer law for their residents. We think sector regulators are in a good position to do this within their inspection and evaluation frameworks.
- 14.38 Our recommendations would be implemented through a combination of government bodies and sector regulators. We have concluded that all our recommendations are practicable. In some cases, the recommendations could be implemented in a variety of ways, but in all cases, we think that the recommendations could be implemented without a lengthy process of fundamental reform to primary legislation. In framing some of our recommendations, such as around online indicative pricing and the role of sector regulators in embedding consumer law, we have also sought to allow flexibility in the detailed design of how they could best be implemented, and there may be trade-offs in the detailed implementation between the level of detail prescribed and the cost of monitoring and compliance.
- 14.39 Should our recommendations be accepted, we expect that the next steps for implementation would involve the CMA taking a prominent role in supporting and working with representatives of government and sector regulators in all nations on the detailed design of changes to regulations and standards. Where appropriate, this would include consultation with LAs and providers and their representative bodies who would be directly affected by the proposed changes.

**Table 14.2: Our consumer protection recommendations**

<p><b>Recommendation</b></p>	<ul style="list-style-type: none"> <li>• We are making recommendations to:</li> <li>• help embed consumer law within the sector, to ensure care homes comply with their obligations and to drive a ‘culture of expectation’ amongst residents about the quality of service and fair treatment they are entitled to expect from care homes; and</li> <li>• clarify the standards of behaviour required of care homes to ensure residents, as consumers, are properly protected from unfair treatment.</li> <li>• Our specific recommendations are:</li> <li>• Sector regulators should take a greater role in helping to embed a culture of consumer law compliance across the sector. While this would involve some cost in ensuring regulators’ staff are trained sufficiently to identify problems, we consider these likely costs to be necessary and proportionate in comparison to the scale of the problems in the sector.</li> <li>• The industry should take steps to develop model contracts that could be recommended for use by care home providers with self-funding residents.</li> <li>• The existing sector-specific regulations are strengthened to require registered care homes to publish indicative fee information for self-funders on their websites (if they have one) as well as any directory website they might appear on, together with information on what is included in and excluded from the weekly fees and any additional upfront fees that are payable. Where a care homes does not have a website, this information should be provided in any information packs sent to enquirers and in marketing materials.</li> <li>• That existing sector-specific regulations are strengthened to require registered care homes to provide a copy of their standard (self-funder) contract and a summary of the important terms and conditions on their websites. Where a care homes does not have a website, this information should be provided in any information packs sent to enquirers and in marketing materials.</li> <li>• That sector regulators review and where necessary strengthen their existing guidance to make clear that a copy of the contract and a summary of the most important terms and conditions should be given to prospective residents and their representatives at an early stage of their decision-making process, and explained to them in a timely way.</li> <li>• That to help facilitate the provision of clear pre-contract information to prospective residents and their representatives in a more consistent way, existing sector-specific regulations are strengthened to require registered care home providers to use a model template in summarising their most important terms and conditions clearly and prominently.</li> <li>• That existing sector-specific regulations are strengthened to require registered care homes to protect residents’ deposits in full against the risk of insolvency.</li> </ul>
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	<ul style="list-style-type: none"> <li>• That sector-specific regulations are strengthened to require care homes to notify the sector regulator if they ask a resident to leave a home or impose a visitor ban.</li> <li>• That sector regulators develop specific guidance for registered care homes on high quality practice to be used when asking residents to leave and when imposing visitor bans or restrictions, to ensure such processes are fair and transparent.</li> <li>• We are also recommending that some existing statutory guidance in England is reviewed and clarified, specifically:</li> <li>• Stronger protection and clearer policy and guidance on the payment of third party top-up fees</li> <li>• In England, we are that the Department of Health consider updating the recommending Care Act statutory guidance so that it is clear that LAs must explain to prospective care home residents and their families and people arranging their care that: (1) care home providers should not approach them or their representatives such as relatives directly to demand a top-up without the involvement of the LA; and (2) that there are significant benefits in arranging a top-up through the LA.</li> <li>• We also recommend that in England the Department of Health should consider making it a requirement that when an LA arranges the preferred accommodation with a third-party top-up, the provider agrees with the LA that its payment and other conditions will be the same, irrespective of whether the third-party contribution is paid to the provider via the LA or directly by the third party.</li> <li>• Clearer guidance on the relationship between NHS Funded Nursing Care (FNC) payments and self-funding resident's own contribution to their fees</li> <li>• In England, we have recommended that the Department of Health revises the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and practice guidance to clarify how the FNC payment affects self-funding residents' fees.</li> <li>• Clearer guidance on permissibility of top up payments for NHS CHC Funded residents</li> <li>• In England, we have recommended that the Department of Health revises the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and practice guidance to further clarify, in the context of CHC residents (1) the types of additional, private services that may permissibly be 'topped up' via private payments to a care home under NHS rules and (2) how the Department of Health and NHS rules on top up payments are monitored, applied to, and enforced against CCGs and providers.</li> <li>• In order to improve complaints resolution to drive up quality standards, we are also recommending:</li> <li>• That sector regulators review and assess: the steps a provider has taken to help ensure that its residents are aware of and able to access</li> </ul>
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	<p>local third-party support; and the effectiveness of feedback processes, including whether a feedback champion is required to act as a conduit between management and residents/relatives, so that a culture of listening to and acting on feedback prevails;</p> <ul style="list-style-type: none"> <li>• That central government in England, the Scottish government and Northern Ireland Executive undertake, in consultation with relevant bodies, a review of the coverage of advocacy services for residents of care homes with a view to ensuring that all residents have access to adequate services which are sufficiently targeted at care home residents.</li> <li>• In England, that central government introduces a statutory requirement for providers to sign-post to the Local Government and Social Care Ombudsman</li> <li>• In Northern Ireland, that the remit of the Northern Ireland Public Services Ombudsman be extended to hear complaints from private funders</li> </ul>
<b>Countries applicable</b>	England, Scotland, Wales, Northern Ireland
<b>Body directed to</b>	National governments and sector regulators, to implement through sector regulations and guidance.
<b>How recommendation might be implemented</b>	<p>Amendments to sector-specific regulations and/or guidance.</p> <p>Should our recommendations be accepted, we expect the next steps for implementation would involve the CMA taking a prominent role in supporting and working with representatives of government and sector regulators in all nations on the detailed design of some of the remedies. Subsequently, sector regulator staff would need some additional training. Some of our recommendations may result in additional costs for regulators which may require additional funding.</p>
<b>Next steps and timeline</b>	<p>We are recommending that the governments and sector regulators implement the changes to sector-specific regulations, standards and guidance as soon as possible, as these will be low cost and have immediate benefits to self-funders (as well as in some instances state funded residents).</p> <p>Alongside this, the CMA will be consulting on and publishing detailed guidance during Spring 2018 on the standards of behaviour we think all care homes should be meeting to avoid infringing consumer law.</p> <p>Following final publication of the guidance, the CMA is prepared to work with trade associations to assist them to develop model contracts for use by care homes.</p>

Source: CMA.

***Consumer decision-making recommendations – helping people make decisions about care.***

- 14.40 In section 10, we explained that we are making a number of recommendations designed to enhance consumer decision-making. Section 10 draws on our evidence from BIT and Research Works. We have concluded that the way in which people approach their and their family's future care needs, needs to change. We are calling on the four national governments to work with the NHS, LAs, care home providers and the third sector to deliver a sustained and coordinated programme of actions to help people make good decisions about their care needs.
- 14.41 Our research is the first step of the process. We are recommending that a working group is set up from stakeholders across the four nations, to develop our recommendations further so they can be implemented in practice. This working group may be able to draw on and be aligned to any existing groups of experts and stakeholders which are looking at reform of the sector. We recommend that the working group takes forward the priority actions from section 10. We are recommending that the working group develops and agrees:
- (a) a set of standards for the provision of information provided on care home or other websites, with the aim of supporting the development of online comparison services and making it easier for people to compare care providers.
  - (b) guidelines for all LAs in providing people with better information on: how the care system works and how to engage with the LA; on care homes in their areas; and advice on choosing a home (for example the questions to ask when visiting homes).
  - (c) a substantial plan for improving the provision of supported decision-making services in the UK.
- 14.42 We also recommend that, in addition to these actions which should be capable of being implemented now, the working group develops and agrees a programme of sustained and coordinated communications to promote awareness of the care system, and to encourage people to plan ahead for possible care needs in later life. We are recommending that the working group should work in partnership with relevant organisations with a recognisable brand name. We recommend the development of communications and prompts which should be trialled, before any widespread implementation, to achieve maximum impact.

14.43 Our intention is that the CMA takes an early lead in facilitating and setting up the membership and terms of reference of the working group, with the expectation that, once the working group is fully established, an independent sector expert can be identified to lead the implementation process.

**Table 14.3: Our consumer recommendations on helping people make informed decisions**

<p><b>Recommendation</b></p>	<p>We are recommending that there should be changes in the information, advice and support available to people with the aim of helping them to make better decisions about the care that they or their friends and family members may need in later life. These recommendations are based on our analysis and research into the experiences of residents and their friends and families, and the behaviours, perceptions and attitudes of people in relation to care in later life.</p> <p>All of our recommendations build on existing provision of information, advice and support provided by LAs, consumer groups and charities and commercial providers. We would expect consumer groups, charities, and community services and networks to be heavily involved in the implementation of these recommendations.</p> <p>Specifically, we are recommending that a working group is set up from all industry stakeholders across the four nations, to take forward our work and to develop our recommendations further so they can be implemented in practice. These measures to be implemented cover:</p> <ul style="list-style-type: none"> <li>• Improvements in the existing provision of supported decision making (which is likely to involve development of online tools, telephone advice services, dementia advisers, social workers, and care navigators) to give people access to the information, advice and support they need to make informed decisions.</li> <li>• Agreement on common standards for the provision of online information to be published on care provider and other websites, with the aims of supporting the development of online search and comparison tools, and making it easier for people to compare providers. This recommendation complements the steps we set out above (under consumer protection) to improve provision of core information on fees and contract terms. In addition, we think that particular consideration should be given to the provision of up-to-date information on vacancies and how care homes should facilitate this.</li> <li>• Guidelines for all LAs on providing people with better information on how the care system works, care homes in their areas, and on choosing a care home.</li> </ul> <p>We think it is vital that all people engage much earlier on in life with the possibility of needing care. We therefore recommend that central government works with an organisation (or organisations) with a recognisable brand name and presence in care of older people to undertake an ongoing programme of work to promote awareness and develop prompts to encourage and support people to consider their care options earlier.</p>
<p><b>Countries applicable</b></p>	<p>All</p>
<p><b>Body directed to</b></p>	<p>National Governments</p> <p>Also, will be directed to relevant sector bodies to encourage participation in the programme.</p>

<b>How recommendation might be implemented</b>	Action by a care working group set up by national governments.
<b>Next steps and timeline</b>	We are seeking to establish the care working group immediately following the market study to draw on expertise gained during the process.
<b>CMA role in implementation</b>	The CMA will seek to establish a working group and may initially facilitate the development and practical arrangements of that group. We will identify sector stakeholders which can take leadership of the group and seek to ensure that the interests of future residents and their relatives are understood and the benefits from our findings are delivered.

Source: CMA.