

Care homes market study: final report

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Glossary

Legal basis for our market study and conduct of the study

1. This appendix provides details of the legal basis for our market study and how we have conducted the study.

Legal basis for our market study and purpose of the final report

2. Under Section 5 of the Enterprise Act 2002, the CMA may conduct market studies. These are examinations into the causes of why particular markets may not be working well, taking an overview of regulatory and other economic drivers and patterns of consumer and business behaviour.¹
3. The purpose of the final report for our market study is to outline:
 - (a) our findings; and
 - (b) our recommendations to address the issues we have identified.

Conduct of the market study

4. Our market study has involved several steps to gather views and information, as summarised below.

Written responses to our publications

5. We consulted on our market study notice, including statement of scope, in December 2016, and on our update paper in June 2017. We received written responses to our statement of scope and our update paper from a range of stakeholders across the UK including care home providers, trade associations, consumer bodies, charities, sectoral regulators, local authority representative bodies, and members of the public. Responses are published on our website.² We received no representations to make a market investigation reference (MIR) and announced our decision not to make such a reference on 1 June.³
6. At the outset, we invited care home residents and their relatives who felt they may have experienced unfair contract terms or practices from care home providers to report details using our online reporting tool, and received over

¹ For more details see [Market studies and investigations - guidance on the CMA's approach: CMA3](#) and [How market studies are conducted: OFT519](#).

² [Care homes market study case page](#).

³ [Notice of decision not to make a market investigation reference under section 131 of the Enterprise Act 2002](#).

150 submissions. We published an anonymised aggregated summary of these responses.⁴ We also received details of around 700 experiences mainly from relatives of residents directed to us following a Which? campaign and via other charities and consumer groups.

7. In September 2017, we published a financial analysis working paper for views and comments.⁵ We considered the responses received in developing the financial analysis presented in the final report.

Written information and data obtained

8. We obtained various pieces of written information and data from a range of stakeholders throughout the market study. These included:
 - (a) written and financial data from a sample of care home providers (around 32 of the largest providers and 48 smaller providers). This included copies of their contracts with care home residents, details of their finances (management accounts), their fees, approaches to assessing prospective residents, complaints and redress systems, and their views on the market;
 - (b) written information from a sample of (LAs) and Health & Social Care Trusts (around 35 in total). This included details of the information and advice they provide to prospective residents/their representatives, their funding for care home places, their commissioning and monitoring of care home placements, any market shaping activities (if relevant), and complaints and redress systems; and
 - (c) data from LaingBuisson, caredata.co.uk and Company Watch to help us develop descriptive statistics and assist in our analysis of care home finances.
9. The CMA designed an online questionnaire in Survey Monkey for providers to complete. The aim of this online questionnaire was to gain some understanding of certain practices carried out by providers, for example, the charging of deposits to new residents, the assessment of funds in advance of moving into the care home for prospective self-funded residents, and the use of guarantors to cover fees if the prospective self-funded resident becomes unable to cover them in the future. A weblink to the online questionnaire was provided to a number of trade associations which had agreed in advance to circulate the online questionnaire to their members across England and the devolved nations. The online questionnaire was designed to ensure

⁴ [Summary of information provided by individuals.](#)

⁵ [Financial analysis working paper.](#)

anonymity of responses to the CMA. Respondents were assured of this anonymity prior to completing the online questionnaire. Due to the methodology used, the results should be interpreted with caution and should not be seen as representative of providers' practices across the UK as a whole, but rather seen as providing some information about these practices.

10. Responses to the online questionnaire were received between 19 September 2017 and 26 October 2017. One hundred and forty-nine providers attempted the online questionnaire across the four nations. As each question was not compulsory, some respondents did not provide an answer to all the questions.

Hearings, meetings and calls with stakeholders including in case study areas

11. We have spoken to more than 150 stakeholders via telephone calls, meetings, site visits (including to care homes), and roundtable discussions. This engagement took place at key points during the study including following publication of our statement of scope and update paper, and as we developed our recommendations. We held more than 50 face-to-face discussions across the UK including several in Edinburgh, Cardiff, Belfast, and London, and others in Llandudno, Nottingham, Wakefield and Birmingham.
12. In the first six months of the study, we focused on five case study areas across the UK (Sunderland; Tunbridge Wells; Edinburgh; Coleraine; and Newport (Wales)) to develop our understanding of how the care and nursing homes market works at a local level. For the case studies, we conducted detailed interviews with some care home providers in the area, relevant LA/public bodies, and local consumer groups.
13. The themes that emerged from our case study interviews were the same as those identified in other discussions with stakeholders. We have not therefore presented the case study findings separately but have drawn on them alongside all the other information gathered to prepare the final report.

Consumer research

14. The consumer research commissioned to inform the market study was qualitative in nature. Qualitative research allows an in-depth understanding of individual experiences and provides an opportunity to explore issues in detail, allowing the researcher to probe and seek to understand the complexities and subtleties of the topic of interest. As many of the objectives of this research were exploratory, rather than seeking to test specific hypotheses, the approach provided the flexibility to understand the complexities and subtleties of the respondent's experiences and motivations. The areas covered were anticipated to be sensitive in nature, such as the context for entering a care

home and paying for care. Therefore, conducting in-depth face-to-face qualitative interviews were felt to be the most appropriate approach.

15. We explored the possibility of conducting a quantitative survey of care homes residents and their representatives. This was not practicable as we could not contact care home residents directly. Moreover, we considered that some residents/their representatives might not have been able to give informed consent or fully answer questions. Therefore, contacting any residents would have needed to be done through the care homes which understandably are very anxious about protecting the welfare of their residents as well as complying with their own obligations on data disclosure. There was no sampling frame available to allow us to characterise the care home population. Consequently, we could not assess whether any sample would be representative.
16. We commissioned three pieces of research to inform the market study:
 - (a) Ipsos MORI conducted qualitative research with decision makers (family members and friends of care home residents, care home residents themselves and social care representatives) around a sample of 80 care home placements in 24 residential and nursing homes for the elderly across the UK. The research explored various issues including: the context for entering a care home; information and support available when finding a home; the process of finding a care home; people's experiences of funding care; their ability to understand contract terms; the scope to move care home; and people's experiences of providing feedback and making complaints about care homes. We published the findings from this research in August 2017.⁶
 - (b) Research Works conducted qualitative research across the UK involving 80 depth interviews and 12 'family' group discussions with people at various stages of needing and considering care either for themselves or others. The objective of the research was to help inform the development of remedy proposals that might address the issues highlighted in Ipsos MORI's consumer research. The Research Works' research focused on what more could be done to provide support and accessible information to people, to ensure that information about care homes is in a consistent format, to encourage people to consider their longer-term care needs in advance of these arising, and to make it easier for people to provide

⁶ [Care Homes: Consumer Research](#).

feedback and make complaints. We have published the findings from this research alongside the final report.⁷

(c) The Behavioural Insights Team undertook a literature review and held workshops with CMA staff and stakeholders to explore the behavioural barriers to good decision making in the care homes market and potential remedies to address them. We have published Behavioural Insights Team's findings alongside the final report.

17. We consider that these three pieces of research make a significant contribution to the understanding of the experiences of care home residents and their families and friends, and to the scope to prompt people to plan ahead of any care needs arising. They help to support the remedies we set out in the final report.

Review of existing research and publications

18. Throughout the study, we considered relevant reports, information and analyses that others have produced. These included reports and research published by government bodies, Select Committees, academics, think tanks, consumer groups, charities and the OFT. The final report refers to this existing work, where relevant.

⁷ Research Works, CMA consumer research, November 2017.

Journeys through the adult social care system by funding source

1. The adult social care system is complex. This appendix provides an overview of three different journeys people may take depending on their funding. The journeys described are not mutually exclusive and people will move between them depending on changes in their care needs and their financial situation.
2. Moving into a care home is often part of a wider journey through the care system. People move into a care home when it is no longer feasible for them to live independently, even with care provided at home. While care services should be focussed on meeting a person's needs, because funding is so important for how people engage with the system, it is helpful to break down journeys by their funding route.
3. The three key funding sources are:
 - **NHS Continuing Health Care (CHC):** someone who has acute medical needs (assessed against national criteria) that can be met outside a hospital or formal medical environment, can have the NHS arrange free nursing care through CHC;
 - **LA funding:** someone who has care needs that do not meet the CHC criteria, but has eligible care needs (assessed against national needs criteria) and assets below a means-tested threshold (assessed against national financial criteria), will be eligible for LA funding. Most people will still be expected to contribute toward the cost of their care; and
 - **self-funding:** someone who does not fall into the first two categories will have to fund their own care. Self-funders are not dependent on meeting any of the state-funded system's eligibility criteria.
4. The same key principles and system applies in all four nations. However, the precise eligibility criteria and funding thresholds vary between the nations. For simplicity English names and criteria are used.
5. These journeys through the system will typically be triggered by an increase in care needs, for example following a fall, or the loss of an alternative care option, such as due to the death of a carer. Advice may then be sought from, amongst others, an LA, a GP, hospital staff, charities or a care home.

6. Journey for someone with primary health needs who may be fully funded by the NHS

- NHS continuing healthcare (CHC) is a free package of care for people who have significant ongoing healthcare needs. It is arranged and fully-funded by the NHS and is separate from the LA-funded system.
- A person can receive CHC in any setting outside hospital, including in their own home or in a nursing care home.
- The NHS will assess a person's continuing healthcare needs against national criteria based on needing care primarily because of health needs. Assessment is based largely on the extent to which the person requires dedicated formal nursing care as opposed to care by care workers.
- If the person is eligible for CHC, the NHS will normally offer them a selection of local nursing homes. After selection of a home by the person, the NHS will arrange for transfer of care, contact and payment.
- CHC is provided free to the person as part of the NHS 'free at the point of delivery'.
- Paying extra to choose alternative accommodation through top-ups is not allowed.
- The NHS will review the situation to ensure the setting continues to meet the person's needs.
- Someone with some nursing care needs who does not meet the CHC criteria may be eligible for a flat rate contribution from the NHS towards the cost of nursing care in their care home. This programme, called Funded Nursing Care (FNC), has its own assessment criteria. FNC contributions are usually paid directly to a care home. In England in 2016/17 the standard FNC contribution is £156.25 each week.

7. Journey for someone who may be funded by a Local Authority

- LA-funding is means-tested against someone's assets and income, and available to people with eligible needs.
- A person may approach their LA for help. Where it appears to the LA that the person may have social care needs, the LA has duties to carry out an eligibility assessment against national criteria of social care needs. This assessment may be conducted by a care manager, social worker or multi-disciplinary team if there are health issues.
- If the person does not have eligible needs, the LA should nonetheless offer advice and guidance for services that may help, such as preventative services, community groups and the voluntary sector. Regardless of the level of need, the

person may choose to pay for care themselves if they are able and be a self-funder.

- If the person does have eligible needs, the LA will develop a care package that will meet their needs and develop a Personal Budget – the amount needed to pay for the package. LAs increasingly try to keep people independent in their own home through home care, but if the person's needs cannot be met in this way, a care package based on a place in a care home may be appropriate.
- Once needs eligibility is determined, the LA will assess the person's ability to pay – ie make a financial assessment. If the person has assets above £23,250 (in England) they will have to pay for the whole of their care package until their assets are below this level. They will be a self-funder – see the self-funder journey box.
- Assets include all savings owned by the person being assessed. Half of any jointly-held capital will be included. The value of someone's home may be included and where jointly-owned split according to the value of ownership. When included, it will be calculated taking account of the market value of the property, less any mortgage or loan secured against it, less a small amount to cover expenses from selling. Someone's home is disregarded in some circumstances, for example where a partner, child or disabled relative will continue to live there. If the person being assessed has given away or lost assets before the assessment, the LA may decide that this was a deliberate attempt to gain from the state-funded social care system and include the value of the assets in the calculation.
- Income is also included in the financial assessment. Income includes most income, most benefits someone is entitled to, regardless of whether they claim them or not. Certain types of income, for example earnings and war widows' special payments, are disregarded.
- If the person's assets are between the upper threshold of £23,250 and the lower threshold of £14,250, a notional income will be taken into account. The person will receive state funding of the care package but be expected to contribute on a sliding scale.
- If the person's assets are below the lower threshold, none of their assets will be taken into account and their care package will be funded by the LA.
- All people will be expected to contribute a proportion of any income they have towards the fees except for a small 'Personal Expenses Allowance' of £24.90 per week (in England).
- If the person has been deemed to have eligible care needs and meets the criteria in their financial assessment for LA-funding, the LA will arrange and contribute agreed funding for a care package.
- If the person has urgent need of care, the care package will be arranged in parallel with the financial assessment.

- Where this care package can only be delivered in a care home, the person must be offered a choice of homes that take account of their preferences, though an LA need only offer a choice of one home.
- If the person has friends or family members who can make an additional contribution, the person may select alternative, more expensive accommodation through a 'third party' top-up'.
- If the person has some nursing needs (but is not in the care home through an NHS CHC route because they have a primary health need) they may qualify for Funded Nursing Care (FNC) – usually paid directly to the care home.
- The LA will then arrange the contract, placement and monitor the person's wellbeing, making sure the care home continues to meet the person's needs.
- If the person's health deteriorates to the point they are eligible for CHC funding in a nursing home, the NHS will assess and will fund care that meets of the person's needs (see NHS CHC journey box).
- People in other parts of the UK have a similar journey although the needs eligibility criteria and the financial assessment thresholds differ.

8. Journey of a self-funder

- Many people with assets do not approach their LA or NHS and directly approach care homes to arrange their care.
- A self-funder who has come through the LA route of assessment should have an indicative care package. Otherwise an assessment may be offered by a GP or other medical staff (for example, on discharge from a hospital) to suggest the level of acuity and type of care home needed.
- A self-funder may obtain guidance and advice from their LA or NHS to help them and their family choose a home. Guidance is also available through charities like Age UK, and people may use professional brokers to help select a home and negotiate fees. People often look to the sector regulators' inspection reports and do site visits to help select care homes.
- A self-funder may decide to move into a care home even though their needs would not be assessed as eligible by a LA or a LA would meet them by providing care at home. More affluent people may choose to move to a care home as a 'lifestyle choice'.
- The self-funding person and their family usually visit a selected range of homes, decide which ones meet their needs and discuss costs with the care home manager. They may have to go on a waiting list for some homes.
- Following negotiation, the self-funder/family sign an individual contract with the care home and arrange to move in.

- If the person's assets fall below the state funding threshold and the person's needs meet the national eligibility criteria, their LA then has duties to meet their needs and contributes to their fees. Once their assets are approaching the upper financial threshold, the person or family can approach their LA to request that their needs are in future met by the LA.
- Once approached, the LA will carry out a needs assessment and a financial assessment. If the person has eligible needs best met in a care home and they are eligible for state funding, then the LA will meet their needs. (See the LA-funded journey box).
- Where the LA takes over responsibility in this way, it will usually try to keep the person in the same care home, however, it may need to move the person if the original care home is more expensive than the LA would normally pay for care that meets the person's assessed needs.
- If the person's health deteriorates to the point they are eligible for CHC funding in a nursing home, the NHS will assess and will fund care that meets of the person's needs (see NHS CHC journey box).

Data, methodology and further results

1. This appendix presents details of the methodologies and sources used in our data analyses and some additional results.

Overview of the care homes market

2. This section describes the methodology and data used to calculate figures in Section 2 of the main report.

Data sources

3. Our main source was a UK-wide dataset on care homes for older people from healthcare consultancy LaingBuisson.¹ We used a December 2016 release that had data for England from December 2016, for Northern Ireland from May 2016, for Scotland from April 2015 and for Wales from July 2015.
4. We added data for bed numbers and fees from Caredata.co.uk (dated February 2017). We added inspection results for England from the CQC (dated January 2017).

Additional results

5. Table C1 shows the total number of beds in the UK and a breakdown by designated residential and nursing care homes, as at December 2016.

Table C1: The total number of care homes and care home beds by registration type (UK, December 2016)

Registration type	Care homes		Beds	
	Number of homes	% of homes	Number of beds	% of beds
Nursing home	4,732	42%	248,657	55%
Residential care home	6,561	58%	206,201	45%
All UK Care homes	11,293	100%	454,858	100%

Source: CMA analysis of Caredata.co.uk and LaingBuisson datasets.

6. Table C2 shows the total number of beds in the UK in December 2016 by type of provider.

¹ A care home for older people is defined as a care home that primarily caters for older people or those with dementia, as identified by LaingBuisson. This definition includes 59% of all UK care homes and 84% of all UK care home beds. The main categories of excluded care homes are those that primarily cater for younger persons with either physical or mental disabilities.

Table C2: Care home beds by sector (UK, December 2016)

Sector	Total care home beds		Residential homes		Nursing homes	
	Number of beds	% of beds	Number of beds	% of beds	Number of beds	% of beds
For-profit	375,804	82.6%	151,635	73.5%	224,169	90.2%
LA	17,877	3.9%	16,311	7.9%	1,566	0.6%
NHS	1,533	0.3%	1,252	0.6%	281	0.1%
Not-for-profit	59,644	13.1%	37,003	17.9%	22,641	9.1%
All UK care homes	454,858	100.0%	206,201	100.0%	248,657	100.0%

Source: CMA analysis of Caredata.co.uk and LaingBuisson datasets.

7. Table C3 shows the number of care homes and beds by the size of the care home provider group.

Table C3: The total number of care homes and care home beds by size of provider (UK, December 2016)

Number of care homes in provider group	Number of providers	% of providers	Total care homes	% of care homes	Total beds	% of beds
25+	30	1%	2,378	21%	136,225	30%
10-24	98	2%	1,378	12%	64,545	14%
5-9	185	3%	1,161	10%	48,050	11%
2-4	793	15%	2,024	18%	74,276	16%
1	4,352	80%	4,352	39%	131,762	29%
Total	5,458	100%	11,293	100%	454,858	100%

Source: CMA analysis of Caredata.co.uk and LaingBuisson datasets.

8. Table C4 shows residential and nursing care home fees by nation and region of the UK. This draws on data from LaingBuisson (December 2016) and Caredata.co.uk (February 2017). This data was not a required field in their datasets meaning the sample is self-selected. What is included in the reported fees may also vary, depending on, for example, whether maximum fees include optional extras. The resulting fee statistics may not be representative.
9. Further points about the data:
- (a) some of the fee data is up to three years old;
 - (b) the data collected represents maximum and minimum fees. The midpoint figure we report is an average of the midpoints of those homes for which we have both maximum and minimum fee data;
 - (c) as they can provide both types of care, nursing homes may specify both residential and nursing fees;
 - (d) Data was collected for single and shared rooms. All fee statistics we report are for single rooms.

Table C4: Care home fees by nation and region and registration type (UK, December 2016)

<i>Nation/region</i>	<i>Average residential weekly fees (£)</i>			<i>Average nursing weekly fees (£)</i>		
	<i>Minimum¹</i>	<i>Midpoint²</i>	<i>Maximum³</i>	<i>Minimum⁴</i>	<i>Midpoint⁵</i>	<i>Maximum⁶</i>
England	527	590	661	658	756	871
East Midlands	489	536	596	536	626	718
East of England	576	651	737	732	818	924
Greater London	619	657	722	735	863	1,008
North East	469	503	535	506	555	592
North West	445	490	541	556	641	741
South East	591	673	773	773	893	1,039
South West	561	637	721	698	796	919
West Midlands	485	531	588	613	712	824
Yorkshire & the Humber	454	504	556	559	659	762
Scotland	582	640	693	633	732	809
Wales	492	529	559	566	626	683
Northern Ireland	457	471	490	560	595	615
UK	527	588	656	646	741	843

Source: CMA analysis of Caredata.co.uk and LaingBuisson datasets.

- 1) Based on a sample of 4,754 care homes for older people.
- 2) Based on a sample of 3,974 care homes for older people.
- 3) Based on a sample of 4,105 care homes for older people.
- 4) Based on a sample of 1,973 care homes for older people.
- 5) Based on a sample of 1,597 care homes for older people.
- 6) Based on a sample of 1,647 care homes for older people.

10. Table C5 shows the number and percentage of care homes in the UK that are purpose-built, as at December 2016.

Table C5: Number and proportion of purpose-built care homes in the UK (December 2016)

<i>Purpose-built status</i>	<i>Total care homes</i>		<i>Residential homes</i>		<i>Nursing homes</i>	
	<i>Number</i>	<i>%</i>	<i>Number</i>	<i>%</i>	<i>Number</i>	<i>%</i>
Not purpose-built	7,153	63%	4,732	72%	2,421	51%
Purpose-built	4,001	35%	1,727	26%	2,274	48%
Unknown	139	1%	102	2%	37	1%
All UK care homes	11,293	100%	6,561	100%	4,732	100%

Source: CMA analysis of LaingBuisson dataset.

11. Table C6 shows the number of care homes in the UK, as at December 2016, by first registration date.

Table C6: Care homes by first registration date (UK, December 2016)

Care home age	Total care homes		Residential homes		Nursing homes	
	Number	%	Number	%	Number	%
Less than 1 year	117	1%	59	1%	58	1%
1 to 3 years	227	2%	108	2%	119	3%
3 to 5 years	263	2%	123	2%	140	3%
5 to 10 years	676	6%	274	4%	402	8%
10 to 15 years	430	4%	186	3%	244	5%
15 to 20 years	900	8%	460	7%	440	9%
20 to 25 years	2,573	23%	1,378	21%	1,195	25%
25 to 30 years	5,551	49%	3,552	54%	1,999	42%
30 to 40 years	450	4%	342	5%	108	2%
40 to 50 years	69	1%	50	1%	19	0%
More than 50 years	37	0%	29	0%	8	0%
All UK care homes	11,293	100%	6,561	100%	4,732	100%

Source: CMA analysis of LaingBuisson dataset.

Mapping choice of care homes

12. This section describes the methodology and data used to calculate the number of care homes in different local areas and generate the map in Section 2 of the main report.

Methodology

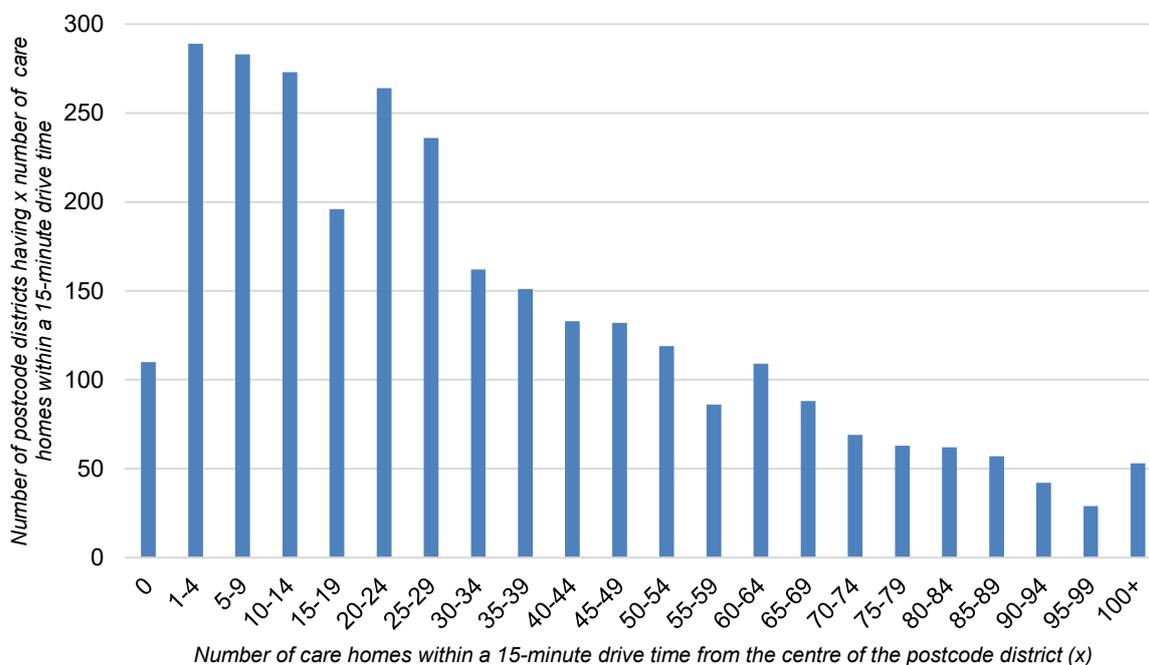
13. This analysis looked at which homes were within a 15-minute drive time of the centre of 3,006 postcode districts in England, Scotland and Wales. Postcode districts are the areas with the same outward code, ie the first half of the postcode, for example WC1B. We excluded Northern Ireland as the data was not available to construct drive times. The data on care home locations came from the LaingBuisson December 2016 dataset. We used a 15-minute drive-time to define the local area based on previous merger decisions by the OFT. These decisions have suggested a lower bound geographic frame of reference based on a 15-20 minute drive time,² which means that our analysis represents a conservative estimate of the number of choices that individuals have.
14. There are a number of points to note when interpreting the results of this analysis, including:
- (a) postcode districts vary in size; and
 - (b) a majority of the population may not live near the geographical centre of the postcode district (especially for rural postcodes).

² OFT (2005), [Final decision Blackstone Group / NHP plc](#). A 15-20 minute drive time equates to three miles for urban areas, five miles for suburban areas and 10 miles for rural areas.

Additional results

15. Figure C1 shows the number of postcode districts by the number of care homes that are within a 15-minute drive from the centre.

Figure C1: Number of areas with given number of care homes (England, Scotland and Wales, December 2016)³

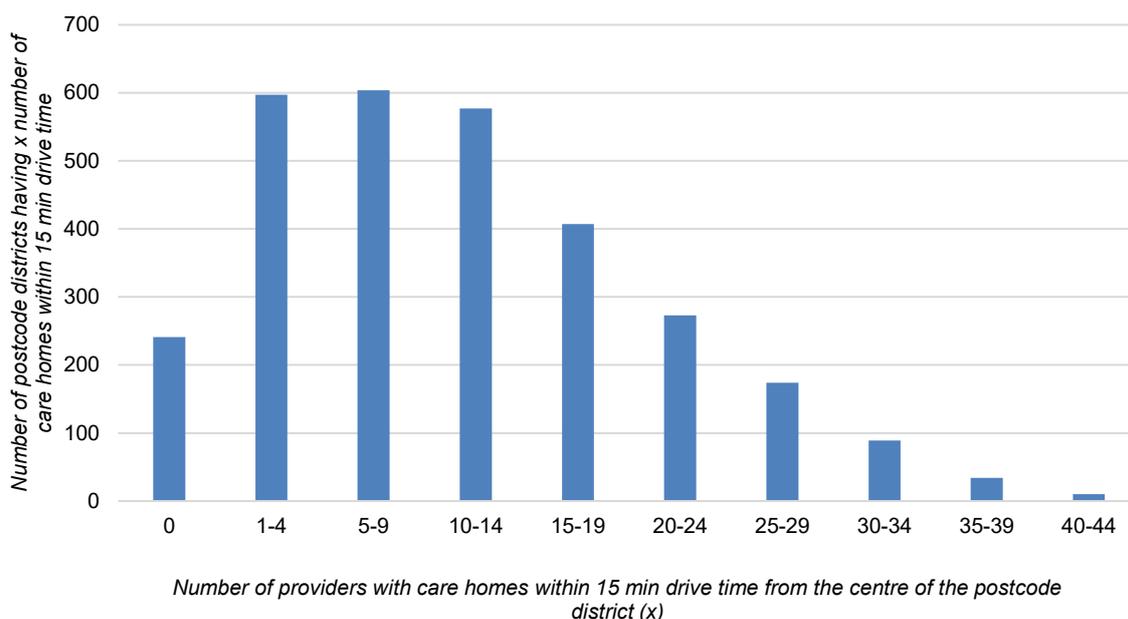


Source: CMA analysis of Caredata.co.uk and LaingBuisson datasets.

16. Figure C2 shows the number of post code districts by how many different providers there are with nursing homes within a 15-minute drive from the centre. This analysis used data on care home groups and registration type from the LaingBuisson December 2016 dataset.

³ Areas defined as locations within a 15-minute drive from the centre of a postcode district

Figure C2: Number of areas with given number of providers with nursing home (England, Scotland and Wales, December 2016)⁴



Source: CMA analysis of Caredata.co.uk and LaingBuisson datasets.

Price differential between LA and self-funded residents

- This section describes the methodology and data used to calculate the price differentials presented in Section 2 of the main report.

Data and methodology

- We obtained data from 26 large care home providers, which covers nearly a third of the industry revenue (see Appendix D).⁵ The data included the number of residents, revenue, and costs, for financial year 2016 for 2,017 care homes.⁶ There was separate data for self-funded and LA-funded residents.
- Two hundred and fifteen care homes were excluded from the differential calculations because they did not have data on fees for both types of residents. Thirty-six care homes had only self-funded or LA-funded residents and a further 179 provided data for either their self-funded or LA-funded residents. However, these homes were included in calculations of average fees.
- We calculated:

⁴ Areas defined as locations within a 15-minute drive from the centre of a postcode district.

⁵ Using LaingBuisson's estimate that the market size was £15.9bn in 2014 in its report 'Care of Older People UK Market Report – 27th edition'.

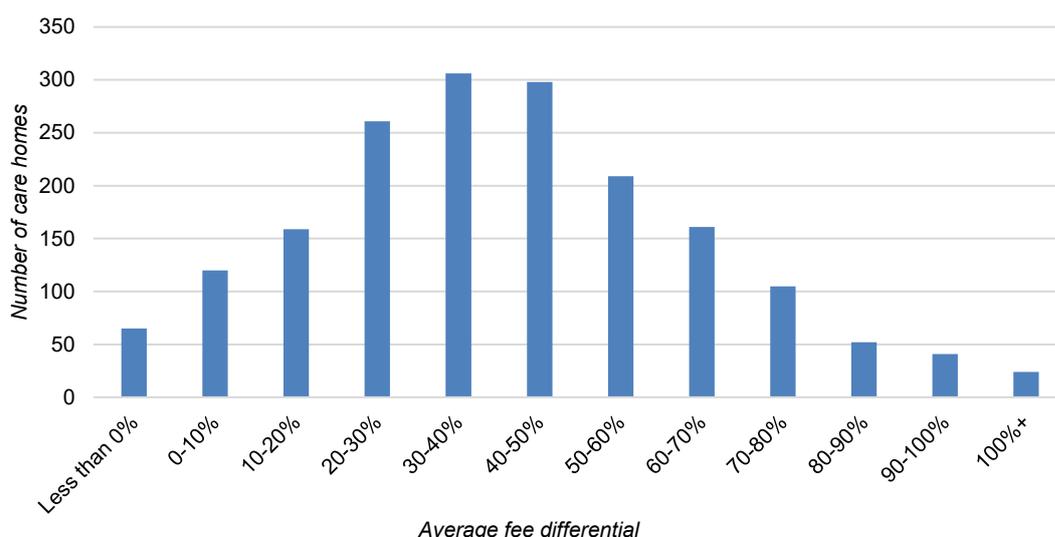
⁶ We received data for a further 98 homes that we excluded from this sample because they were missing key data or were outside the UK.

- (a) for each care home, the difference between the average revenue per week per self-funded residents and LA-funded residents, divided by average revenues per LA-funded resident; and
- (b) then an average of this figure across all care homes. Our approach gives equal weight to each observation in the sample (regardless of some care homes being larger than others).⁷ We did this to understand how prevalent price differentials are in terms of generalised behaviour across providers. Nevertheless, we found that results weighted by number of beds, residents and revenue produced similar, albeit slightly lower, average fee differentials.

Additional results

21. Figure C3 below shows the distribution of fee differentials by care home. A small number of care homes have higher average revenue from LA-funded residents and so a negative differential.

Figure C3: Price differentials by care home, UK 2016



Source: CMA analysis of data from 25 large UK care home providers (one provider has no care homes used in this figure).

22. Table C7 shows the average fee levels and price differentials by region for England, Scotland and Wales in 2016.⁸

⁷ An additional risk is that the differential for care homes with a small number of self or LA-funded residents could be sensitive to the care needs of particular individuals.

⁸ 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.

Table C7: Average fee levels and price differentials by region, 2016

<i>Nation/region</i>	<i>Average LA fee per week per resident (£)</i>	<i>Average fee per self-funder (£)</i>	<i>Average fee differential (£)*</i>	<i>Average fee differential (%)</i>	<i>Median fee differential (%)</i>	<i>Number of care homes**</i>
England	£610	£851	£245	43%	41%	1,690
East Midlands	£586	£781	£195	35%	34%	182
East of England	£584	£856	£274	50%	49%	240
Greater London	£733	£1,051	£325	49%	47%	114
North East	£568	£669	£121	23%	23%	136
North West	£544	£776	£232	45%	44%	239
South East	£710	£1,063	£348	52%	49%	245
South West	£657	£876	£226	37%	36%	161
West Midlands	£605	£829	£242	45%	46%	175
Yorkshire & the Humber	£533	£722	£191	37%	36%	198
Scotland	£640	£880	£240	38%	35%	170
Wales	£602	£800	£199	36%	34%	53
UK	£621	£846	£236	41%	40%	1,980

Source: CMA analysis of data from 25 large UK care home providers (one provider has no care homes used in this table).

* The average fee differential may not be the difference between the average self-funder and average LA fee.

23. Table C8 shows average fee levels and price differentials by proportion of LA-funded residents in 2016.

Table C8: Average fee levels and price differentials by proportion of LA-funded residents, 2016

<i>Average Proportion of LA residents (%)</i>	<i>Average LA fee per week per resident (£)</i>	<i>Average SF fee per week per self-funder (£)</i>	<i>Average fee differential (£)*</i>	<i>Average fee differential (%)</i>	<i>Median fee differential (%)</i>	<i>Number of care homes**</i>
0-10%	£918	£1,156	£272	36%	31%	65
10-20%	£764	£1,018	£272	40%	35%	119
20-30%	£707	£980	£272	41%	39%	116
30-40%	£672	£929	£267	42%	39%	153
40-50%	£610	£885	£265	45%	44%	176
50-60%	£589	£837	£249	43%	43%	253
60-70%	£574	£809	£240	43%	42%	323
70-80%	£556	£777	£220	41%	39%	376
80-90%	£573	£782	£209	39%	36%	256
90-100%	£605	£726	£144	27%	29%	143
Pure LA	£1,167	N/A	N/A	N/A	N/A	29
Pure self-funder	N/A	£1,034	N/A	N/A	N/A	7
UK	£621	£846	£236	41%	40%	2016

Source: CMA analysis of data from 25 large UK care home providers (one provider has no care homes used in this table).

* The average fee differential may not be the difference between the average self-funder and average LA fee

** A care home that did not specify the number of LA-funded residents was excluded from this table.

Projections of demand for care home places

24. This section describes the methodology and data used to calculate the projections of demand for care homes presented in Section 6 of the main report.

Data and methodology

25. We reviewed projections of demand for care home places from four sources:

- (a) The Personal and Social Services Research Unit (PSSRU).⁹
 - (b) LaingBuisson.¹⁰
 - (c) Newcastle University.¹¹
 - (d) Institute of Public Care, Oxford Brookes University (IPC).¹²
26. These studies 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) as follows:
- (a) The PSSRU, Kingston et al and IPC projections cover only England, while the other two projections cover the entire UK.
 - (b) To standardise the projections to a single starting year (2015), we used the geometric average growth rate implied by the given base year and first future year for which projections were available to increase or decrease the base year population figure.¹³
27. For comparison, we also did our own projection based on population growth figures from The Office for National Statistics (ONS)¹⁴ and the census figures for the proportion of older people who lived in care homes in 2011.¹⁵ We assumed that the propensity in each age group of older people living in care homes stays the same as it was in 2011.
28. Table C9 shows the standardised forecasts using four external studies as well as the CMA estimate using ONS population growth figures.

⁹ The Personal and Social Services Research Unit (PSSRU) (2015), 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.

¹⁰ LaingBuisson, [Care of Older People UK Market Report 27th edition](#).

¹¹ Newcastle University: Kingston et al (2017), [Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies \(CFAS\)](#), The Lancet ('the Newcastle Study').

¹² Institute of Public Care, Oxford Brookes University (2017), 'Projecting Older People Population Projection'.

¹³ For example, LaingBuisson give a starting (base) year of 2014 and a projection for 2020. To generate the 2015 population we used $[(\text{Projection}_{2020}/\text{Population}_{2014})^{(1/6)}] * \text{Population}_{2014}$.

¹⁴ ONS (2015), [National population projections](#), (Table A2-1); ONS (2014), [Changes in the Older Resident Care Home Population between 2001 and 2011](#).

¹⁵ 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 cover only England and Wales and use a different definition of 'a person residing in a care home' to the other sources.

Table C9: Summary of UK care home population estimates

Source	Residents covered	Base year	2015 care home population	2025 care home population	2015–2025		
					Increase	Average annual growth rate	Growth (%)
PSSRU*	Publicly-funded	2015	204,762	247,619	42,857	1.9%	20.9%
	Self-funded	2015	186,905	261,905	75,000	3.4%	40.1%
	All	2015	391,667	509,524	117,857	2.7%	30.1%
LaingBuisson**	All	2014	438,846	501,821	62,976	1.4%	14.4%
Kingston et al (Newcastle Study)*	Medium dependency only	2015	62,304	83,062	20,758	2.9%	33.3%
	High dependency only	2015	200,448	264,469	64,021	2.8%	31.9%
	High and medium dependency	2015	262,751	347,531	84,780	2.8%	32.3%
IPC POPPI	All	2017	354,880	474,355	119,475	2.9%	33.7%
CMA	All	2011	352,216	467,422	115,206	2.9%	32.7%

Source: CMA analysis and PSSRU, LaingBuisson, Kingston et al, IPC, and ONS.

* The UK figures shown in the table is extrapolated from the England projection, based on the same number of care home residents per capita in the devolved nations as England and an England population share of 84%.

** The LaingBuisson estimates also include physically disabled persons, as well as older people. The 2016 edition of the LaingBuisson report 'Care of Older People UK Market Report' is the last to include care homes for physically disabled younger people in the scope of the report. The CMA analysis of LaingBuisson datasets indicates that this segment of the market is small (approximately 15,000 beds in 500 care homes).

*** This is generated by applying the growth rate to the base population (where the base year differs from 2015).

Financial analysis

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Introduction

1. This appendix is an update to the Financial Analysis Working Paper, which was published on 11 September 2017.¹ This appendix reflects the comments that we received from stakeholders. Even though it is intended to be a stand-alone document, it should be read alongside Section 4 of the main report.
2. Care homes² in the UK are mainly³ operated by the private sector.⁴ Most providers serve both self-funded and state-funded⁵ residents, but to varying degrees. Over half of all residents in care homes have some of their costs paid through state funds⁶ (LAs and the NHS, or Health and Social Care Trusts in Northern Ireland), and the care is usually delivered by the private sector.
3. The public sector contracts directly with private sector providers for care home places. The price paid by the public sector is based on commercial terms and this interaction between the public and private sectors is an important determinant of the financial performance of the industry.
4. Care home providers, industry analysts and regulators have raised concerns about the current financial performance and future sustainability of the industry, in particular providers and care homes that primarily cater for local LA- funded residents. Some providers have told us that LA fee rates have covered less than the full⁷ cost of providing care, and that this trend has been particularly acute over the last 7 years. Other challenges facing the industry include increasing staff costs and difficulties in the recruitment and retention of care workers⁸ and nurses.
5. We have been told that reductions in LA fee rates have had several negative outcomes as follows:
 - (a) some industry analysts and providers have told us that they have observed investment for new care homes going almost entirely into care

¹ [Care homes market study: working papers](#).

² Providers of residential care for older people aged 65 years or more in residential homes (care homes which only provide accommodation and personal care) and nursing homes (care homes which provide personal care and nursing).

³ Some LAs and the NHS operate their own care homes. However, they comprise an insignificant proportion of the overall market.

⁴ Private sector providers include for profit and not-for-profit providers such as charities and our analysis includes both these categories.

⁵ LAs are the largest single purchasers in their local areas, but the NHS (and HSC Trusts in Northern Ireland) also procure care home services.

⁶ Care of Older People UK Market Report 27th edition, 2016, page 197 by LaingBuisson. The large providers' dataset also shows a similar proportion.

⁷ The full costs include the operating costs and the capital costs.

⁸ Care workers refer to paid staff. This differs from carers, who can be unpaid, and whose examples include family members.

homes aimed primarily at self-funded residents,⁹ with almost negligible sums directed at the care homes which are primarily aimed at LA-funded residents.¹⁰ Some providers have added that they have been building new care homes in locations with higher proportions of self-funded residents and that they have been restricted in building new capacity in certain locations due to the lack of self-funded residents.

- (b) some providers have told us that they have scaled back their capital expenditures¹¹ on those care homes, which primarily cater for LA-funded residents¹² and that they are spending only limited amounts to undertake basic refurbishments or to meet minimum care standards.
- (c) some providers have told us that, since 2010,¹³ the real fee rates paid by LAs have reduced on average. This is consistent with the CQC's analysis. The CQC reported that from 2010/11 to 2013/14 the fee rate per week paid by LAs in England for residential and nursing care fell from £673 to £611 (at 2015/16 prices).^{14,15} It noted that LA focused providers have been exposed to 'severe financial strain', and it found that those with more than half of their turnover funded by LAs achieved, on average, 10% less fee income per bed and generated almost 28% less profit per bed, compared with other providers.¹⁶
- (d) the CQC has said that the sustainability of the adult social care industry in England is approaching a 'tipping point'. It considered that this was driven by a challenging financial climate that had resulted in unmet demand for an ageing population, living with long-term conditions.¹⁷ In its 2016/2017 report, the CQC welcomed the £2 billion made available by the Chancellor of the Exchequer in the Spring 2017 budget, but its overall position remained unchanged. The report stated that in some areas of the country, social care had moved further away from a tipping point, and in other areas it had moved closer to that point.¹⁸ The CQC also observed that it

⁹ [Care homes market study update paper](#), paragraph 7.12.

¹⁰ Some LAs have told us that they have managed to attract some investment by offering financial incentives such as favourable prices on land acquisition and block contracts (paragraph 3.6).

¹¹ This includes extensions to increase capacity (number of beds).

¹² This affects care homes with higher proportions of LA-funded residents, and homes with lower proportions of LA-funded residents.

¹³ The Comprehensive Spending Review was launched in 2010. The NAO has estimated that central government has reduced its funding to LAs by 37% in real terms between 2010/11 and 2015/16.

¹⁴ Health Foundation, Representation to the 2015 Comprehensive Spending Review, reported in CQC The State of Health Care and Adult Social Care in England 2015/16.

¹⁵ The King's Fund reported that 81% of LAs cut their spending in real terms on social care for older people since 2010. In more than half of LAs the reduction was at least 10%. However, the picture is not uniform –18% of LAs maintained or increased spending (Kings Fund, September 2016).

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

¹⁷ CQC news, '[Adult social care 'approaching tipping point', warns quality regulator'](#)'.

¹⁸ CQC's *The State of Health Care and Adult Social Care in England 2016/17*

had come across instances where LA-focused care home providers were exiting and that some providers had handed back care home contracts to LAs.¹⁹

(e) one market expert, LaingBuisson, has estimated a 'funding gap'²⁰ of £1.3 billion a year in the care homes industry in England with regards to the LA-funded residents.²¹

6. Some stakeholders have also raised concerns about the high financial gearing levels among some of the large providers, especially those owned by private equity funds. These analysts have also pointed out that several of these highly-g geared providers also have significant exposure to LA-funded residents.

Financial analysis

7. In response to these concerns we have performed a financial analysis of the industry. Our analysis aims to inform the debate regarding:

(a) the short (ie up to approximately 3 to 5 years) to medium (ie up to approximately 6 to 10 years) term financial viability; and

(b) long term sustainability (ie greater than approximately 10 years) of the industry.

8. For a care home provider to:

(a) operate and be financially secure in the short to medium term, its revenues need at least to cover the operating²² costs, while delivering a reasonable quality of care, and that it should not have unsustainable levels of debt; and

(b) be sustainable in the long term, its operating profits should exceed the costs of financing investment in the industry, both in terms of property and in the specialist equipment required to operate a care home. Where revenues, driven by fee rates, are sufficient to cover both operating costs

¹⁹ In its state of healthcare and adult social care in England 2015/16 report, the CQC cites data from ADASS that suggests that 32 LAs had residential or nursing care contracts handed back to them in the six months up to May 2016.

²⁰ An estimate of the average fee per resident actually paid by LAs less LaingBuisson's estimate of reasonable total costs.

²¹ LaingBuisson news (January 2017), '[Care home funding shortfall leaves self-funders filling £1.3 billion gap](#)'.

²² Operating costs include the cost of maintaining (upkeep of) the assets arising out of general wear and tear. However, it excludes the cost of new capital expenditure such as the purchase of new equipment or significant repairs to depleted assets. Operating costs do not include the cost of capital.

and a return on investment, and this is expected to continue, this should encourage investment in capacity to help meet future demand.

9. In section 4, we summarise the key findings of our financial analysis. An important objective of this analysis is to understand whether the industry has been generating adequate revenues to cover its operating costs, and, crucially, to encourage new investment. We have sought to assess the financial performance of the industry overall, and separately for providers and care homes focussed on LA and self-funded residents. We have also disaggregated the data to understand whether there are different patterns for different types of providers, for example by geography and the type of care provided.
10. We have obtained data from two sources:
 - (a) Companies House. We extracted the audited financial statements for 7,553 companies in the UK including England and the devolved administrations.²³ The primary financial statement used in the analysis has been the profit and loss statement. The period of analysis is between 2010 and 2016. For the profitability analysis, we have used data for 5,763²⁴ of the 7,553 care homes companies. The average annual revenues of this dataset during from 2010 to 2015 was £10.4 billion, thus comprising just under three quarters²⁵ of the estimated market size of £15.9 billion.²⁶ We note that not all companies had filed their 2016 financial statements with Companies House during the course of our analysis. Nevertheless, we obtained the 2016 financials for a sizeable proportion of the market to form a view on the aggregate operating profit margin.²⁷ We subsequently refer to this as the 'Companies House financial dataset'.²⁸ We understand that this is the largest dataset that has recently been used for financial analysis of the industry.

²³ We identified these companies by using their SIC codes 871 and 873 on Companies House. Therefore, this dataset only includes companies registered with Companies House in the UK. We also identified additional care homes from a CQC database. <http://www.cqc.org.uk/about-us/transparency/using-cqc-data#directory>

²⁴ The total number of companies from 2010 to 2016 in the Companies House extract was 7,553. However, 3,189 of these companies had nil values in their P&L and we excluded these companies from the profitability analysis. Hence, as a starting point, we analysed 5,763 companies for the profitability analysis. Where relevant, we have disaggregated or chosen resident mix segments of this dataset for our analysis.

²⁵ Using the aggregate revenue from this dataset in 2015 of £11.9 billion.

²⁶ Care of Older People UK Market Report 27th edition, 2016 by LaingBuisson estimates that the market size was £15.9 billion in 2014.

²⁷ The aggregate 2016 revenue was £4.6 billion.

²⁸ For the financial risk analysis, we used data for 2,016 of the 7,553 care home companies. We subsequently refer to this as the 'Companies House debt analysis dataset'.

- (b) Large providers in the UK. We obtained detailed financial information from 2015 to 2017²⁹ from 26 providers. Included in this was the financial information of approximately 2,000 care homes operated by these providers. The average annual group revenue during this period for these providers collectively was £4.3 billion, thus comprising nearly a third of the estimated market size measured by revenue. We have used this dataset for the profitability and financial risk analysis and subsequently refer to this as the 'large providers' dataset'.³⁰
11. We note that the datasets from the two sources complement each other since:
- (a) some of the large providers, for whom we have obtained financial information, do not file their group consolidated accounts with Companies House,³¹ and are thus excluded in the Companies House financial dataset. However, these group level findings are included in the large providers' dataset; and
- (b) the Companies House financial dataset includes small and medium sized providers (SMEs). Therefore, our combined datasets have a balance between large providers and SMEs.
12. Our analysis and commentary relates to the industry, and not to individual companies. So, we have presented all our analysis at an aggregate level,³² not at the level of any individual provider. However, we note that there are variations among the financial performance of providers and among individual care homes within the same group. Where it varies due to key factors related to the industry, we have disaggregated the analysis (see paragraph 9). However, the findings also vary due to factors specific to individual care homes.
13. We acknowledge that the performance of some care homes will be better or worse than the aggregated results. These could be driven by the resident mix, size, region and efficiency. Nevertheless, our analysis provides a robust indication of financial performance and sustainability for the industry as a whole and most providers because:

²⁹ We have used their actual results for 2015 and 2016, and forecasts for 2017.

³⁰ Where relevant, we have disaggregated or chosen resident mix segments of this dataset for our analysis.

³¹ This is because these entities are not registered in the U.K. We understand that several of these entities are registered offshore.

³² Aggregation of the financial results of several companies. For example, the EBITDAR margin = (total revenue generated - total operating costs incurred) / the total revenue generated by all the firms in the Companies House financial dataset. I.e. the disclosed margin is not a standard average of all 5,763 companies.

- (a) of the large size of our Companies House financial dataset, which covers most of the market;
 - (b) the distribution of operating profit margin results clustered around the industry average was not wide. In other words, most companies earned operating profit margins that were reasonably close to the industry average, and the ones that generated profit margins away from the mean do not significantly alter the aggregated results;
 - (c) no single company or a collection of a few companies distorted the industry average operating profit margin;
 - (d) we found a similar pattern of profitability and consistency between our aggregate results (see Figures 1, 2 and 4), and scenarios that we ran that only included companies that had traded throughout between 2010 and 2015 (see paragraph 107). This shows that the financial results of companies that recently started filing accounts or ceased to trade on the Companies House register do not distort our aggregate results; and
 - (e) similar results with regards to profitability trends and drivers were obtained when we compared the aggregate analysis from the Companies House financial dataset against the large providers' dataset, and also against views of stakeholders as to the financial performance of the industry.
14. Our financial analysis excludes the results of the smallest of the care home businesses, who are required to file abbreviated accounts.³³ We do not have reason to believe the financial results for microbusinesses should be significantly different from the industry aggregate, apart from the use of family labour into these owner managed businesses, which may have made them more resilient in absorbing increasing staff costs.
15. The findings of our analysis have been summarised below and the detailed analysis including the methodology and the full presentation of the findings has been laid out in Annex A and B.

Profitability analysis

16. Our analysis has sought to measure the profitability of the care homes industry. We have used measures of profitability and financial performance, which we understand are generally used in the industry, as described below.

³³ GOV.UK guide: [Prepare annual accounts for a private limited company](#).

Explanation of operating costs and profits

17. The standard metric to measure accounting profitability of the care homes industry is operating profit margins, which is a return on revenue measure (in percentage terms) equal to the relevant profit margin divided by revenue. We have explained the relevant operating profit margins in the Table 1 below. For the avoidance of doubt, the operating margins do not include the capital cost (cost of capital), which is discussed in paragraph 18.

Table 1: Profitability definitions

Profit margin	Definition	Costs included to calculate the margin
EBITDARM	Earnings before interest, tax, depreciation, amortisation, rent and management fees. This is used to measure the operating profitability of individual care homes.	Staff costs associated with providing care and services in the care home. For example, payroll costs of care workers and nurses. Non-staff operating costs incurred at the care home level to operate the home. For example: food, utilities, maintenance and other overheads.
EBITDAR	Earnings before interest, tax, depreciation, amortisation, and rent. This is used to measure the operating profitability of providers. It is also used to assess the ability of providers to generate adequate profits (and cash) to meet rental payments. It excludes property related costs such as rent, depreciation and interest costs.	Costs as EBITDARM and Central (head office) costs such as group finance, legal and management's salary. Fees related to charges levied by shareholders, mostly private equity funds, in relation to management services that they have provided the company.
EBITDA	Earnings before interest, tax, depreciation and amortisation. This is used to assess the ability of providers to generate adequate profits (and cash) to meet interest payment obligations.	Costs as EBITDAR and rent
EBIT	Earnings before interest and tax.	Costs as EBITDA and depreciation and amortisation, which do not have a cash impact
PBT	Profit before tax	Costs as EBIT and interest expense
PAT	Profit after tax	Costs as PBT and: and tax
Exceptional items	Non-recurring or one off costs that a provider would not incur in the normal course of operating a care home. Examples include restructuring costs, gains or losses on disposal, and redundancy payments. The analysis of margins pre-exceptional items gives a truer position of the operating profitability.	

Explanation of the capital cost and economic profits

18. The capital cost is the return that investors³⁴ require to invest in a business. When considering any capital investment, investors factor in the opportunity cost of that investment. This is the return that the investor could earn by investing in another business instead with a similar level of risk. This return is required both to cover the cost of providing finance³⁵ and a margin to reflect the risk taken by investors.³⁶
19. Risk is an unavoidable part of any investment. Part of the risk faced by investors in the industry is the result of the general economic environment, eg the economic cycle and interest rate changes. Risk can also arise from factors that are specific to the care homes industry. Examples include uncertainty over the levels of future LA fee rates. If investors consider that the risks of investing in the care homes industry are particularly high, they will seek higher returns. Where expected returns to new investment are below the level required to compensate investors for risk, then they may not invest in the care homes industry. We note that the principle that returns to investors need to take account of risk over the life of the investment applies to care home providers of all sizes and complexities in terms of their operations and sources of finance.
20. Therefore, providers need to earn an economic profit (see Table 2), over and above break-even operating profits, to cover the cost of investing in the assets that are required to operate a care home. In our analysis, we have used a 6.5% rate of return, based on comparisons with other industries and trends in market data (see paragraphs to 138-155 for further details).

Table 2: Calculations with regards to the capital cost

Measure	Calculation
Capital cost	Capital employed x % rate of return
Total cost	Operating costs + capital cost
Economic profit/(loss)	Revenue – total costs
Economic profit margin	Economic profit / revenue

21. The capital cost is similar to other overhead costs³⁷ within the cost base of providers, to the extent that it is incurred in order to acquire and invest in the

³⁴ The providers of finance can broadly be considered as debt financiers and/or equity shareholders.

³⁵ This relates to the time value of money. The essence is that an amount of money (e.g. £100) is worth more to an investor today, than the same amount of money on any given date in the future.

³⁶ We note that even the public sector applies a discount rate of 3.5% with regards to its investment decisions. [HM Treasury: The Green Book](#).

³⁷ Examples of overhead costs include consumables and maintenance costs.

facilities within a care home. 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 (P&L) accounts of providers.

22. The capital cost is a real cost for the business with a cash flow impact, for example holders of debt finance are paid interest and equity investors are paid dividends. However, the capital cost is unusual in that it is not directly measurable as per accounting standards, and is not part of the reported operating costs in the profit and loss (P&L) accounts of providers. Providers incur both operating costs and the capital cost, which together can be termed, 'total costs'. 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 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.
23. 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.

Summary of findings

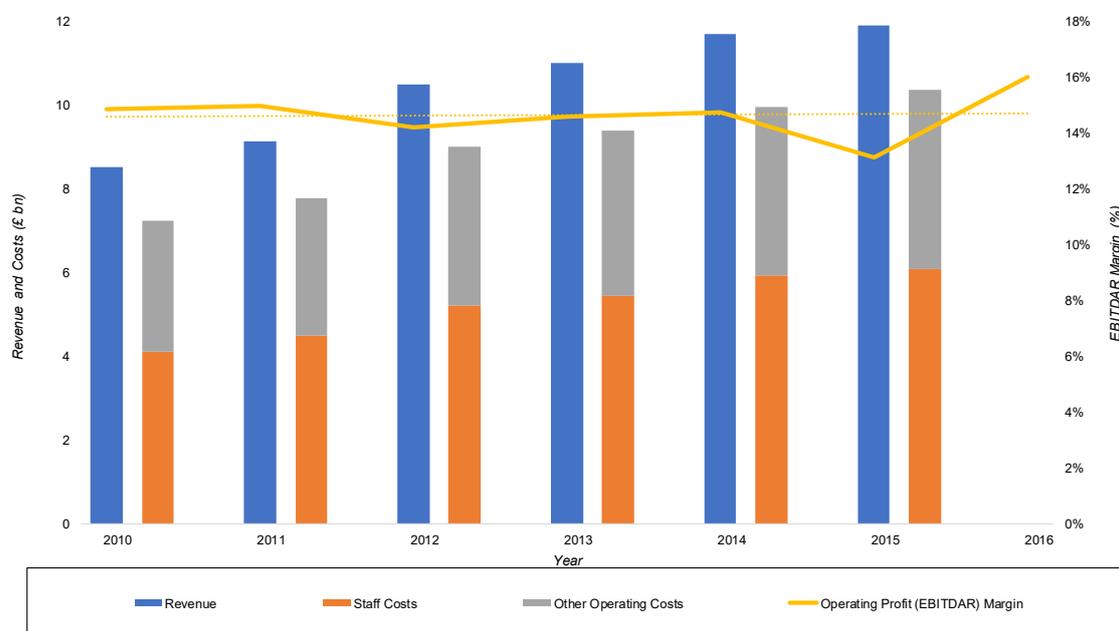
Aggregate profitability

24. In this section, we provide analysis of the financial performance of the industry in aggregate, based on the data and profit measures described above.

Operating profits

25. We have assessed the trends in revenue, operating costs and operating profit margins, using the Companies House financial dataset.³⁸

Figure 1: Aggregate industry operating profits, 2010–2016



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

Note:

1. This analysis includes the results 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 paragraph 10(a))
3. The yellow dotted line represents the trend in the operating profit margin between 2010 and 2016.

26. Figure 1 indicates that the industry, in aggregate,³⁹ has generated consistent and positive operating profit margins, measured by the EBITDAR margin. Also, despite a challenging environment given LA fee levels, industry revenues have increased by more than inflation over the period, and this has broadly offset the effects of operating cost inflation (see paragraphs 103-106). In other words, increases in operating costs⁴⁰ have been matched by increases in revenue.
27. Hence, this margin has remained flat during the period of review, and has averaged approximately 14%. This is despite increasing levels of wage rates, driven by increases in the National Minimum Wage over this period and contrary to stakeholder submissions that operating profit margins of providers have significantly declined.

³⁸ It covers around approximately three quarters of the industry by revenue in 2015.

³⁹ This includes providers focused on LA and self-funded residents.

⁴⁰ Operating costs comprise staff costs and other operating costs.

28. The finding that care home providers have generated positive operating profit margins is supported by analysis from the large providers' dataset. This shows that 26 providers generated positive operating profits, measured by pre-exceptional EBITDAR. The average margin in 2015 and 2016 was approximately 20%.⁴¹ Even though the National Living Wage came into effect on 1 April 2016, we also observe that the 2016 aggregate margin did not significantly decrease from 2015. In addition, aggregated forecasts show that providers expect this margin to increase incrementally in 2017 (Table 3).
29. 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 2016.⁴² We understand that NHS Funded Nursing Care⁴³ payments increased significantly in 2016;⁴⁴ and more recently, increased some LAs have increased fee rates in response to increasing wage costs.⁴⁵
30. Positive aggregate operating profit margins imply that the industry, overall, has been viable in aggregate in the short term, ie it has generated adequate revenues to cover its operating costs, which comprise the largest portion of its cost base and which also has a significant impact on cash flow.
31. Our assessment of the short-term sustainability of the industry is corroborated by the low levels of insolvencies, at approximately 44 per year (around 0.1% providers in the industry), between 2010 and 2016 (see paragraphs 117-120). We, however, note that the insolvency rate does not tell us how much capacity is leaving the market.⁴⁶

Economic profits

32. In addition to measuring operating profitability based on accounting data, we have considered the economic profitability of the industry. In particular, we

⁴¹ We observe a difference in the reported margins between the datasets as the two measures of profitability are not entirely like-for-like, however, they follow the same pattern in that EBITDAR margins have been positive and stable can be observed in both datasets.

⁴² See Appendix D, Figure 13.

⁴³ See paragraph 11.34 for an explanation of NHS funded nursing care.

⁴⁴ <https://www.gov.uk/government/news/nhs-funded-nursing-care-rate-for-2016-to-2017>

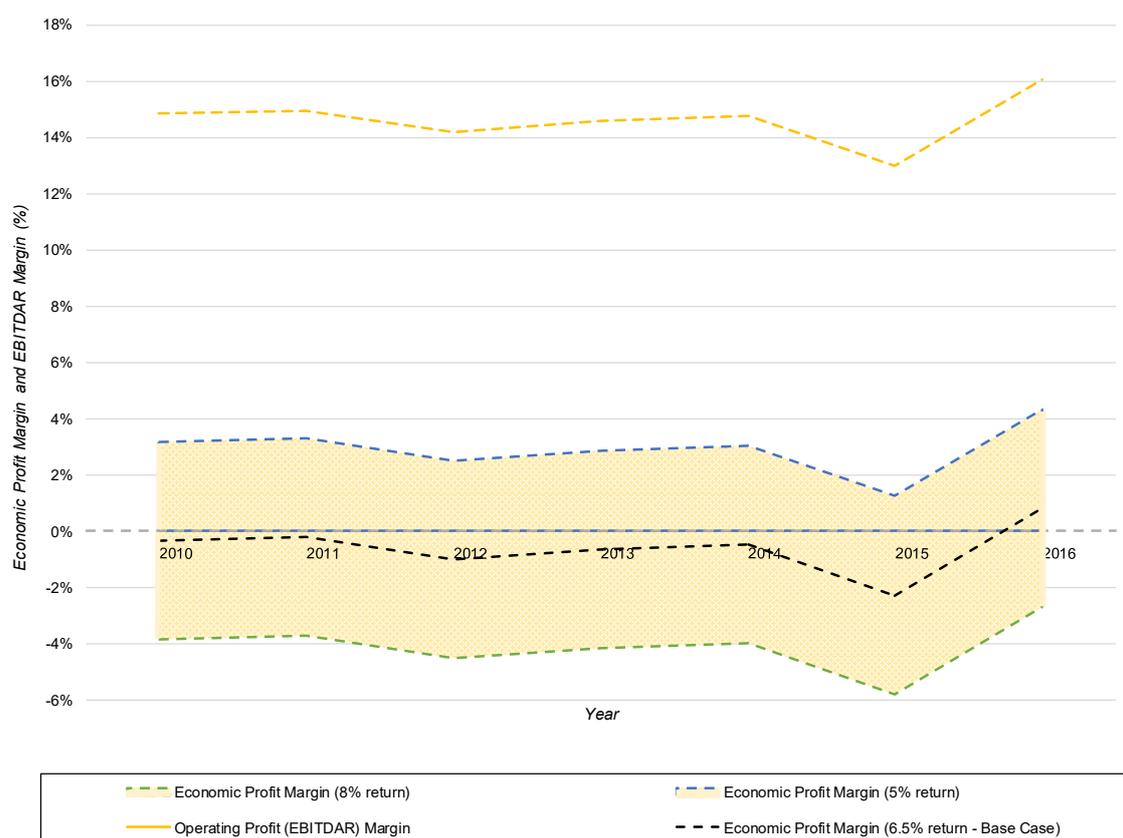
⁴⁵ Illustrated by the findings in the ADASS 2017 Budget Survey, which showed that providers including those with LA-funded residents reported increasing fee rates between 2016/17 and 2017/18 (Figure 21): <https://www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf>.

⁴⁶ Insolvencies can result in a going concern outcome (home sold to new buyer) or the closure of a care home (liquidation). Also, providers can exit the market through non-insolvency routes such as a planned closure.

have looked at whether revenues have covered the total costs including investment costs, ie the capital cost.

33. The analysis of economic profitability requires a broader set of assumptions, compared to the analysis of operating profitability, which relies on observable and audited numbers. Most importantly, we have assumed values of assets used in the industry, which cannot be observed directly from the financial statements. Hence, we have used a wide dataset of market based valuations for properties, which we have used to estimate suitable values for the industry.
34. Figure 2 provides our estimate of a range for the aggregate economic profitability of the industry on this basis. In it, we assumed that the rate of return ranges between 5-8%, with a base case of 6.5% (see paragraphs 138-155 for further details on the rate of return).

Figure 2: 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 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. ie 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.

35. Figure 2 indicates that the industry, in aggregate,⁴⁷ has 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%. The black dotted line shows the economic profits and losses using our base case of 6.5% rate of return.
36. Based on the range of outcomes in the yellow shaded area in Figure 2, we can infer that investors, in aggregate, have narrowly recovered or under-recovered their expected returns. Using our base case 6.5% rate of return (black dotted line), these results suggest that the industry in aggregate has just about achieved the minimum levels of economic profits to remain financially sustainable.
37. Even though this analysis is dependent on several assumptions, it is reasonable to consider that not all investors in the industry would have been making sufficient returns, ie their revenues would have been below total costs.

Summary of aggregate profitability analysis

38. The key messages from this profitability analysis, overall, are that:
 - (a) in recent years, the operating profit margins have been positive and broadly stable (see Figure 1). In addition, the aggregated operating profit margins for the large providers are expected to increase incrementally in 2017 (see paragraph 28, Table 3 and paragraph 106); and
 - (b) given the ongoing financial challenges⁴⁸ to the industry, if there continues to be the expectation that financial performance is likely to decline, then there could be a risk that the industry may not be sustainable in the long term.
39. As discussed above, these figures are based on aggregate data. Hence, the profitability of homes varies significantly across providers, especially according to how residents are funded, ie whether they are LA-funded or self-funded. The other drivers of profitability include the region, and type of care. We discuss these disaggregated analyses further in the next sections.

⁴⁷ This includes self-funded residents and-LA-funded residents.

⁴⁸ For example, increasing staff costs coupled with uncertainty over fee rates.

LA vs self-funded profitability

40. Based on submissions by stakeholders that finances are particularly challenging for LA-funded providers and care homes, we have sought to compare the profitability of providers that focus on self-funded residents to those that focus on LA-funded residents.
41. We note that most care homes and providers have both LA and self-funded residents, but to varying degrees. This means that there is no direct measure, on a per resident basis, of how LA and self-funded residents contribute to the total costs of the industry, as these homes and providers report their costs on an aggregate basis. Nevertheless, we have been able to use our datasets to estimate the relative contribution of LA and self-funded residents towards total costs.
42. For example, we have had to use regions as a proxy for funding source when analysing the Companies House financial dataset (see paragraphs 109-111). When analysing the large providers' dataset, we have used the overall resident mix at a group and individual care home level. We also note that the Companies House financial dataset and large providers' dataset may have been reported on a differing basis (also, see footnote to paragraph 28). Such differences would explain the divergences in observed margins between providers focussed on LA and self-funded residents (see paragraphs 43-46 and Figure 4).

Operating profits: LA-funded versus self-funded residents

43. The key findings from the Companies House financial dataset and large providers' datasets are that providers and care homes with greater proportions of LA-funded residents have, in aggregate, earned lower, but positive, operating profit margins compared to those with greater proportions of self-funded residents.
44. By analysing the large providers' dataset (see paragraph 10(b)) for their group level results, the findings are that the 26 providers collectively generated EBITDAR margins of 21% between 2015 and 2017.⁴⁹ However, providers that generated the greatest proportions of revenue from LA-funded residents⁵⁰ earned significantly lower EBITDAR margins at 17%. In comparison, providers

⁴⁹ Calculated using actual reported figures for 2015 and 2016 and forecasts for 2017.

⁵⁰ Greater than 67% revenue from LA-funded residents at the Group level using the large providers' dataset.

with relatively lower proportions of revenue generated from LA-funded residents earned the highest EBITDAR margins of 27%.⁵¹

45. Similar findings also emerge when we analyse the large providers' dataset for their care home level results between 2015 and 2016 for the 26 providers. Using their actual results for 2015 and 2016, we observe that these care homes collectively generated EBITDARM margins of 27%. However, those with the highest proportions of self-funded residents⁵² generated significantly higher EBITDARM profit margins at 37%, compared to those care homes with primarily LA-funded residents⁵³ that only generated 22% margins (see Figure 13).
46. The relative profitability of providers and care homes with greater proportions of self-funded residents is corroborated by analysing data from the Companies House financial dataset for small and medium-sized (SMEs) companies.⁵⁴ The findings are that all these SMEs collectively generated average EBITDAR margins of 15% between 2010 and 2015. However, regions with relatively higher proportions of LA-funded residents⁵⁵ earned lower EBITDAR margins at 13%. Providers in regions with mixed⁵⁶ proportions of residents, and consequently lower proportions of LA-funded residents,⁵⁷ generated the highest EBITDAR margins of 17% (see paragraphs 109-111).

Operating profit margins at a care home level: resident mix

47. The purpose of this analysis is to understand the effect of LA fees on operating profit margins, which we can measure at the level of the individual care home.⁵⁸ We have tested this by separating care homes into the following resident mix segments:
 - (a) primarily LA-funded care homes (more than or equal to 75% LA-funded residents within a care home);

⁵¹ Between 40% and 63% revenue from self-funded residents at the Group level using the large providers' dataset.

⁵² Greater than 75% self-funded residents within each care home using the care home level data from the large providers' dataset.

⁵³ Greater than 75% LA-funded residents within each care home using care home level data from the large providers' dataset.

⁵⁴ These companies overwhelmingly tend to operate in the region in which they are registered with Companies House.

⁵⁵ 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 more than 60% LA-funded residents.

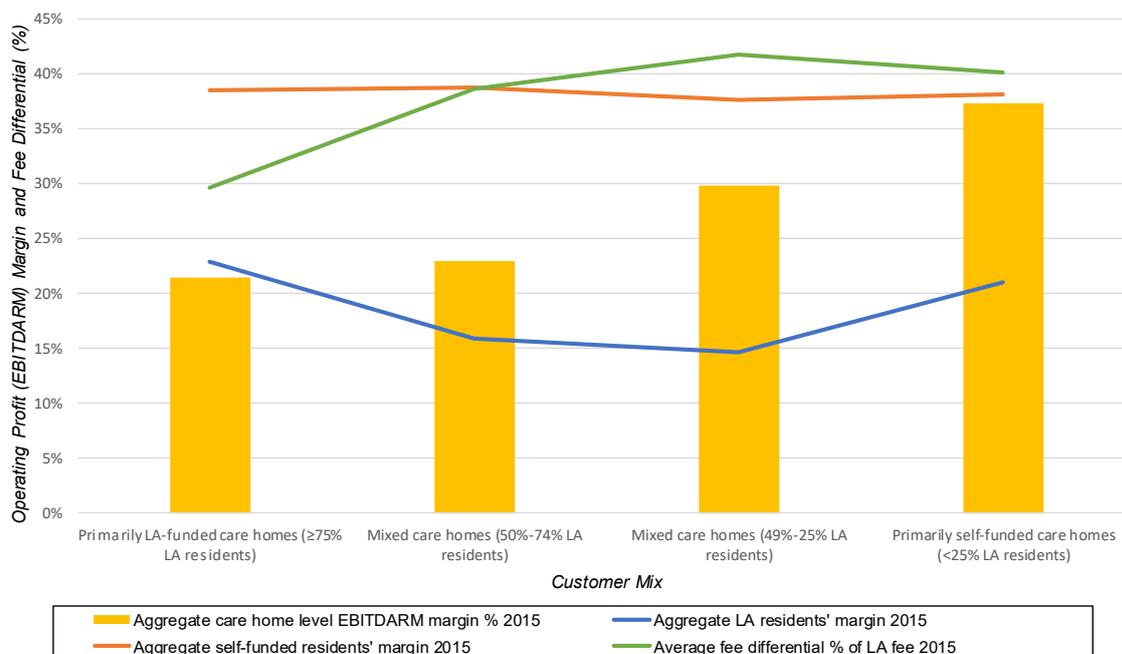
⁵⁶ Mixed regions include both LA and self-funded residents.

⁵⁷ Similarly, we allocated companies to regions with lower proportions of LA-funded residents if that region had below 60% LA-funded residents.

⁵⁸ We have used EBITDARM to assess the profitability at the care home level.

- (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 3. Operating profit margins of care homes with differing proportions of LA-funded residents, 2015



Source: CMA analysis of large providers' dataset.

48. The key messages from our results in Figure 3 are 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 their 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 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) result in (b) is driven by the fee differential, which is highest in mixed care homes (green line). We have found that the key driver of profitability is most likely to have been the lower fee rates paid by LAs compared to the

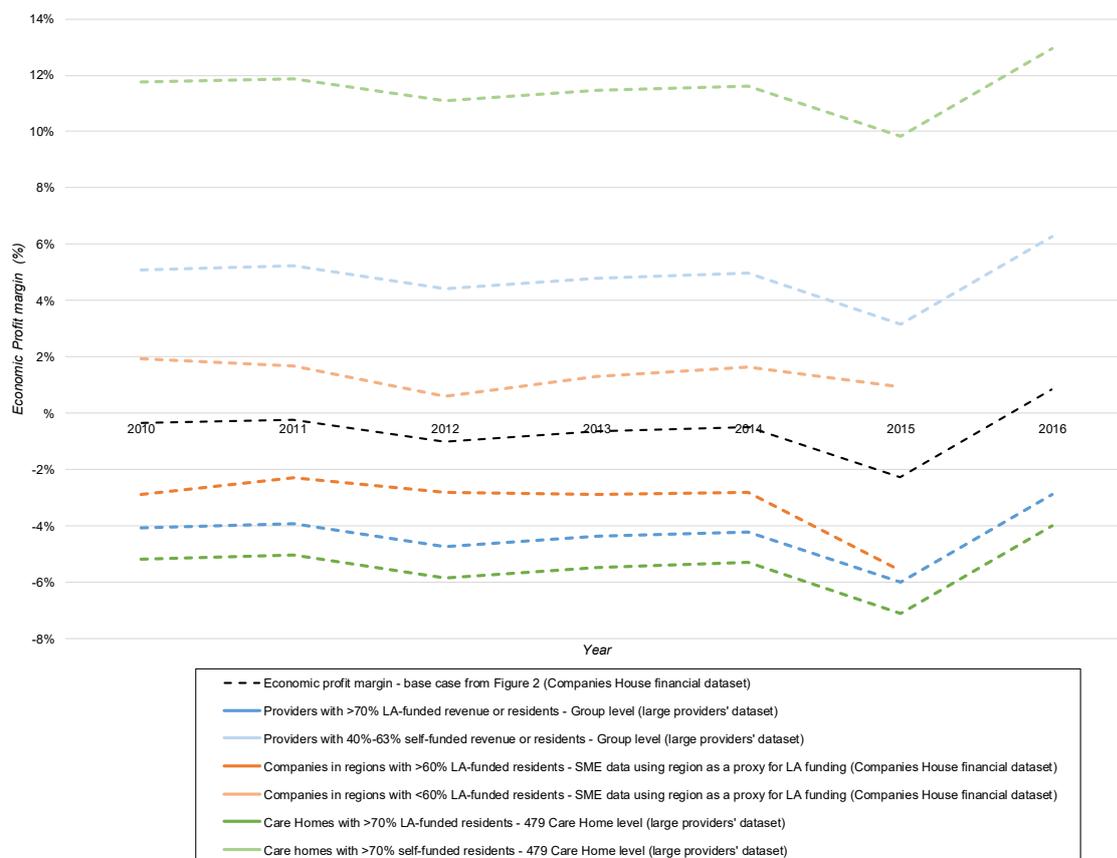
fee rates paid by self-funded residents (see the discussion of fee differentials in paragraph 2.40).

49. This indicates that care homes have relied on self-funded residents to aid their sustainability. Self-funded residents have made a greater contribution towards common costs. However, this reliance is most pronounced in mixed care homes.
50. Also, it is the higher fees charged to self-funded residents that have enabled the industry to remain sustainable, in aggregate. This is evident when we assess Figure 2 alongside Figure 4. Figure 2 shows that the industry has generated break-even levels of economic profits. Figure 4 shows that primarily LA-funded care homes have generated economic losses, whereas primarily self-funded resident care homes have generated economic profits.

Economic profits: LA versus self-funded residents

51. The industry overall (ie which includes LA and self-funded residents), generated break-even levels of economic profits between 2010 and 2016 (see Figure 2). We also observe that the providers and care homes with the highest proportions of LA-funded residents and SMEs located in regions with the highest proportions of LA residents generated significantly lower operating profit margins than those care homes with higher proportions of self-funded residents (see paragraph 43). Therefore, it is reasonable to infer that, in aggregate, the providers, care homes and companies with the greatest proportions of LA residents would have generated economic losses and those with the opposite resident mix would have generated economic profits.
52. We illustrate this in Figure 4. This models the effects on the aggregate economic profits (see Figure 2) of the observed differences in the operating profits between the care homes, providers and companies with the greatest proportions of LA-funded and self-funded residents (see paragraphs 43-46).

Figure 4: 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 submissions from some large providers.

Note:

1. We have used a 6.5% return for the base case and all modelling of scenarios (green, blue and red lines).
2. Economic profit = EBITDAR – capital cost.
3. There were too few data points for SMEs to be able to carry out the analysis for 2016 using the Companies House financial dataset (red line).
4. We used 479 homes for the care home level analysis (green line). This is because these care homes provided us with up to data market valuations on their property assets, which we used in this analysis. We used the ratio of annual aggregated revenue to aggregated property market values from this dataset (see paragraph 143) for the company level data using the Companies House financial dataset, and the group level data using the large providers' dataset.
5. For the Group level (large providers' dataset) (light blue line) and companies house financial dataset (light red line), no company or provider had in excess of 54% and 63% self-funded residents respectively.

53. Figure 4 shows that the care homes, providers and companies with the greatest proportions of LA-funded residents⁵⁹ made economic losses and those with greatest proportions of self-funded residents⁶⁰ made economic profits. In other words, the LA revenues, overall, have been lower than total costs, at least in the recent years for which we have data.

⁵⁹ Companies in regions with at least 60% LA funded residents, providers with at least 70% revenue from LA funded residents and care homes with at least 70% LA funded residents.

⁶⁰ Companies in regions with 42%-54% self-funded residents, providers with 37% to 63% revenue from self-funded residents and care homes with at least 70% self-funded residents.

54. Care homes and providers with the greatest proportions of LA-funded residents have generated adequate revenues to cover their operating costs (see paragraphs 43-46). These homes have, on average, been operationally viable in their ability to meet day-to-day expenses. However, they have not been economically viable (Figure 4) in terms of being able to provide a sustainable return to investors, which would be required for investors to provide capital required for ongoing modernisation and investment in new assets for the longer term.
55. This implies that these providers have economic incentives 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 operate⁶¹ until such time.
56. On the other hand, the results suggest that the providers with the greatest proportions of self-funded residents have been 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 mostly been directed at care homes which are focussed primarily on self-funded residents.⁶²
57. The differences in the observed economic profit margins (see Figure 4) between providers and care homes focussed on LA and those focussed on self-funded residents can be explained by the differences in the average fee rates between LAs and self-funded residents.
58. The results shown in Figure 4 and paragraphs 43-46 for the performance between the care homes and providers focussed on LA and self-funded residents is consistent with:
 - (a) information provided to us by large providers on the differences between fee rates between LA-funded residents and self-funded residents; and
 - (b) the analysis from the large providers' dataset which shows that LAs have been the largest revenue stream (just under half) for these large providers, and that these providers have earned lower fees per resident than self-funded and NHS funded residents (see Figures 12, 13 and 14).
59. This economic profit analysis relies on several assumptions, and therefore our analysis of the financial performance of the providers and care homes

⁶¹ In that they have generated positive operating profit margins.

⁶² We have seen a few instances where LAs 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 3.9.

focussed on LAs should be used with some caution, compared to the analysis on the relative operating profit margins, which uses actual reported numbers.⁶³ Nevertheless, we have tested a range of approaches to measure the relative profitability of care homes and providers focussed on LA-funded residents and the findings provide a consistent pattern that operating profitability has been lower and economic profitability is likely to be negative.

Summary of findings on LA-funded and self-funded residents

60. In summary, our aggregated analysis shows that:
- (a) the overall revenues at an industry level have been close to total costs (Figure 2);
 - (b) revenues generated by providers that have the greatest proportion of LA-funded residents have, overall, been lower than total costs but have been higher than operating costs (Figure 4);
 - (c) revenues generated by providers that have the lowest proportion of LA-funded residents, and consequently greater proportions of self-funded residents, have, overall, been higher than total costs (Figure 4); and
 - (d) we can, therefore, infer that providers have generated most of their profits, in aggregate and on a per resident basis, from non-LA-funded residents. In other words, self-funded residents have made a higher contribution towards fixed costs and common costs such as overheads. However, providers have been loss-making in economic terms, ie returns below the capital cost, on LA-funded residents.
61. Given that the costs to serve residents, irrespective of their funding source, in any care home are generally similar⁶⁴ and that occupancy levels between these sub-groups do not differ significantly,⁶⁵ our analysis indicates that this difference in profitability can be attributed to lower fee rates having been paid by LAs. This is also consistent with data on the fee differentials paid between LA and self-funded residents that large providers submitted to us. However,

⁶³ This analysis does not consider whether the quantity and type of care procured is optimal.

⁶⁴ Almost all providers we asked submitted that the costs to serve LA-funded residents and self-funded residents does not significantly differ within a home. That is, it costs a similar amount to serve residents with a similar acuity of needs, irrespective of the source of funding, in the same care home.

⁶⁵ Most care homes have a mixture of LA and self-funded residents. We also understand that providers set occupancy KPI targets for care homes across their portfolio of homes, which do not differentiate between LA and self-funded residents.

this analysis does not take account of any differences in the individual services received by self-funded and state funded residents.⁶⁶

Results by nation: operating profits

62. We have also compared the operating profitability of providers based on the country in which they operate by using the Companies House financial dataset between 2010 and 2015⁶⁷ for SME providers. The findings are that the average levels of EBITDAR margin were highest in Wales (22%), followed by England (16%), Scotland (14%) and Northern Ireland (12%).⁶⁸

Nursing and residential care: operating profits

63. The findings from our analysis also demonstrate that companies registered as nursing homes generated higher operating profit margins than those registered as residential care homes.⁶⁹ Specifically, the findings from the Companies House financial dataset are that the EBITDAR margin for nursing care homes has consistently been higher, on average, at 16% between 2010 and 2015,⁷⁰ than that for residential homes which has been 12% on average.⁷¹

Significance of top-ups

64. We also observe that top-up fees are not a significant revenue stream for the large providers, and are therefore unlikely to affect, significantly, their profit margins. When using the large providers' dataset, we have found:
- (a) for 22 providers, top-up fees accounted for only 1.5% of their total revenue.
 - (b) for 17 providers that submitted values for top-ups, top-up fees accounted for 1.9% of their total revenue.

⁶⁶ In other words, all else being equal, the cost of, for example, the building and servicing a 'room with a better view' would not differ significantly from a 'room with a worse view'.

⁶⁷ We did not conduct this analysis for 2016, but not all companies had filed their financial statements with Companies House during the course of this analysis.

⁶⁸ See paragraph 113 for further details.

⁶⁹ Registration with Companies House.

⁷⁰ We did conduct this analysis for 2016, but not all companies had filed their financial statements with Companies House during the course of this analysis.

⁷¹ See paragraph 114 for further details.

The relationship between LA fee rates and total costs of care

65. 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.
66. Based on our analysis as illustrated in Figures 2 and 4 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 to £1.1 billion. We describe in Annex C the methodology we have used.
67. We found in Figure 2 above that the sector, in aggregate, has been covering its total costs, ie that economic profits have been close to break-even levels. Given that LA fees have been below total cost, this indicates (Figure 3) that this shortfall is offset by self-funder fee rates being above total cost.
68. 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

69. 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.
70. 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 costs 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. Using this approach, we estimate that the funding shortfall is in the range of £200-300 million.
71. 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

72. 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.
73. 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.
74. 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 for 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

75. The size of the additional funding shortfall required 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 6.4);
 - (b) increases in staff costs (paragraph 4);
 - (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.

Financial risk

76. Certain stakeholders have raised concerns about the financial risk arising both from the levels of debt on the balance sheets of providers, and off-balance sheet risks such as those arising from sale and lease back transactions. Concerns were raised about the financial risks of providers

owned by private equity funds, coupled with significant exposure to LA-funded residents. Therefore, we have undertaken some high-level analysis to assess the levels of debt in the industry.

77. High levels of debt⁷² (gearing) can increase the financial risk profile of a provider because:
- (a) a provider must make regular cash payments to repay its debt⁷³ to avoid default. Hence, it must generate a sufficient level of operating cash flows in each period. However, even relatively minor movements in a provider's cash flows, either arising from changes in revenue or costs, could dramatically affect its ability to do so;
 - (b) a provider must also adhere to its debt covenants. These can either be financial (eg gearing ratios) or non-financial such as a negative pledge⁷⁴ that might restrict its ability to borrow further. An actual or potential breach of its covenants could trigger a restructuring event that could restrict further funds to the provider from the lender, or at its worst lead to an insolvency; and
 - (c) providers with long term debt⁷⁵ are also likely to have pledged some or all of their assets⁷⁶ as security. During normal trading conditions, this restricts the use of these secured assets for other purposes. However, during distressed⁷⁷ trading conditions, it gives the creditors the leverage to pursue their interests over those of other stakeholders such as equity investors. As a practical example, the secured creditors could file for an insolvency.

Requirement and role of debt in the industry

78. We consider that the key driver of profitability in the industry is the exposure to LA-funded residents. As we explain below, financial risks arising from the high levels of debt should not, and is not, the key driver of sustainability.
79. A provider with industry average levels of operating profitability (given our results in Figure 1) and whose capital structure is fully funded by equity capital (ie the assets have been purchased with the equity financing) would not,

⁷² Debt is booked as a liability on its balance sheet.

⁷³ The cash repayments relate to interest charges and capital repayments. The frequency and timing of these payments will depend on the type of debt instrument.

⁷⁴ An undertaking by the borrower (provider) to a specified lender not to create a class of creditor that ranks above that specified lender, with regards to priority for repayment.

⁷⁵ Secured debt such as term loans are the most common form of debt for companies that do decide to borrow.

⁷⁶ In the case of a care home, this is likely to be its land and building.

⁷⁷ For example, if a provider is unable to generate adequate cash flows to meet its debt service obligations.

ordinarily, incur significant additional non-discretionary expenses and cash outflows after paying for its operational costs. The most significant cash outflow post operating costs would be dividends, which is at the discretion of management. This capital structure aids a provider with regards to adverse cash-flow movements that could trigger an insolvency.

80. However, if the same provider were to fund its capital structure with debt, then its financial risk profile would increase. This is because the provider must generate regular and adequate cash flows to repay the interest and capital, and also adhere to its debt covenants (paragraph 77). However, as we explain below, the level of risk is dependent on the types of debt instruments and gearing ratio (proportion of debt to equity capital).
81. The cash flow management for care homes, with moderate levels of debt, is straightforward and carries relatively low levels of financial risk, because:
- (a) the industry benefits from increasing and constant demand from an ageing population. Thus, revenues are relatively predictable, as are the key costs; and
 - (b) given that the industry requires significant investment in capital expenditure in land, building and equipment, it can benefit from and obtain a significant proportion of its debt from secured lending. This attracts a lower rate of interest and predictable capital repayments.
82. However, the financial risk would be significantly increased if the provider were to opt for unsecured lending or high yield bonds. 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.
83. 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.

Our results

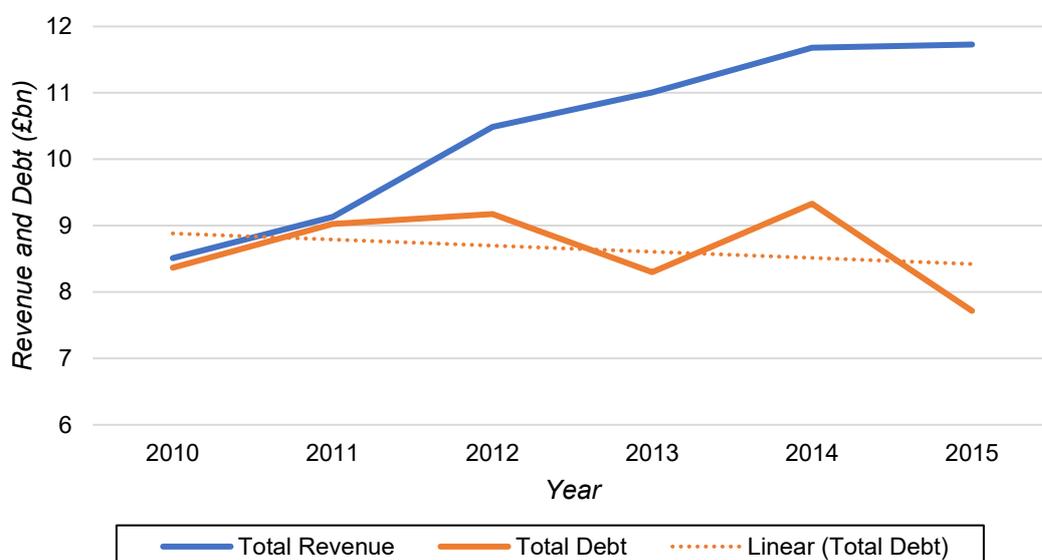
84. Our analysis suggests that risks arising from debt are unlikely to pose a significant threat to the financial sustainability of the industry. However, this

does not imply that certain over geared providers carrying unsustainable levels of debt are not at risk of default or financial distress.

Companies House financial dataset

85. We have reviewed the audited financial statements of 7,553 companies between 2010 and 2016. Of these, 2,016 companies 27% (of 7,553) carried some debt on their balance sheets in any given year between 2010 and 2015.⁷⁸ These 2,016 companies generated an average annual revenue during this period of £10.4 billion and carried £8.7 billion of net annualised debt.⁷⁹

Figure 5: Total revenue and total debt, 2010–2015



Source: CMA analysis of P&L and Balance Sheet information of the Companies House financial dataset.

86. Figure 5 shows that for these 2,016 companies, net debt declined between 2010 and 2015, despite the revenue growth, suggesting a trend towards deleveraging in the industry. This could be driven by providers unwilling, or unable, to take on extra debt. The latter could arise due to a tightening of lending and credit to the industry.

87. We also disaggregated these 2,016 companies based on their size in terms of revenue. The top quarter of these companies by average revenue over the period have been classed as large, the second and third quarters have been classed as medium sized and the last quarter has been classed as small.

⁷⁸ 2016 was excluded from this analysis as there were half the number of filed accounts in 2016 as not all companies had filed accounts by the time of this study.

⁷⁹ Net debt = Short-term debt + long-term debt + intercompany debt + finance lease liabilities - cash

88. The findings indicate that net debt is most heavily concentrated in large companies (82%), compared to medium sized (16%) and small (2%) companies.

Large providers' dataset

89. We also analysed the large providers' dataset for the period between 2015 and 2017.⁸⁰ Of the 26 providers in the dataset, 22 carried debt on their balance sheets. These 22 providers generated £4.0 billion of annual average revenue during this period and carried debt on their balance sheets of £3.3 billion.
90. We observe that the debt is not concentrated in private equity owned providers, any more than it is in non-private equity owned providers. For example, of the 22 providers that we reviewed for this analysis, those owned by private equity funds had a similar ratio of revenue to debt as other providers.

Conclusion on debt

91. The care homes industry is one that has significant asset investments, both in property and in assets within homes. We are, therefore, not surprised to observe that there is some debt associated with these companies in order to finance these assets. However, the levels of debt, in aggregate, do not look unusually high.
92. Whilst some large providers have significantly more debt than SMEs, the findings suggest that these debt levels have not been increasing in aggregate. Whilst this does not imply that debt levels within all these highly-gearred providers are sustainable, it does not indicate any immediate concerns about financial viability across the industry as a whole.

⁸⁰ Financial year 2015 and 2016 numbers are actuals and financial 2017 year numbers are forecasts.

Annex A: Operating profitability analysis

93. The annex lays out the methodology, and some additional findings from our profitability analysis. As noted in paragraph 10, we have sourced our data from Companies House and the large providers.

Use of operating profit margins

94. We have used the EBITDAR and EBITDARM margins (see Table 1) to assess the operating profitability of providers and individual care homes respectively. EBITDAR includes all costs of operating a care home and any central charges for shared services such as finance, legal and management fees. Both these margins exclude property related costs such as rent, lease, depreciation and interest. Providers can choose different ways to finance their portfolio of care homes and these affect the P&L differently. For example, the relevant property related charges in the P&L would differ depending on whether a property is:

- (a) bought outright with equity shareholder's cash, with no property related charge in the P&L;
- (b) rented, in which case the entire rental payment would be included as 'rent', with no depreciation charge in the P&L;
- (c) leased and classified as a finance lease⁸¹ for accounting purposes, the financing cost would be included under 'interest', with a depreciation charge in the P&L; or
- (d) mortgaged, the financing cost (only the interest element) would be included under 'interest', with a depreciation charge in the P&L.

95. By excluding property related costs, the pre-exceptional EBITDAR margin provides a comparable benchmark to assess the operating profitability of care homes. The EBITDAR margin also excludes the effects of changes in accounting policy. For example, changes in lease accounting could result in expenses being recognised under interest and depreciation, instead of under rent.

⁸¹ The risks and rewards associated with owning the asset are with the lessee.

96. In our analysis, we have used the pre-exceptional⁸² EBITDAR margins as the operating profit margin metric to ensure consistency and comparability of reported results.
97. EBITDAR is also an indication of the ability of providers to generate adequate cash inflows before the requirements to make other cash outflows such as those related to property, which can be significant at approximately 13% of revenue (Table 3); corporation tax, which is not payable by loss making companies; and capital expenditure and dividends, which have the potential to be deferred for a period.

Companies House financial dataset

98. We have analysed the financial performance of approximately 5,763 care home companies⁸³ in the UK between 2010 to 2016⁸⁴ using their statutory accounts⁸⁵ from Companies House. We identified these companies by their SIC codes,⁸⁶ and, where applicable, the CQC registrations.⁸⁷
99. The combined total revenue in 2015 of these 5,763 companies was £11.9 billion. When compared to the estimated market size of £15.9 billion,⁸⁸ the dataset represents nearly three quarters of the market, measured by revenue.⁸⁹ It is also spread over a seven-year period and includes companies in all phases of their business life cycle including growth, maturity and decline. As far as we are aware, this is the most complete dataset on which any financial analysis of UK care homes has been based in recent years.
100. We note that this dataset includes many new company registrations and companies that have also ceased trading during the same period. We consider that such companies are likely to be at an early phase of their growth or the later phase of decline, and thus sometimes tend to report financial results that are significantly different from companies that have been

⁸² These include one off gains or losses that are not part of the normal operating cycle. Examples include restructuring costs, gains or losses on disposals or assets and penalty payments.

⁸³ This includes group accounts filed with Companies House, and subsidiary accounts when no group accounts have been filed with Companies House.

⁸⁴ To account for differences in the financial year ends across the 5,763 companies, we have allocated companies to financial years based on the year in which most of the reported results fall. For example, if a company's year-end is June (ie the financial year falls evenly across two calendar years), its accounts are assigned to the later of the two years.

⁸⁵ This includes group accounts filed with Companies House, and subsidiary accounts when no group accounts have been filed with Companies House.

⁸⁶ SIC codes 871 and 873

⁸⁷ Nursing homes providing care to the elderly <http://www.cqc.org.uk/content/how-get-and-re-use-cqc-information-and-data#directory>

⁸⁸ Care of Older People UK Market Report 27th edition, 2016

⁸⁹ Even though the £15.9 billion relates to 2014, we consider that the market size would not have significantly changed to the extent that the large size of our datasets become insignificant compared to the overall market.

operating for several years. We have taken this into account in our profitability analysis.

101. We have also disaggregated the dataset to assess the profitability of care homes in different regions, between nursing and residential care homes and the impact when care homes have differing proportions of LA-funded residents.

Findings on operating profits

Aggregate operating profits

102. As a starting point, we aggregated each of the line items in the P&L⁹⁰ for each year from 2010 to 2016 for the 5,763⁹¹ companies in the dataset.⁹²
103. The fully aggregated findings as per Figure 1 indicate that the EBITDAR margin remained relatively stable between 2010 and 2014 at approximately 15%. However, the margin declined by approximately 2% between 2014 and 2015, which can mostly be attributed to the rate of revenue growth slowing down and being flat, whilst costs increased slightly. However, the EBITDAR margin increased by 3% between 2015 and 2016.
104. Overall, we observe that the EBITDAR margin has not eroded between 2010 and 2016. The average EBITDAR margin over the period was approximately 15%. This shows that the companies, in aggregate, have generated adequate revenues to cover their operating costs for each of the years from 2010 to 2016. Also, the relatively flat EBITDAR margin can be explained by increases in revenue largely keeping pace with the increases in operating costs (for example staff costs).⁹³ In other words, average operating costs as a percentage of revenue remained flat at approximately 84-87% over this period.
105. For those companies that have consistently reported⁹⁴ staff costs, we can observe a clear trend of aggregated staff costs increasing over time.

⁹⁰ For example, EBITDARM margin = the sum of EBITDARM for the 5,763 care home companies/the sum of revenues for the 5,763 care home companies.

⁹¹ The total number of companies from 2010 to 2016 in the Companies House extract was 7,553. However, 1,790 of these companies had nil values in their P&L and we excluded these companies from the profitability analysis. Hence, as a starting point, we analysed 5,763 companies for the profitability analysis.

⁹² This includes group accounts filed with Companies House, and subsidiary accounts when no group accounts have been filed with Companies House.

⁹³ The average annual rate of revenue and operating cost growth between 2010 and 2016 were 7.0% and 7.3% respectively. Staff costs are the single largest cost item, comprising half of aggregated revenue. Thus, small increases in staff costs such as pay rates can have an important bearing on operating profits.

⁹⁴ In Figure 1 and subsequent disclosures using Companies House financial dataset, we recognise that the staff costs line item may be under-reported, ie staff costs could instead be included within other operating costs and

However, between 2010 and 2015 staff costs as a percentage of revenue accounted for, on average, approximately 50% of aggregated revenue, which suggests that the industry has managed its increases in staff costs by increasing its revenue, in particular fee rates.

106. The introduction of the National Living Wage in April 2016, has been captured in the financial data for 2016 for 3,521 companies amounting to £4.8 billion of revenues. The findings for 2016 show that EBITDAR margins increased in 2016 by 3% to 16% (Figure 1).

Sub-section of aggregate operating profits

107. Using the Companies House financial dataset,⁹⁵ we selected companies that had traded⁹⁶ for each of the years between 2010 and 2015. We found that there were 919 such companies⁹⁷ (see paragraph 100 for the underlying reasons for doing so). These 919 companies generated £8.5 billion of revenue in 2015 and thus this sub-set comprises approximately 71%⁹⁸ of aggregated revenue (see paragraph 99).

not disclosed as a separate line item under staff costs. This simply relates to account classifications between staff costs and non-staff operating costs, it does not change the reported EBITDAR margins.

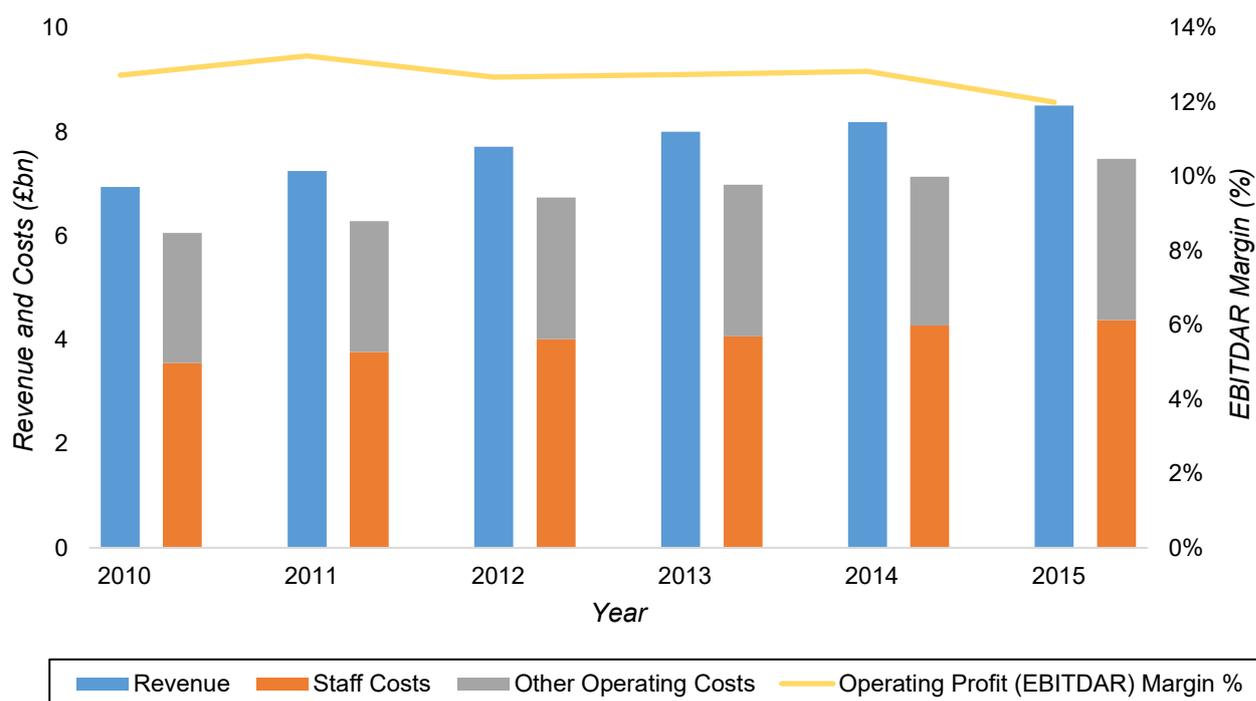
⁹⁵ See paragraphs 10(a) and 102.

⁹⁶ Companies that had P&L data between 2010 and 2015. Hence, we excluded from the dataset any companies that had not generated revenue between 2010 and 2015.

⁹⁷ The number of companies for which we could obtain P&L financial data for each year from 2010 to 2015.

⁹⁸ £8.5 billion revenue out of a total £11.9 billion revenue in 2015 for the entire dataset.

Figure 6: Aggregate operating profits for trading companies, 2010–2015



Source: CMA analysis of P&L information of the Companies House financial dataset.
 Note: This analysis includes the effects of self-funded and LA-funded residents on profitability.

108. Figure 6 shows that by using this sub-set of trading companies, the findings are broadly consistent with those for the Companies House financial dataset (see paragraphs 103-106).

LA-funded and self-funded residents operating profits

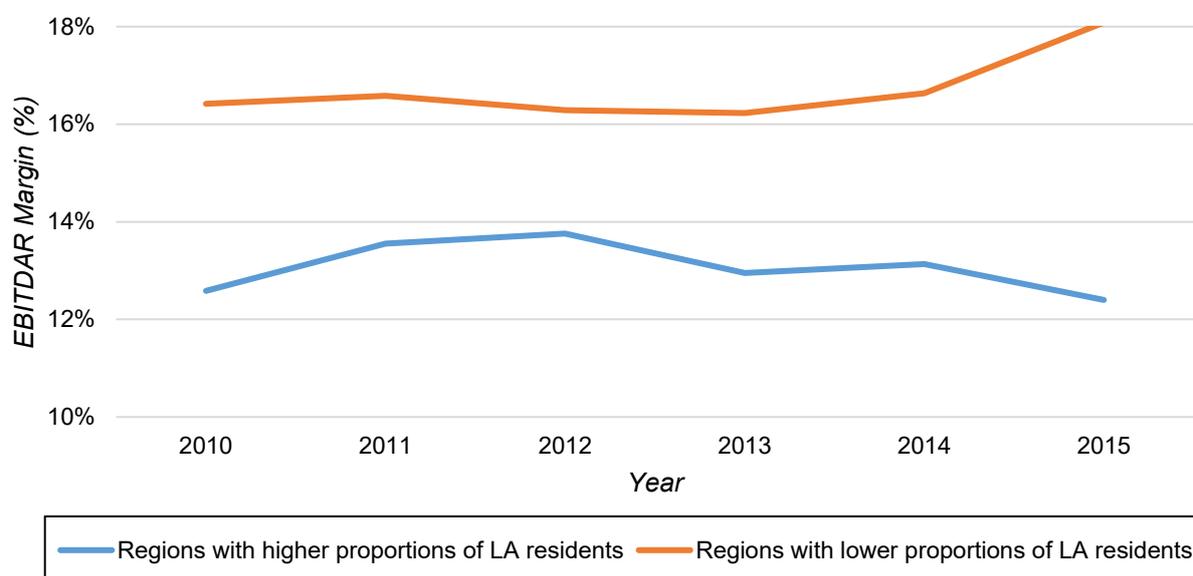
109. We have sought to understand whether, and the extent to which, providers and care homes focussed on LA-funded residents have been less profitable than those focussed on self-funded residents. However, the Companies House financial dataset does not disclose the resident mix⁹⁹ of companies. Therefore, we have used regions as a proxy to understand the effect of LA-funded residents on profitability.

110. We identified regions with higher and lower proportions of LA-funded residents.¹⁰⁰ Then, using the Companies House financial dataset, we selected

⁹⁹ The proportions and/or numbers of LA and self-funded residents within a care home company.
¹⁰⁰ We obtained the proportions of LA-funded residents in each region, from data sourced from LaingBuisson (September 2014): Care of Older People UK Market Report 27th edition. We also sense checked this to data from NHS digital, which identifies regions based on proportions of care home places purchased by the LA.

SMEs to use in this analysis.¹⁰¹ As a third step, we grouped these SMEs by region and by whether they appeared to serve predominantly LA-funded residents.¹⁰²

Figure 7: Aggregate EBITDAR margins for regions with higher and lower proportions of LA-funded residents, 2010–2015



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

111. The findings indicate that the EBITDAR margins between 2010 and 2015 have consistently been lower at, an average of 13%, for providers in regions with higher proportions of LA-funded residents.¹⁰³ This compares to an average of 17% for providers in regions with lower proportions of LA-funded residents.¹⁰⁴ We also observe that the gap in the margins has widened since 2013.

The four nations – operating profits

112. Using the Companies House financial dataset for SMEs, we compared the operating profitability of providers in the four nations.

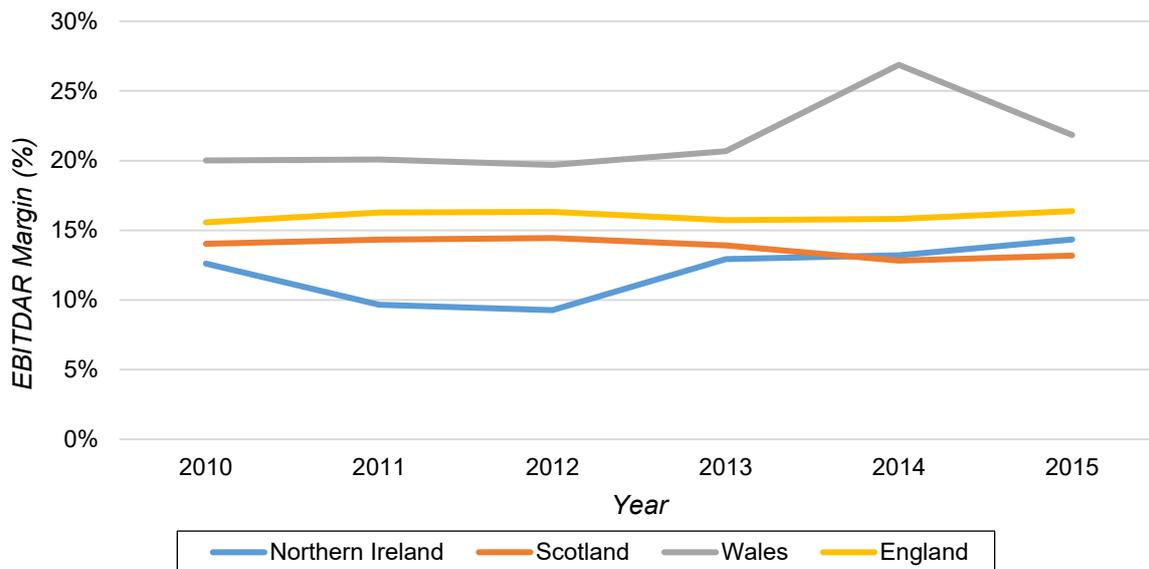
¹⁰¹ A SME, by and large, tends to operate in the region in which it has registered with Companies House ie a company's registered address with Companies House. This contrasts to large providers, whom we have excluded, who have significant operations in regions outside their registered address with Companies House.

¹⁰² We have used a cut off threshold of 60%, ie if a region had 60% or more of its residents funded by the LA, then we have grouped this as a 'region with higher proportions of LA-funded residents'. We have applied the same principle and cut off point of 60% for 'regions with lower proportions of LA-funded residents' (see Figure 3).

¹⁰³ 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.

¹⁰⁴ Similarly, we allocated companies to regions with lower proportions of LA-funded residents if that region had less than 60% LA-funded residents.

Figure 8: Aggregate EBITDARs margin for England, Northern Ireland, Scotland and Wales 2010–2015



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

113. Figure 8 shows that providers in Scotland and Northern Ireland have been less profitable than providers in England, and providers in Wales have been the most profitable.

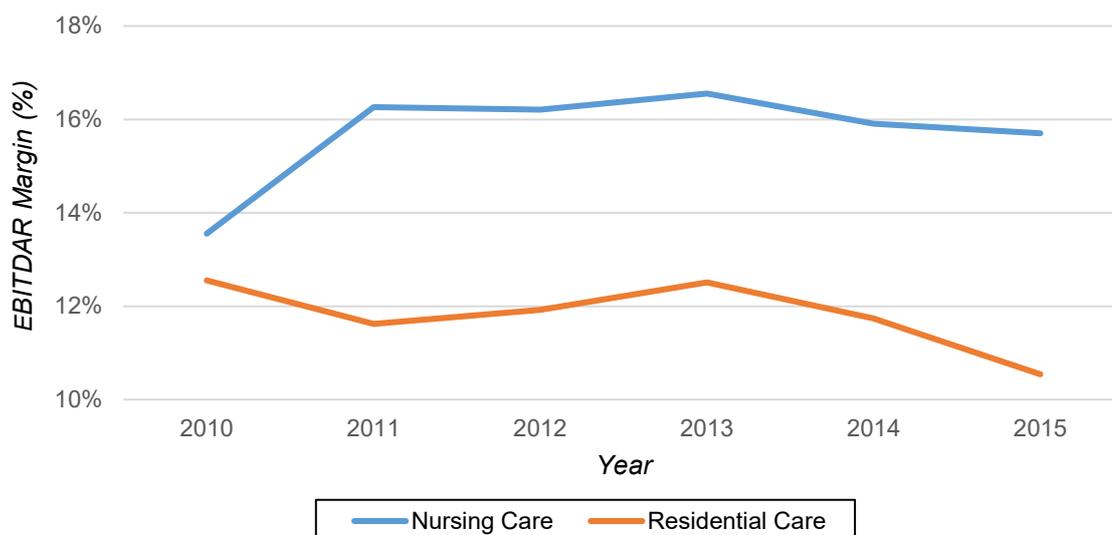
Nursing and residential care – operating profits

114. Using the Companies House financial dataset for trading companies,¹⁰⁵ we have assessed the financial performance of companies registered as nursing and residential care homes.¹⁰⁶

¹⁰⁵ See paragraphs 107 and 99.

¹⁰⁶ We identified whether a company was a nursing or residential care home by its SIC registration with Companies House. Specifically, we grouped those companies with a SIC codes 871 as nursing homes; and those companies with a SIC code 873 as residential care homes.

Figure 9: Aggregate EBITDAR margins for nursing and residential care homes, 2010–2015



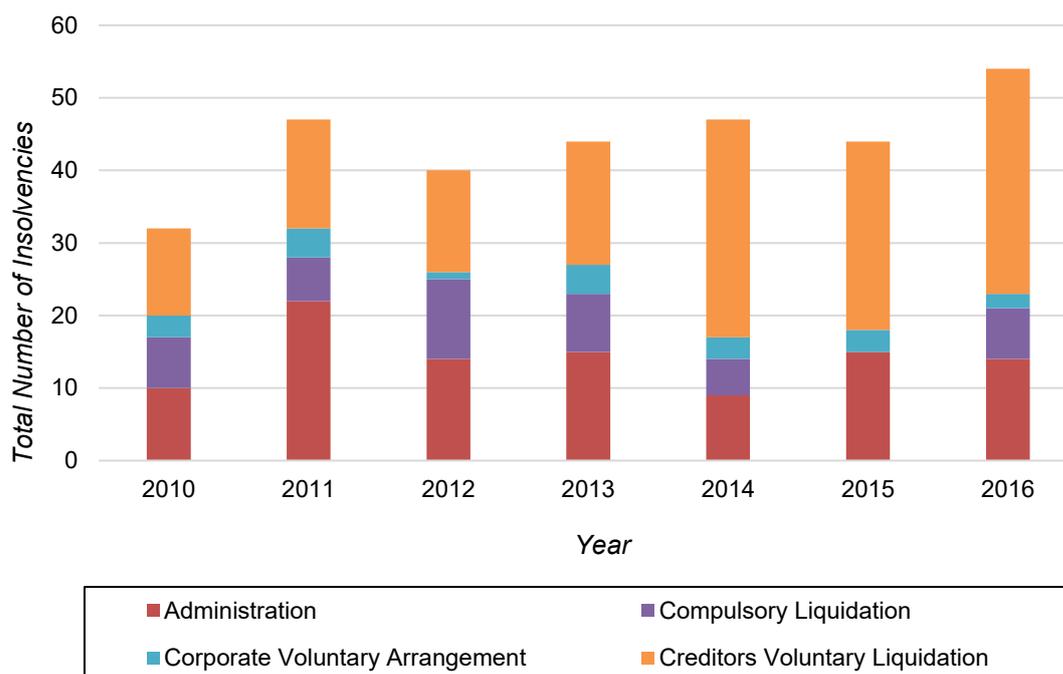
Source: CMA analysis of P&L information of Companies House financial dataset.

115. Figure 9 shows that between 2010 and 2015, the EBITDAR margin for companies registered as nursing care homes have consistently been higher at an average of 16%, compared to an average of 12% for companies registered as residential homes. The divergence in the margin has been increasing since 2013, driven by the relative deterioration in financial performance of residential homes.
116. We understand that higher margins for companies registered as nursing homes could be driven by them commanding higher fee rates despite some additional costs to provide nursing care.

Insolvency data from the Insolvency Service

117. We obtained a list from the Insolvency Service of all insolvencies in the UK between 1 January 2010 and 31 December 2016 for companies registered under the SIC codes 871 and 873. These codes relate to care and nursing homes for the elderly.

Figure 10: Number of insolvencies by type, 2010–2016



Source: Insolvency Service.

118. Figure 10 shows that the level of insolvencies in the UK since 2010 has been low, relative to the overall number of providers, at approximately 44 companies a year. There has been no significant increase in this level, relative to the number of providers in the industry, since 2010.¹⁰⁷ We also observe an increase in the numbers of voluntary insolvency arrangements, where a company’s directors voluntarily enter an insolvency. This contrasts to the declining trends in administrations or compulsory liquidations, where the insolvency procedures are led by the creditors.

119. Separately, we also observe that no large UK-wide provider has entered any formal insolvency procedure, since Southern Cross Healthcare Group plc went into administration in 2011.

120. Regulators and lenders have told us that as far as the care homes industry is concerned, creditors tend to resort to insolvency as a last measure, thus preferring to work out going concern solutions. Even when a care home enters an insolvency procedure, stakeholders make all reasonable attempts to run the care home while attempting to sell it as an operating business.

¹⁰⁷ We note that the insolvency data excludes care home providers that exited the industry without having filed for an insolvency. Such exits could either be the result of market conditions culminating in a deterioration of financial performance or planned exits where, for example, the owners of smaller care homes choose to retire. The impact on overall capacity in either case would depend on whether the new owner of the care home continued to operate it.

Large providers' dataset

121. We have analysed a dataset of 26 providers across the UK between 2015 and 2017. The average annual revenue during this period for these providers was £4.3 billion. The dataset also contains financial information on approximately 2,000 individual care homes.

Group level findings

Aggregated

122. Using the large providers' dataset, we have constructed an aggregated P&L for 26 providers (Table 3).

Table 3: Aggregated P&L for 26 large providers, 2015–2017

Aggregated income statement for 26 large providers					Year on year (YOY) Growth	
£'million	2015 (Actual)	2016 (Actual)	2017 (Forecast)	Average (2015 to 2017)	2015- 2016	2016- 2017
Revenue	4,144	4,314	4,453	4,304	4.1%	3.2%
Staff costs	2,447	2,518	2,548	2,505	2.9%	1.2%
Non-staff operating costs	634	710	720	688	12.1%	1.4%
EBITDARM	1,063	1,086	1,184	1,111	2.1%	9.0%
EBITDARM %	25.7%	25.2%	26.6%	25.8%	(1.9%)	5.7%
Management fee	203	221	234	219	9.0%	5.7%
EBITDAR	860	865	950	892	0.5%	9.9%
EBITDAR %	20.8%	20.0%	21.3%	20.7%	(3.5%)	6.5%
Rent	406	373	403	394	(8.2%)	8.0%
EBITDA (pre-exceptional)	454	492	548	498	8.3%	11.3%
EBITDA (pre-exceptional) %	11.0%	11.4%	12.3%	11.5%	4.0%	7.9%
Exceptional items (costs)	341	13	56	137	(96.1%)	318.8%
EBITDA post-exceptional	113	478	491	361	324.9%	2.7%
EBITDA post-exceptional %	2.7%	11.1%	11.0%	8.3%	308.2%	(0.5%)

Depreciation and amortisation	243	222	237	234	(8.7%)	6.9%
EBIT	(131)	256	254	126	(296.0%)	(0.9%)
EBIT %	(3.2%)	5.9%	5.7%	2.8%	(288.3%)	(4.0%)
Interest expense	164	176	189	177	6.8%	7.8%
Profit before tax	(295)	81	64	(50)	(127.3%)	(19.9%)
Profit before tax %	(7.1%)	1.9%	1.4%	(1.3%)	(126.2%)	(22.4%)
Additional profitability measures						
EBIT (pre-exceptional)	211	270	310	264	28.0%	15.0%
EBIT (pre-exceptional) %	5.1%	6.2%	7.0%	6.1%		
Profit before tax (pre-exceptional)	46	94	121	87	103.2%	28.6%
Profit before tax (pre-exceptional) %	1.1%	2.2%	2.7%	2.0%		
EBTDA (pre-exceptional)	289	316	358	321	9.2%	13.3%
EBTDA (pre-exceptional) %	7.0%	7.3%	8.0%	7.5%		
Costs as a % of revenue						
	2015	2016	Forecast	Average		
Staff costs	59.1%	58.4%	57.2%	58.2%		
Non-staff operating costs	15.3%	16.5%	16.2%	16.0%		
Management fee	4.9%	5.1%	5.3%	5.1%		
Rent	9.8%	8.6%	9.0%	9.2%		
Exceptional items	8.2%	0.3%	1.3%	3.2%		
Depreciation and amortisation	5.9%	5.1%	5.3%	5.4%		
Interest expense	4.0%	4.1%	4.3%	4.1%		
<u>Property related expenses</u>						
Rent and interest	13.8%	12.7%	13.3%	13.3%		
Rent, interest and depreciation	19.6%	17.9%	18.6%	18.7%		

Source: CMA analysis of P&L information submitted by 26 large providers (the large providers' dataset)

123. Table 3 shows that the average pre-exceptional EBITDAR margin in this dataset between 2015 to 2017 is 21%. This margin has been stable in 2015 and 2016, and is forecast to increase incrementally in 2017. Submissions made by several large providers state that operating profit margins have held up between 2015 and 2016, and are expected to hold up in 2017 due to: increases in the average weekly fees; couple with increased occupancy

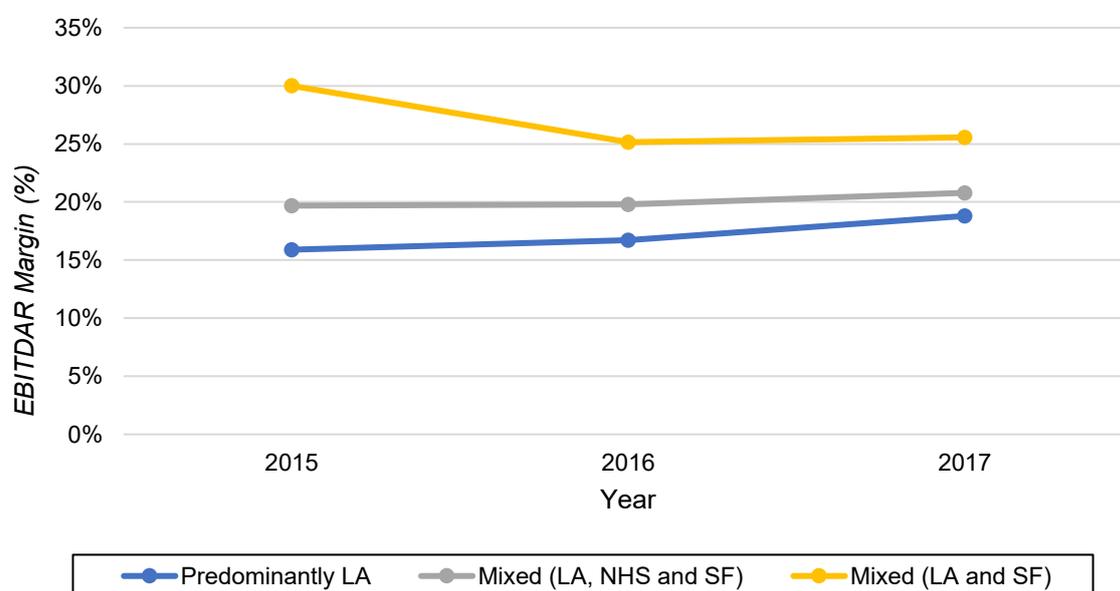
levels: greater use of permanent staff: and reductions in the levels of agency staff.

124. Another finding is that property related costs, such as rent, depreciation and interest expense accounts for, on average, 19% of revenue. These costs have also been relatively stable, when measured as a proportion of revenue. Property related costs that have a cash flow impact, such as rent, and interest accounted for approximately 13% of revenue in 2015 and 2016.
125. The management fee and central costs line item is significant at 5% of revenue, averaged over this period. Central costs relate to head office costs and management fees relate to charges levied by shareholders, mostly private equity funds, in relation to management services. We consider that central costs are not a significant cost for most large providers, and therefore, a significant proportion of such costs are likely to relate to management fees.

Providers with predominantly LA-funded residents.

126. We have also grouped the 26 providers in the large providers' dataset based on the proportion of their revenues that they generated from LA-funded residents.

Figure 11: Aggregated average EBITDAR margin of companies based on proportion of their revenues by source of resident funding, 2015–2017 (forecast)



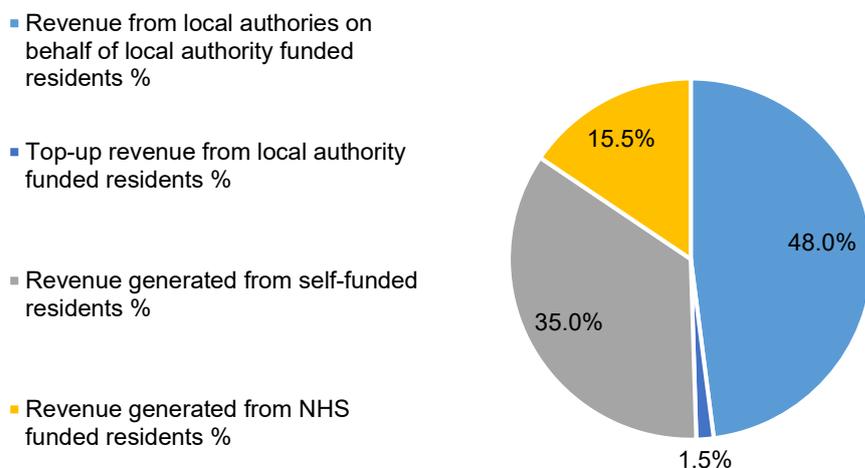
Source: CMA analysis of P&L information submitted by 26 large providers (the large providers' dataset)

127. Figure 11 shows that those providers that have greater proportions of LA-funded residents¹⁰⁸ generated lower EBITDAR margins compared to providers with lower proportions of LA-funded residents.¹⁰⁹

Analysis of revenue streams

128. We have assessed the revenue streams by source for 22 of the 26 providers in the provider dataset for 2015 and 2016.

Figure 12: Average revenues generated by providers by source of resident funding, 2015–2016



Source: CMA analysis of P&L information submitted by 22 large providers (the large providers' dataset)

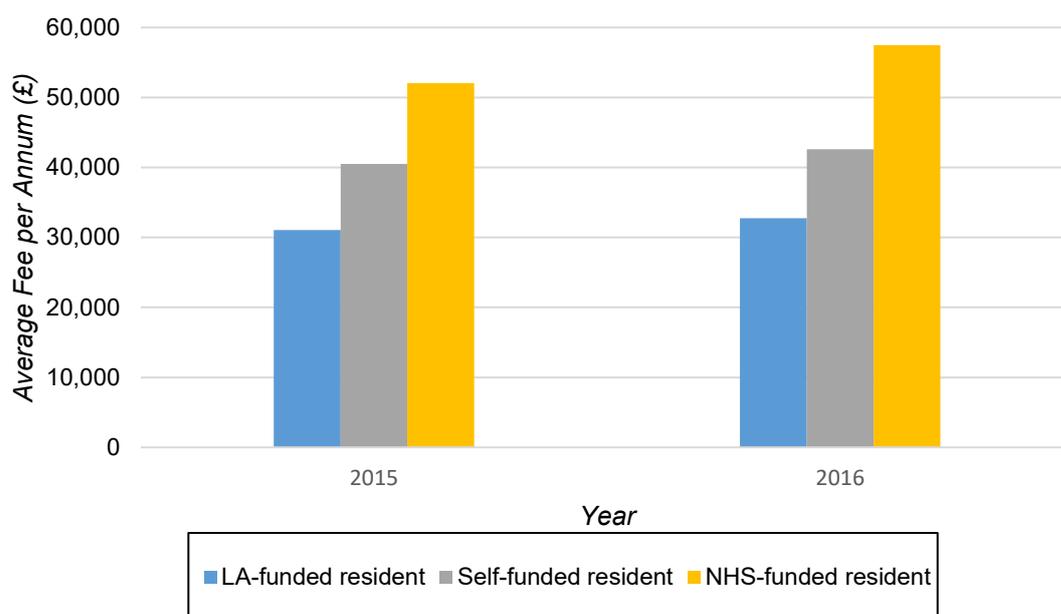
129. Figure 12 shows that LAs accounted for nearly half of the revenue for these providers. Revenue from self-funded residents accounted for over a third of total revenue. This shows the relative importance of LA-funded residents via its impact on profitability for these providers in aggregate.

130. We have also compared the average fee per resident generated by these 22 providers on from LA, NHS and self-funded residents.

¹⁰⁸ Providers with at least 70% revenue from LA funded residents.

¹⁰⁹ Providers with at least 70% revenue from self-funded residents.

Figure 13: Average annual fee per resident by source of resident funding, 2015–2016



Source: CMA analysis of P&L information submitted by 22 large providers (the large providers' dataset)

131. Figure 13 shows that providers, on average, generated less revenue per LA-funded resident than per self-funded resident.

Care home level findings

Aggregated operating profits

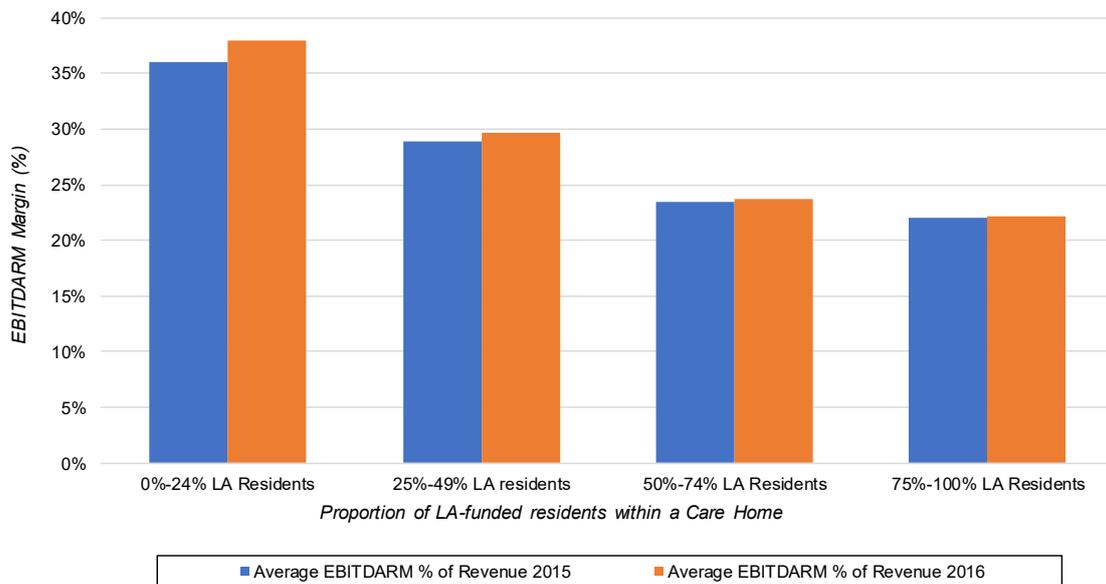
132. As part of the large providers' dataset, we used detailed care home level data for 2015 and 2016 from 26 providers for their approximately 2,000 care homes. The total revenues generated by these care homes amounted to an average of approximately £3.5 billion during this period.

133. We found that the average EBITDARM margin over this period was 27%. We also observe a slight increase in margin between 2015 and 2016, despite the introduction of the National Living Wage on 1 April 2016.

LA- funded and self-funded residents – operating profits

134. We have also assessed the impact on operating profitability of LA-funded residents for these care homes operated by the large providers.

Figure 14: Average EBITDARM margin % for care homes based on proportion of LA-funded residents, 2015–2016



Source: CMA analysis of Provider supplied care home level data for approximately 2000 care homes (the large providers' dataset)

135. Figure 14 indicates that care homes with higher proportions of LA-funded residents generated lower EBITDARM margins.

Annex B: Capital cost

136. In this section, we describe our approach to estimate the capital cost.
137. The findings from our analysis indicate that the current market returns (ie economic profit margins) are broadly in line with our estimate of the capital cost (see Figure 2). We have performed this analysis using data from providers and have made various assumptions as described below.

How to measure the capital cost

138. The capital cost is calculated as the product of the:
- (a) value of the assets invested in the business (capital employed); and
 - (b) required rate of return (%) on capital.

Capital employed: asset valuation

139. The asset valuation used in the capital cost calculation should, in principle, be the market value of those assets. This is because the market values reflect what those assets could be sold for, as an alternative to using those assets for their current purpose. For example, in the case of a care home, the current use of property would be in the provision of care, and the alternative use of property could be the redevelopment of that property into residential real estate. This is also referred to as the opportunity cost of those assets. We have made the following assumptions:
- (a) in relation to assets with an alternative use, such as land and buildings, we consider that the valuation methodology should be similar to the normal practice used in the real estate industry. For example, valuations conducted by chartered surveyors. We see no reason why this methodology would significantly differ for land and buildings in the care homes industry; and
 - (b) in relation to other assets, such as beds and other facilities (equipment) required to operate a care home, we consider that the valuation of assets should be based on the actual investment cost, which should be depreciated to reflect the age of the assets.
140. In the case of our economic profit analysis, we have been unable to obtain up-to-date asset valuations for companies in the Companies House financial dataset. However, we have used recent market data on asset values provided

by several¹¹⁰ care home providers at the care home level. This has allowed us to estimate the benchmark levels for the asset values of the care home companies under analysis in the Companies House financial dataset.

141. We have assumed that an investor in a new care home would have to purchase property, (land and buildings), equipment, and contribute towards the funding of the operations with working capital and cash. The investor would require a return on those assets. Therefore, we have included these assets in the capital employed, and then applied a % rate of return on those assets (capital employed) to estimate the capital costs.
142. We now describe how we estimated the market values of assets.
143. For property, we have calculated the ratio of annual aggregated revenue¹¹¹ to aggregated property market values¹¹² of those 479 care homes for which we have market data on asset value. We then applied this market based average ratio to the:
 - (a) aggregated revenues in the Companies House financial dataset to estimate the property market values. This feeds into the economic profit margins in Figure 2 and Figure 4 (red lines).
 - (b) aggregated group revenue in the large providers' dataset. This feeds into Figure 4 (blue lines).
 - (c) aggregated revenues generated by the 479 care homes in the large providers' dataset as our most detailed dataset of care homes. This feeds into the Figure 4 (green lines).
144. We also used the average revenue to property value ratio for our base case analysis in Figure 2 and 4. However, in Figure 4, we used separate ratios for LA and self-funded homes for the large providers' dataset. We were able to disaggregate the 479 homes for whom we have property market data into care homes that focussed on LA and self-funded residents.¹¹³ Our data showed that self-funded care homes had higher property values per resident and therefore this ratio was higher for self-funded care homes. This finding is consistent with stakeholder submissions that new self-funded care homes

¹¹⁰ 6 large providers submitted care home valuations that cover 479 care homes.

¹¹¹ We used the revenues for FY 2015 and 2016 for care homes from 479 large providers, which generated annual revenues of £1 billion.

¹¹² We obtained and used recent market values for the same 479 number of care homes.

¹¹³ LA care homes were identified as those that had greater than 70% LA-funded residents. Self-funded care homes were identified as those that had greater than 70% self-funded residents.

tend be of higher specification and in more expensive areas, thus requiring more investment.

145. For equipment, we obtained an estimate of the typical capital expenditure spend in a residential and nursing home, on a per resident basis.¹¹⁴ A large provider told us that equipment, fixtures and fittings for a new home costed in the range of £8,000 - £15,000 per bed.
146. For both the Companies House financial dataset and large providers' datasets, we then multiplied the mid-point of this range to the number of residents within each dataset.¹¹⁵

Our estimate of the rate of return

147. We have not undertaken new analysis on the rate of return. However, we consider that it is reasonable to assume a 5-8% rate of return on capital employed, measured in real terms. If investors are earning profits equivalent to a return on assets of around 5-8%, combined with a reasonable expectation that fees will be determined in a way that reflects such a return on capital consistently over time, then it should be sufficient to attract investment.
148. We consider that a 5-8% rate of return in real terms for the care homes industry is reasonable on the following grounds:
 - (a) our private healthcare investigation found a pre-tax market rate of return on capital employed of around 9% in nominal terms (ie including inflation). In other words, we found that investors in the private healthcare industry would, on average, have required returns of 9% on capital invested in the sector.¹¹⁶
 - (i) For that portion of the capital, which is invested in long-lived assets such as land, we consider that a starting assumption is that prices in the long-run would more likely remain constant in real rather than in nominal prices. Therefore, investors would require, an annual return based on a lower real capital cost in order to obtain a total nominal return (including inflation) of around 9%. For example, based on the Bank of England's Consumer Prices Index inflation target of 2%,¹¹⁷

¹¹⁴ We used the following methods to account for the number of residents: (a) for the Companies House financial dataset, we have estimated the number of residents per company by dividing the aggregated companies' annual revenue by the annualised average weekly fee in the UK for residential and nursing homes which is approximately £700; and (b) for the large providers' dataset, we used a combination of their submitted results if available, or an estimate similar to method (a) above using average care home fees observed in the large providers' dataset, where a few providers did not submit resident numbers.

¹¹⁵ We also made an adjustment for reported working capital and cash balances.

¹¹⁶ <https://www.gov.uk/cma-cases/private-healthcare-market-investigation>

¹¹⁷ [Bank of England: Monetary Policy Framework](#).

the real rate of return in the long-run would be expected to be equivalent to around 7%.

- (ii) Our financial analysis indicates that operating profit margins have been relatively stable, without significant volatility.
- (iii) Care homes carry lower commercial risk in that demand for care home beds carries lower risk than that for private healthcare. This is because half of the care home industry's revenues (unlike that for private healthcare) are funded by the state. Also, the need for care is likely to remain strong due to the demographics arising out of an ageing population.
- (iv) Hence, we would expect the average risk-adjusted rate of return required by investors in the care homes industry over the medium to long term, to be lower than that for the private healthcare industry.

(b) At the same time, we consider that the care homes industry faces some commercial risk around fees and staff costs. We discuss in this section that there have been challenges to profitability as costs have risen and LA fees have been falling. We expect that this risk is higher than that faced by essential services or regulated monopolies, where the returns are determined by economic regulators. Recent regulatory determinations are consistent with a pre-tax capital cost of 3.5%-4.5% relative to inflation for such regulated companies.¹¹⁸

149. We also note that the market estimates for the cost of capital, driven largely by interest rates in the Organisation for Economic Co-operation and Development,¹¹⁹ and including the UK, are currently at very low levels.¹²⁰

150. Our estimate of the 5-8% rate of return in real terms is also within the range of a trade association's recommendation with regards to the National Care Home Contract (see paragraph 3.7). It added that providers would be willing to accept a lower return on LA-funded residents if the LA could provide certainty with regards to occupancy by way of block contracts, as opposed to spot purchasing.

151. For our base case in the analysis, we have used a rate of return of 6.5% in real terms.

¹¹⁸ Recent CMA decisions are at: <https://www.gov.uk/topic/competition/regulatory-appeals-references>. We note that there is now a suggestion that the WACC for utilities may be lower than this in forthcoming reviews in the water sector.

¹¹⁹ Organisation for Economic Co-operation and Development

¹²⁰ OECD data: [Long-term interest rates](#) and [short-term interest rates](#).

152. We have also used a range on 5-8%, in real terms (see Figure 2), which we apply to our benchmark asset value calculation. We note that, in practice, the range for the rate of return will be wider, as some providers will have asset values that are significantly higher or lower than our average/mid-point benchmark. However, we consider that this range is informative in understanding the likely pattern of returns over the industry.
153. We note that some investors and industry analysts have indicated that the required rate of return may be higher than that we have used in our analysis, especially in relation to investment in new capacity. We would not be surprised if it were the case that providers of new equity were seeking higher returns.
154. Nevertheless, our analysis provides a benchmark. It will be a commercial decision for any investor as to whether a higher return would be necessary and appropriate in any given circumstances and whether other investors can be found which are willing to invest for returns closer to the benchmark level.
155. The aim of our estimate of the rate of return is to identify an aggregate benchmark level at which we would expect that the industry, as a whole, would be financially sustainable and could meet demand for capacity.

Annex C: Gap between LA fee rates and total costs

Introduction

156. This annex describes our approach, methodology and assumptions that we have used to estimate the gap between LA fee rates and total costs for LA-funded residents in the UK.
157. We have used data of 1,840 care homes from the large providers' dataset. It contains detailed financial metrics such as revenues, operating profit margins (EBITDARM), and fee levels paid by LAs and self-funded residents within a home.

Our approach

158. Our financial analysis shows that LA fee rates have been below total cost (see Figure 4). In other words, the average LA fee rate has been below the average total cost, giving rise to an 'underpayment' on a per LA resident basis. If we were to multiply the average underpayment in the industry by the average number of LA residents, we will get an estimate of the 'gap' in aggregate, between what LAs are paying and what they should be paying to cover total costs.
159. We have considered two ways to assess this gap:
- (a) the first is to aggregate the economic losses generated by all care homes in the UK, and use this aggregation as a proxy for the gap, in particular for those care homes which are most at risk in respect of their financial sustainability; and
 - (b) the second is to estimate what it would cost if all LAs in the UK raised their fees to at least cover total costs for all LA residents. We have used this approach.
160. We decided to focus on the second approach (paragraph 159(b)). This approach is consistent with our expectation that LA fees should cover total costs over time to ensure financial sustainability. We do not have sufficiently granular data to allow us to accurately estimate economic losses on a care home-by-home basis for the whole of the market. Also, providers can be loss making for reasons other than the level of the fee rates paid by LAs. For example, there may be low occupancy levels if a home has just opened or has been poorly rated. However, we have calculated the gap between LA fees and cost under both methods, and the scale of our estimates are similar for each approach.

161. We have calculated the gap between LA fees and cost for care homes with differing resident mixes (see paragraph 47). The reasons for doing so is that the results vary among these resident mixes:
- (a) 'primarily LA-funded care homes' (at least 75% of the residents within a care home are LA-funded) have made economic losses (Figure 4) and are in the greatest risk in terms of their long-term sustainability; and
 - (b) 'mixed residents care homes' (50-74% and 25-49% LA-funded residents within a care home) have remained sustainable due to higher fees and margins generated from self-funded residents (Figure 3). These care homes, in aggregate, have a similar resident mix to that of the industry in aggregate, which shows breakeven levels of economic profits (see Figure 2); and
 - (c) 'primarily self-funded resident care homes' (less than 25% LA-funded residents within a care home) have generated economic profits (Figure 4) and are not at risk.
162. The key reason for the variance in financial performance among these resident mix segments (paragraphs 43-46) are the differences between the LA fee rates and rates paid by self-funded residents in the different resident mix segments. For example, the fee differential is higher in mixed care homes than in primarily LA funded care homes (Figure 3).
163. We have presented our analysis of the gap for 2015, which is the year for which we have detailed financial results from both datasets. The gap will vary year-on-year, depending on the financial performance of the industry. Nevertheless, we consider that our estimate of the gap for 2015 provides a good indication of its current levels, based on comparing our data for 2015 with the data available for other years.

Assumptions

164. We have made some assumptions to calculate the gap. We have estimated that:
- (a) the total number of LA-funded residents in the UK is 200,000. This is based on the LaingBuisson report for 2014.¹²¹ We assume that the total number of LA-funded residents would not have changed significantly between 2014 and 2015;

¹²¹ LaingBuisson Care of Older People 27th Edition, 2014

- (b) 41% of LA-funded residents in the UK reside in primarily LA-funded care homes, 56% in mixed care homes and 3% in primarily self-funded care homes. We obtained these proportions from our dataset of 1,840 care homes operated by the large providers. Hence, in using these proportions, we have assumed that they do not significantly differ from the rest of the market. We have sense checked this assumption, and we would expect to find that most LA-funded residents reside in mixed care homes, which make up the majority of the market. Also, we would expect to find a very low proportion of LA-funded residents in primarily self-funded care homes;
- (c) fee differentials vary among large, SME¹²² and microbusiness¹²³ providers; and
- (d) the proportion of the care homes market operated by large, SME and microbusiness providers is 33%,¹²⁴ 50%,¹²⁵ and 17%¹²⁶ respectively.¹²⁷

How we measured the underpayment per LA resident

165. We now describe the methodology used to calculate the two key components of the underpayment:
- (a) the average total cost, per resident; and
 - (b) the average fee, per LA- funded resident
166. We calculated these components for each of the resident mix segments. Our estimate of the gap, which is based on the difference between LA fees and cost, will include some care homes that have generated positive or breakeven economic profits (revenues are at least as high as total costs),¹²⁸ but are

¹²² Obtained from an independent study, which showed a lower fee differential than for large providers identified in paragraph 2.40

¹²³ We applied a lower fee differential for microbusinesses than for SMEs.

¹²⁴ Using our large providers' dataset, we observe that 26 large providers generated aggregated revenues of £4.1 billion or approximately 26% of the industry (total market size of £15.9 billion) Our large providers' dataset does not consist of all large providers in the market. Hence, it reasonable to assume that the including the remaining large providers to the 26 for whom we have data, would constitute a third of the market.

¹²⁵ A government body estimates that SME providers make up 60% of beds. LaingBuisson in their 2014 report estimated that SMEs constitute 30% of the market. Therefore, we have assumed a figure close to the mid-point of 50%.

¹²⁶ This is the remainder of the market. I.e 100% for the whole of the market – 33% for large providers – 50% for SMEs = 17% for microbusinesses.

¹²⁷ For the purposes of our analysis, the total 200,000 estimated LA residents in the market were split as follows: 66,666 (33%) were estimated to be in large providers, 100,000 (50%) were estimated to be in SMEs and 33,333 (17%) were estimated to be in microbusinesses.

¹²⁸ These care homes may be covering their total costs from self-funded residents.

receiving fees from LAs that are below total cost. This is due to self-funder fees exceeding total cost in those care homes.

Total Cost per resident

167. We calculated the average total cost per resident by:
- (a) adding the reported operating costs¹²⁹ for the 1,840 care homes with our estimate of the capital costs¹³⁰ for these care homes to arrive at the total cost; and then
 - (b) dividing the total cost by the total number of residents in these 1,840 care homes.
168. Several large providers have told us that the costs to serve LA residents do not significantly differ from serving self-funded residents, within a care home. Therefore, we have assumed that the average total cost for per resident (LA and self-funded residents) (as described in paragraph 167) would be the same for LA residents.

Average fee per LA resident

169. We derived the average fee per resident, (ie for both LA-funded and self-funded residents), by applying the economic profit or loss margin for the industry, within each resident mix segment, to the total cost per resident (as described in paragraph 167). For example, if the total cost per LA resident was £500 per week and the economic loss margin in the primarily LA-funded care home was -5%, then the LA fee would be: $£500/105\% = £476$. It is important to note that:
- (a) the economic profit margin for the industry, as a whole, was based on the Companies House financial dataset (Figure 2); and
 - (b) our care home level results show that the different resident mix segments generated differing levels of profitability. This is illustrated in Figure 4, which shows that primarily LA-funded care homes generated economic losses, while primarily self-funded care homes generated economic profits. We then modelled the observed differences between the economic profits among the different resident mix segments to their mean average (using the care home level dataset) onto the aggregate industry

¹²⁹ Operating cost = Revenue – EBITDARM. This is an aggregate of the 1,840 care homes.

¹³⁰ The capital cost was calculated on a similar basis to that described in paragraphs 138-146. In particular, we used market value data from the large providers to estimate the capital employed on which we applied a 6.5% rate of return.

economic profit margin. This gives a measure of profitability based on the larger Companies House financial dataset that includes the financial results for most of the industry.

170. We then calculated the average fee per LA resident for each for the resident mix segments by using the:
- (a) fee differentials among resident mix segments. For example, Figure 3 shows that the fee differential and costs are higher while LA operating profit margins are lower in mixed care homes than in primarily LA resident care homes. Therefore, our analysis considers the differing average LA fee per resident in care homes with different resident mixes.
 - (b) fee differentials for large, SMEs and microbusiness providers (see paragraph 164(c)); and
 - (c) proportions of LA-funded and self-funded residents within each resident mix segment. The average resident fee calculated (as described in paragraph 169) is an average of LA fees and self-funded fees within a particular resident mix segment. Therefore, we used the proportion of LA residents and self-funded residents to calculate the average LA fee and self-funded.

How we measured the gap between revenues and costs for LA-funded residents

171. We calculated the gap by multiplying the underpayment per LA resident by the number of LA residents within each resident mix segment and for the different sizes of providers (paragraph 164(d)).

Results and implications

172. Table 4 below shows the results for the gap for each resident mix segment.

Table 4: Gap between current LA fee rates and our estimate of total costs

	Primarily LA-funded care homes	Mixed care homes	Primarily self-funded care homes	Total
Gap	£200 million to 300 million	£700 million to £800 million	Not significant	£900 million to £1,100 million

Source: CMA analysis using the large providers' and Companies House financial datasets

173. Table 4 tells us that if the fees paid by all LA-funded residents in the UK were increased to their total costs, then the gap is estimated to be in the range of £900 million to £1,100 million.
174. Our estimate of the gap relies on a number of assumptions. We have provided a range, rather than a point estimate, which we think includes the most likely measures for the gap, although it would be feasible to construct assumptions which would imply higher or lower numbers for the gap. In addition, the gap will change over time, for the reasons explained in paragraph 75 and also on the financial performance of the industry. However, we consider that our results are a good estimate of the scale of the difference between revenues and costs:
- (a) First, our estimate is not significantly different from similar analysis conducted by other market experts (see paragraph 5(e));
 - (b) Second, as a reconciliation, we have estimated that the gap equates to around 10-15% of total costs. This gap is lower than half of the fee differential (see paragraph 2.40), which might indicate a gap of 20%. This is because total (operating and capital) costs are lower in care homes with more LA residents and highest in care homes targeted at self-funded residents; and
 - (c) Third, when we used the method mentioned in paragraph 159(a) using both datasets,¹³¹ our results were not significantly different from the £200 to £300 million funding shortfall we identified in primarily LA-funded care homes.

¹³¹ For the Companies House financial dataset, we aggregated economic losses for care homes that generated economic losses. For the large providers' dataset, we followed the same methodology and extrapolated for the rest of the market.

Analysis of consumer protection issues

Introduction

1. All care home residents are entitled to strong protections against unfair contract terms (and notices) and unfair business practices.
2. In general, care homes and self-funders are free to agree whatever contractual terms and conditions they wish to. But these terms and conditions, and the way in which care homes deal with residents and their representatives, must not be unfair under consumer law (see paragraph 6 below) and must also comply with relevant sector-specific rules. Consumer protections are especially important in this market given the vulnerability of people, the significant harm that may arise from residents being treated unfairly, and the importance of residential care as a service.
3. We have identified a number of consumer protection concerns,¹ some of which have the potential to breach consumer law. Although consumer law can apply to the contracts that local authorities (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.
4. In part, this reflects the weaker bargaining position many self-funders (or, as the case may be, their representatives) find themselves in when choosing a care home. Local authorities are likely to be in a much more equitable bargaining position when placing residents in care homes, as evidenced by most of the terms and practices of concern we have seen only applying to self-funders (for example, the need to pay deposits and other large upfront charges, the wide discretion for care homes to increase fees during the resident's stay, and the charging of fees for an extended period after death). However, our concern around some care homes' terms and practices when asking residents to leave (or imposing visitor bans) applies to all residents, regardless of how their care is being funded. We have also identified some other concerns around top up payments that are specific to state funded residents.

¹ This is based on a review of submissions by stakeholders including national charities, experiences reported to us by members of the public and our review of a sample of UK care home provider contracts, sales materials and other documentation. See a [summary of individual responses](#) on the full range of consumer issues that have been reported to us by members of the public.

5. These concerns are outlined in the following paragraphs and set out in the order of a typical customer journey.

Relevant consumer law

6. The CMA has powers to enforce a range of consumer laws, including:
 - (a) **Part 2 of the Consumer Rights Act 2015 (CRA)** – the CRA protects consumers against unfair contract terms and notices. This means that care homes' terms need to be fair and transparent. They should strike a fair balance between the care home's rights and obligations and those of the resident². If terms in a care home contract are found to be unfair, they will not be enforceable against the consumer.
 - (b) **The Consumer Protection from Unfair Trading Regulations 2008 (CPRs)** – broadly speaking, the CPRs prohibit traders from engaging in unfair commercial practices in their dealings with consumers. Homes that mislead (for example, by giving false information or failing to tell people about important things that are likely to affect their decisions in a clear, timely manner), behave aggressively or otherwise act unfairly towards residents or their representatives are likely to breach the CPRs. The CPRs apply at any stage of a care home's interaction with residents, whether before, during or after a contract is made (if at all). This will cover the period before they have made choices about which care home to choose and any time after they have moved into the home.

Consumer protection issues

Lack of indicative prices on websites

7. We have found a lack of indicative pricing information on many care home provider and care home directory websites.
8. Most of the provider websites we have looked at do not contain any indication of the weekly fees typically charged to self-funders. This is reinforced by other research:
 - (a) Citizens Advice found that only 7% of people surveyed who had arranged a care home place in England said they were provided with upfront

² A term is unfair 'if, contrary to the requirement of good faith, it causes a significant imbalance in the parties' rights and obligations arising under the contract, to the detriment of the consumer'. The requirement of 'good' faith embodies a general 'principle of fair and open dealing'.

information about care home fees, such as through the website or marketing materials, prior to making contact;³

- (b) A Which? analysis of 100 UK care home websites found that 86 provided no pricing information;⁴
 - (c) Of the 141 providers who responded to a question in a CMA online questionnaire, only 41 (29%) said they gave an indication of the typical self-funder fees on all or some of their websites.
9. Similarly, we have found that many care homes do not submit indicative fee information to care home directory websites. For example:
- (a) only 40%⁵ of the 19,000 registered UK care homes have chosen to submit any indicative fee information to the carehome.co.uk website;⁶
 - (b) only around 4% of registered care homes in England display 'cost of care' information on the NHS Choices website;⁷
10. Omitting indicative fee information from websites increases the time and effort ('search costs') involved for people to 'shop around' and identify different care homes that may fall within their budget, often in circumstances when a decision has to be made under significant time pressure. In addition, lack of up front awareness of how much may be charged may make people more vulnerable where fees (and other costs) are gradually disclosed during the choosing phase, as they may have already become 'committed' to a particular care home by this point.
11. When choosing a care home, costs play a key role in shaping people's range of choice, as affordability is important. For example, Citizens Advice research⁸ found that nearly three quarters of people (74%) gave care home fees 'some' or 'lots' of consideration. CMA consumer research also suggests that self-funders try to exclude homes that are too expensive for their budget from the outset of their search, if they already have some knowledge of the fees.⁹ Residents or, more often, their representatives, tried only to visit homes that

³ 'Taking greater care: Why we need stronger consumer protections in the care home market' Citizens Advice (December 2016).

⁴ Which? research, July 2017.

⁵ Based on an analysis of the caredata.co.uk dataset. This includes all registered care homes, not just those for people aged over 65.

⁶ Carehome.co.uk describes itself as 'the leading UK Care Home website with over 16 million visitors per year'.

⁷ As of June 2017, 638 care homes displayed indicative costs of care on the NHS Choices website, which is only 4% of all care homes in England. This percentage includes all care homes, rather than just those which primarily cater for older people. These figures imply that at most 7% of care homes for older people display indicative costs of care information on NHS Choices.

⁸ 'Taking greater care: Why we need stronger consumer protections in the care home market' Citizens Advice (December 2016).

⁹ Ipsos MORI. CMA consumer research page 49.

they considered were in budget. Suitable homes were determined on perception of affordability, information on websites or calling the home. However, 'prices were often not clarified [by homes] in advance of a visit'. Therefore, the timeliness of disclosure of such fees is important, so that consumers can take efficient decisions.

12. We consider that information about the fees payable by residents is likely to be 'material information' for the purposes of consumer law (under regulation 6 of the CPRs). We take the view that this is information that prospective residents or their representatives need, in this context, to take an informed decision about the choice of care home, or simply whether to call, visit or make further enquiries of the care home.
13. Further, a lack of indicative up front pricing information is likely to exacerbate the harm caused by practices where charges are revealed to residents only gradually throughout the selection process (sometimes known as 'drip pricing'), since it is very hard for consumers to understand and compare the total price they are being asked to pay without seeing the full picture. Given the context in which prospective residents (as consumers) typically make decisions, we think a care home is more likely to comply with the CPRs where they give accurate indicative fee information on their websites. This kind of pricing information should already be to hand if a prospective 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).
14. Where providers do include indicative fees on websites, this is typically done by showing either the range of fees charged (for example: nursing £1,000 – £1,200 per week depending on the services required and individual circumstances) or a 'from' price (for example: residential fees from £900 a week). We have, however, found instances where it is not 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 prospective residents as to the true cost of care at the home (potentially breaching consumer law).

Resident deposits

15. Some providers ask for a substantial deposit in advance from self-funding residents¹⁰, which is refundable when the resident leaves or dies, provided that no outstanding fees are owed to the care home¹¹. The deposit can

¹⁰ We understand that similar deposits are not required from state-funded residents.

¹¹ This is distinct from a 'reservation' deposit which may be taken in order to hold a room for a resident.

typically be the equivalent of two weeks' or four weeks' fees and we have seen examples where this can amount to £4,000–£5,000.

16. Although the taking of deposits does not currently appear to be an industry-wide practice, Citizens Advice research found that over a third of people (37%) said they had put down a deposit and nearly 1 in 5 people had put down a deposit of £1,000 or more.¹² We have concerns around the practice of taking large deposits.

Reasons for taking deposits

17. We have been told by some providers that deposits may be used:
 - (a) to cover non-payment of both residential care fees and any additional extras – although residential care fees are often paid in advance by residents, by the end of the month there is no remaining balance, and any extras are invoiced in arrears;
 - (b) to offset any outstanding balance due when the resident leaves or dies, against a backdrop of increasing cost provision being made to cover bad debts, and the risk of potentially long delays in fees/charges being paid if probate is being sought;
 - (c) to alleviate the short-term financial risk to a provider where a self-funder can no longer meet the cost of their care and alternative funding is being secured, or where a family member is applying to the Court of Protection to have a Power of Attorney put in place (where the resident no longer has capacity and there is no longer a legal contracting party against whom to enforce payment of fees).
18. Although there may be some legitimate reasons for taking deposits, it is not always clear why providers require residents to pay a substantial deposit, particularly if the care home fees are being paid monthly in advance (before the service is incurred). Further, unlike the private rented sector, security deposits are also less likely to be needed to cover damage to the care home resident's room or missing items.
19. We would be less likely to have concerns under consumer law where the requirement to pay a deposit is specific, transparent and prominent as to what must be paid and the deposit is set low enough so that it merely reflects and protects the provider's legitimate interests, without creating an imbalance in

¹² ['Taking greater care: Why we need stronger consumer protections in the care home market'](#) Citizens Advice (2016).

the rights and obligations of the parties. For example, large deposits are more likely to give rise to fairness concerns on the basis that they may be seen as a disguised penalty and/or undermine the consumer's right of set-off where the provider has failed to meet its obligations under the contract (see further, below).

Deposit protection

20. 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. However, unlike in the private rented sector, there is currently no specific regulatory requirement for deposits to be safeguarded in full against the risk of insolvency.
21. 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 do not. For example, of the 20 providers who said they charged a deposit and responded to a question in a CMA online questionnaire asking if residents' deposits were protected in full against the risk of insolvency, 14 said resident deposits were not protected¹³. During the course of our market study, some providers have told us they are taking steps to further protect deposits.
22. Generally speaking, in an insolvency, those owed money are paid in a strict order of priority, as determined by statute. There may not be enough money to pay everyone and the lower a creditor's position in the priority order, the less likely they are to recoup the money they have lost. Unsecured creditors are paid after secured and preferential creditors. This means that if a care home provider were to become insolvent, there is a risk that residents, who will usually be unsecured creditors, would not get their deposit back in full.
23. We consider that, where residents are not informed that their deposit will not be protected before they take the decision to choose the care home (and are therefore unaware of the risks that their money is being exposed to), this may breach consumer law. Similarly, if money taken as a deposit is being used for purposes that go beyond protecting the provider's legitimate interests (for example, to fund the general running expenses at the care home), a failure to inform a prospective resident of this in a clear, accurate and timely manner may breach consumer law – indeed the very description of such money as a 'deposit' is likely to be a misleading action.

¹³ Of the 18 providers who asked for a deposit of fixed amount more than £500 and/or 2 weeks fees or more (ie 2 weeks, 4 weeks, more than 4 weeks) 13 said they didn't protect the resident's deposit in full against insolvency (eg by protecting in a separate trust account, or through taking out insurance or a bond).

Disputes over return of deposits

24. Some charities have highlighted the potential for disputes in the return of deposits when a resident moves to another care home or dies – for example a Citizens Advice survey found that 7% of those who put down a deposit said they did not get it back.¹⁴ We have only found limited evidence during our market study of this happening, for example a review of data provided by some providers indicated that only a very small number of deposits were subject to dispute. This could in part reflect the vulnerable circumstances many people find themselves in when organising a move or following the death of a relative, where they may be less inclined to challenge the amount of the returned deposit.
25. We still have concerns from a review of contracts that some providers have a very wide discretion to withhold or retain deposits, for example for ‘**any** reason’ or ‘for **any** breach of the contract’, and do not always set out clearly in the contract what deposits will be used for and the process for disputing any amounts withheld from the deposit (or associated invoices).
26. We are also concerned that the use of deposits to offset any outstanding fees or charges can discourage or prevent residents or their representatives effectively from challenging disputed bills or invoices, for example through the right of set-off.¹⁵ We are concerned that doing so could be an unfair or even aggressive practice under consumer law, and terms which give providers a wide discretion to retain money from deposits may be unfair under unfair terms legislation. Further, while the care home may seek to withhold deposits to avoid having to initiate court proceedings to recover outstanding debts, such proceedings may ultimately be the only form of redress for residents or relatives whose money is then unfairly withheld.

Time taken to return deposits

27. We have been told by some providers that although they aim to return or refund deposits within 30 days, on average it can take longer to do so (for example, more than 40 or 50 days), and in some individual instances much longer (such as where there are delayed responses from estates or there is no next of kin). It is important that providers return deposits as quickly as possible, and undue delays may amount to a breach of contract, or otherwise infringe consumer law.

¹⁴ [‘Taking greater care: Why we need stronger consumer protections in the care home market’](#) Citizens Advice (2016).

¹⁵ Where consumers have an arguable claim under the contract against a trader, the law generally allows them to deduct the amount of that claim from anything they have to pay.

Other substantial upfront payments

28. Some providers require residents to pay substantial upfront charges (which may be in addition to paying a month's fees in advance and in some instances a deposit) on or before moving into a care home. These may include administration charges, or one-off 'management' type fees.
29. We have concerns that some of these one-off charges may be sprung on people late in their decision-making process and may therefore come as an unwelcome surprise due to a lack of transparency. In particular, they may only be brought to the attention of the resident or their representatives 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 that are being provided in return, may also be opaque or not clearly explained or may be misleading through its overall presentation. Indeed, terms imposing a non-refundable charge as a condition for entering a care home may be unfair under consumer law.
30. We are concerned that 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 information been provided in a clear, accurate and timely manner. Prospective residents and their families are likely to be focused upon the level of the weekly residential care fees and may be surprised to find out only, perhaps late in the sales process, that a large, opaque, non-refundable additional charge is required. By the time someone visits a care home they may already have an emotional commitment to securing a place in that home and are much less likely to challenge the charge or walk away (particularly if they are under time pressure, have limited options, or don't want to appear to be 'penny-pinching'). This is further exacerbated where prospective residents are given a relatively short time in which to make a decision or risk the room being offered to someone else.¹⁶
31. The element of surprise may be exacerbated by the fact that these type of one-off fees do not appear to be commonly charged in this market, as most providers incorporate administrative and other business costs associated with running a care home within their overall weekly fees. For example, of the 132 providers who responded to a question in a CMA online questionnaire, 6 (5%) said they asked residents to pay an additional one off charge when or before moving in. This can also mean it is much harder for people to compare prices between care homes.

¹⁶ Ipsos MORI, CMA consumer research, page 48.

32. We also have concerns that the payment of a substantial, non-refundable charge may deter residents from subsequently exercising their right to leave the home. This is particularly so if they are unhappy or their circumstances change shortly after they have moved in but they have already incurred significant expense.

'Hidden' extra charges

33. 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.
34. Concerns have been raised by some charities and consumer groups that there may sometimes be a lack of clarity and visibility about what extra charges are payable, whether these are mandatory or optional and how much these might be. For instance, it can be hard to discover before moving into a care home:
- (a) what the weekly fees include and what needs to be paid for separately, landing residents with large unexpected bills for additional services.
 - (b) How much the additional services, such as hairdressing, will cost and whether the care home adds its own additional surcharge on top of such costs when these are provided by a third party; and
 - (c) how much an accompanied visit to a medical appointment may cost, for example the hourly rate for a member of staff.
35. Citizens Advice research¹⁷ 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 year¹⁸. Which? also analysed 100 care home websites and reported that 91 offered no detail on any charges made in addition to room rates¹⁹.

¹⁷ ['Hidden charges in care homes, Exploring consumer protections in the care home market'](#), Citizens Advice, February 2016.

¹⁸ In the same report, Citizens Advice referred to the support they had provided to people who had incurred unexpected bills, such as a £1,000 phone bill.

¹⁹ [Which? research, July 2017](#)

36. We are concerned that the point at which information about any extra charges becomes clear may come too late for some residents – for example, although they are typically mentioned in the contract itself and documents such as the service user guide or information packs, these may sometimes only be given to the resident shortly before admission or when moving into the home. As a result, residents may find themselves in receipt of large unexpected bills for additional services or goods that they may have thought would be included in their weekly fee or provided free, for example, by the NHS.

Not providing contract terms to prospective residents in a clear and timely way

37. Entering a contract with a care home is a major decision which can have significant financial 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, only giving them the contract after they have moved in, or failing to let them have sight of it at all. Care homes which do this may risk breaching consumer law²⁰ (as well as sector-specific regulations and standards), as people should always have a real opportunity to read and understand contracts before becoming bound by them. Further, the terms that appear in such documents may not be incorporated into the contract with the resident, meaning that the care home may not be able to rely on or enforce those terms at all.
38. We have been told about people not being given sufficient time to read and consider the contract properly, or being asked to sign the contract before it was explained to them. For example, 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, and that individuals and their families are frequently given less than 24 hours to review a contract before signing.²¹ Even more concerning, Citizens Advice research in England found that a quarter of people (25%) surveyed said they were only given a copy of the contract after the resident had moved in, and 11% said they had not been given one at all.²²
39. Based on our review of a number of providers' 'sales' processes and policies, we are concerned that prospective residents and/or their representatives will typically only be shown the contract at a point when there is a 'serious' intention to move in. Although some providers have told us that they can't

²⁰ Under consumer law, a care home's contract terms must be transparent so that a prospective resident is in a position to make an informed choice before signing the contract. Additionally, it is likely to be a breach of the CPRs where the provider omits, hides or provides in an unclear, ambiguous or untimely manner, information that the resident or their representatives need to take informed decisions about a care home.

²¹ [Independent Age response to CMA Update Paper](#), August 2017.

²² 'Taking greater care: Why we need stronger consumer protections in the care home market' Citizens Advice, 2016.

finalise details of the contract until a care needs assessment has been carried out and there has been a discussion about the fees, this should not prevent them from giving a copy of the pro-forma contract in a much more timely way (as well as highlighting the most important terms in the contract). This concern is exacerbated by CMA consumer research which found that care homes only give prospective residents relatively short timeframes in which to make a decision or risk the room being offered to someone else.²³

40. CMA consumer research also found that although discussion of the terms may come up informally at the finding stage, very little is often written down. Many respondents in the consumer research felt that terms and conditions were standard across care homes and assumed that they had been told everything they needed to know in the informal discussion if there had been one, and so did not engage with the contract or what was included when signing the contract.²⁴ Although face-to-face explanation (alongside brochures and key facts documents) can serve a valuable purpose as a means of drawing attention to the more important terms, we think such terms need to be fully explained to (and understood by) residents and their families at a much earlier stage of their decision-making process, before they are contractually bound.
41. More generally, many care homes do not appear to be providing prospective residents and their relatives with copies of their standard contracts or information on important terms at an early stage of the customer journey, such as when searching for a care home or making an initial enquiry. A Which? survey of 100 UK care home websites found that only three care home providers made their terms and conditions available online.²⁵ Similarly, of the 137 providers who responded to a question in a CMA online questionnaire, only 25 (18%) said they included a copy of either their standard self-funder contract, resident agreement (or a summary of key terms from it) on their website. Which? also contacted 50 care homes by telephone to request additional information, including contracts, but only 17 sent further information.
42. We think providers need to take particular care to communicate important terms to prospective residents and their representatives at any early stage, given that the circumstances in which they are looking for a care home (often short of time and under emotional stress) means they may have greater difficulty in exercising choice effectively. In our view, transparency under consumer law is more likely to be achieved if information is conveyed as early as possible, for example, by including contracts and a summary of the most

²³ Ipsos MORI, CMA consumer research, page 48.

²⁴ Ipsos MORI, CMA consumer research, page 73.

²⁵ Which? research, July 2017

important terms on websites and in materials sent out in response to initial enquiries.

Failing to make contract terms clear and understandable

43. We have also reviewed a number of care home contracts, and found that they can vary greatly in how user-friendly and easy to understand they are in the language they use, length and layout. Consumer law requires that written terms in consumer contracts are transparent; they must be in plain intelligible language, so that the consumer can understand the nature of all the rights and obligations they have under the contract and they are put into a position where they can take an informed decision about whether or not to enter into the contract. Some of the contracts we have seen may not meet this standard. Terms which have not been communicated to consumers before they enter into the contract may not be incorporated into the contract at all, and so may not be relied upon or enforced by the care home.

Need to 'guarantee' payment of care home fees

44. 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 (mainly based on the average length of stay of a resident in the care home). This typically involves the care home either:
- (a) checking a prospective resident's finances to ensure that they have sufficient funds to self-fund for the minimum period, where providers will undertake a financial assessment during the admission process reviewing prospective resident's savings, investments, pensions, and properties. Of the 129 providers who responded to a question in a CMA online questionnaire, 48 (37%) said they always did such an assessment; or
 - (b) asking the resident to sign a declaration that they have sufficient funds to self-fund for the minimum period – so the resident effectively self-certifies after a discussion about their finances. Of the 130 providers who responded to a question in a CMA online questionnaire, 53 (40%) said they required self-funding residents to confirm that they had sufficient funds/assets to fund their place for a minimum period.
45. 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. Some providers have also suggested there may be some

benefits to prospective residents in helping them to plan their care needs, for example:

- (a) to determine and signpost to prospective residents whether they would be entitled to LA funding or a Deferred Payment arrangement that they and their families may not be aware;
 - (b) as part of financial safeguarding ensuring that residents/families fully understand the likely costs of staying in the home for the full duration of their stay, providing them with an early opportunity to consider cheaper alternatives.
46. However, where a provider's contract terms or policies prohibit or deter self-funding residents from approaching the LA where they become eligible for state funding during this period, such a requirement is likely to be unfair under consumer law. Age UK highlighted an example of a contract that asked residents to guarantee to fund their own care for two years and not to approach the LA in that time.²⁶
47. Similarly, where a resident has a contractual obligation to notify the care home within a specified timeframe where they anticipate they will become eligible for LA funding, we would be concerned where that period is excessively far in advance as, in practical terms, it will be very difficult for a resident to comply with such an obligation.

Use of guarantors

48. More generally, some providers may ask an individual nominated by the resident to co-sign the contract as a 'guarantor', whereby they agree to be liable for the fees in the event the self-funding resident is unable to continue to pay (although providers have told us this is not usually linked to any minimum funding period). Of the 130 providers who responded to a question in a CMA online questionnaire, 24 (18%) said this was often or sometimes a requirement.
49. We have seen examples of contracts where the guarantor's role and the circumstances in which they will be liable are not clearly set out or explained, or where there is a lack of clarity around the terminology being used to describe the different roles and responsibilities of individuals acting as guarantors, third party contributors, representatives or similar. We consider that not clearly, accurately and prominently explaining this kind of important

²⁶ 'Behind the headlines: stuck in the middle – self-funders in care homes', Age UK (September 2016).

information may be a breach of consumer law, as it hinders people's ability to take properly informed decisions.

50. As such, we are concerned that individuals who are being asked to act as guarantors or in a similar capacity (which involves them agreeing to a potential financial commitment) may not always be in a position to understand their potential liability for covering (unknown) future costs, even though they themselves may sometimes have little income or savings.
51. We also have concerns about terms that we have been told about by the Relatives and Residents Association that may require a resident's representative to commit in advance to paying 'top up' fees for a certain time period if the resident's funds run down, or which may make someone who has power of attorney over a resident's affairs personally liable for guaranteeing the payment of fees (which are likely to change over time).²⁷ We consider such terms are potentially unfair under consumer law, where the guarantor/sponsor cannot foresee and evaluate their potential liability and evaluate the practical implications for them, at the point they sign the contract.
52. Some of the practices and terms we have seen therefore raise concerns under consumer law about their transparency and fairness.

Third party top up fee arrangements

53. 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.²⁸ There were approximately 48,000 care home residents across the UK in receipt of a third party top up in 2016, representing 26% of all council supported residents²⁹.
54. 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 a LA is involved in the arrangement. For example, under the Care Act in England local authorities 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. The LA also remains responsible for ensuring that the whole fee (including the top-up)³⁰ of

²⁷ [Relatives & Residents Association response to CMA Update Paper](#), July 2017.

²⁸ Top-up fees arise when the prospective resident's preferred care home costs more than the amount specified in the residents' budget set by the LA. Top-up payments must be distinguished from charges made by the home for extra items not covered by the home's core residential fees, such as hairdressing, which the care home can charge to the resident.

²⁹ LaingBuisson (May 2017), *Care of older people UK market report*, 28th edition, page 218.

³⁰ The LA will remain liable for the top-up until it can recover the costs or make alternative arrangements.

any care it has contracted is paid to the provider. This means that if for whatever reason a third party cannot continue paying a 'top-up', then the third party top-up agreement is managed in a stable way with the LA deciding whether to move the person into standard accommodation that does not require a top up or to pay the top up themselves.

Top up fees agreed privately between a care home and third party

55. 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 UK³¹ of instances where care homes have approached relatives directly to demand top-ups without the agreement of the LA. As well as meaning that the third party will not benefit from the protections when a LA is involved in the arrangement, we think this is also potentially a breach of consumer law, since third parties could be misled about their rights, and be hindered from making properly informed decisions.
56. Concerns have also been raised over the way in which some LAs are meeting their duties under the Care Act in relation to managing third party top up arrangements. In particular, recent Independent Age research³² said that:

Of the 119 local authorities we received responses from: - 24 local authorities do not keep any information relating to third party top-ups, raising questions about their oversight of top-ups; - 11 local authorities are not involved in all the third party top-up agreements set up with state-funded care home residents in their area, contrary to Care Act guidance. This means 35 councils (around 1 in 4 of the councils we received responses from) cannot fully or routinely demonstrate they are meeting all their Care Act duties on managing third party top-ups.

Third parties being asked to pay top up fees directly to the care home

57. Under the statutory guidance to the Care Act (in England), where a LA is meeting someone's needs by arranging a care home, we understand 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 local authorities should deter such arrangements

³¹ 'Behind the headlines: the 'top up' stealth tax on older people in state-funded residential care', Age UK (September 2016)

³² 'Caring about the Care Act, A Freedom of Information Research Briefing', Independent Age, November 2017.

because ‘multiple contracts risk confusion’ and the LA may be unable to assure itself that it is meeting its responsibilities.³³

58. However, 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. This is likely to mean that the third party will sign a contract with the 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.³⁴
59. 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 in conflict, with those between the LA and care home (even if not enforced by the care home). This could also mean that terms which a care home wishes to rely on may not be properly incorporated, or may be so inconsistent as to be unenforceable against the third party. We have found examples where providers appear to require the third party to sign their standard self-funder contract (or a variant of it) or a standard residency agreement (which is applicable to both LA and self-funded residents) whose terms may differ from those in the LA agreement – such as how long top-up fees are payable after death.
60. 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 of time after the death of the resident than would have been the case under the LA agreement. This raises potential concerns under consumer law.

Fee increase terms

61. 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

³³ Ultimately, if the arrangements for a ‘top-up’ were to fail for any reason, the LA would need to meet the cost or make alternative arrangements, subject to a needs assessment. The Care Act statutory guidance states that local authorities should therefore maintain an overview of all ‘top-up’ agreements and should deter arrangements for ‘top-up’ payments to be paid directly to a provider.

³⁴ 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.

market where most residents are unlikely to move care home because of the stress and inconvenience involved.

62. Our review of a sample of self-funder contracts (and other information provided to us by care homes) has found that most typically purport to allow the provider to increase the resident's fees following an annual review of their fees, or even more frequently in circumstances where:
- there has been an unexpected increase in the care home's costs;
 - there has been an increase in the resident's care needs; and/or
 - the resident moves to a better room.

Wide discretion to increase fees

63. The 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'.
64. In addition to an annual increase, the majority of contracts we have seen reserve the right for the provider to increase fees at other times. While we do not generally object to appropriate fee increases where someone's care needs change or they move to a more expensive room, we are concerned that contracts typically include a wide range of other reasons for putting up fees – 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 – or a general statement that the resident's fees may change over time. Some providers have told us that they have not relied on these terms in practice (and have only put up fees as part of their annual review) but this does not mean that they won't seek to do so in the future.³⁵ We have also seen contracts that give no reasons at all for why fees may increase.
65. Consumer law generally requires that consumers must be able to foresee, at the time they first enter the contract, how the price may change over the life of the contract. This is likely to require contracts to set out clearly the circumstances in which changes may occur and the method of calculating the price change. We therefore think that terms in contracts which permit a care

³⁵ Under consumer law, a finding of unfairness does not require proof that a term has already caused actual harm, and a term may be open to challenge if it could be used to the detriment of consumers.

home to increase fees arbitrarily, without reference to clear, objective and intelligible criteria, are likely to be unfair. In these circumstances, residents may not be able to foresee and understand (on the basis of such criteria) the increases that may be made and evaluate the practical implications for them, before they make a decision to move in. Such terms may also be open to misuse, since residents can have no reasonable certainty that fee increases are related to any objective criteria or are cost-reflective, in a market where the resident is less likely to be able to take effective action to avoid the fee increase, by moving out for example.

66. We also think that, while on the face of it care home contracts are of indeterminate duration, the practical reality is that they typically operate as short term contracts, given that we understand the average length of stay in a care home is around 24 months.³⁶ This means that providers should be much better able to anticipate and control changes in their own costs than residents can possibly be.

Escaping the effect of fee increases

67. Under consumer law, a term allowing fee increases should also ensure that the consumer is given reasonable notice of any increase and genuine freedom to escape its effects (ie a right to terminate the contract without penalty before it takes effect). Most of the contracts we have reviewed give 28 days' notice of annual fee increases and allow the resident to give notice to leave before the increase comes in to force if they are unhappy.
68. However, Citizens Advice research found that some care homes in England are giving residents extremely short notice periods – nearly one in ten (8%) of the care homes in England that it mystery shopped only gave a week's notice of fee increases, and 7% of survey respondents said they had experienced a short notice increase in care home fees of less than 4 weeks.³⁷ Where this is the case, this raises concerns that providers' contract terms may be unfair under consumer law (and potentially sector-specific rules which prescribe that reasonable notice of changes needs to be given).
69. Generally speaking, a right to give notice to end a contract before an increase takes effect and leave without penalty would normally enable consumers to

³⁶ A survey of research by Laing-Buisson indicates that life expectancy in care homes is around 24 months. Life expectancy in residential homes (30 months) is longer than nursing homes (16 months). These averages hide considerable variation in the length of stay of individual residents, with research indicating that median life expectancy is much lower than the mean. This is because there are a small number of residents who survive for a long time, pushing up the mean life expectancy figure. Laing-Buisson, Care of Older People UK Market Report 27th edition, page 170.

³⁷ 'Taking greater care: Why we need stronger consumer protections in the care home market' Citizens Advice (2016).

avoid an unwanted fee increase (even though this may not make the term fair), but this is not the case in the care homes market. The possibility of moving provider is often not a desirable or practical option for older people in care homes and, as such, there is a lack of competitive pressure in relation to the frequency and amounts of fee increases. CMA research³⁸ suggests that people feel ‘disempowered’ to do anything about increasing fees because of the likely stress and inconvenience involved in finding and moving to another care home. As a result, and given the inherent vulnerability of many care home residents, they may feel ‘trapped’ and will be likely to have no choice but to pay significant or unexpected fee increases. This is reinforced by the data some providers have given us, which suggests that only a very small number of residents give notice to leave because they are unhappy with fee increases, or challenge the amount of any proposed fee increases.

70. As such, we take the view 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). This is especially relevant in these circumstances, where the evidence we’ve received supports the view that residents rarely challenge fee increases and feel they have no choice but to accept them.

Relationship between NHS Funded Nursing Care (FNC) payments and self-funding residents’ fees

71. 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 (care provided by registered nurses in nursing homes is an NHS responsibility). Over 79,000 care home residents in England are eligible for FNC, which is set at a national standard rate and is currently about £155 per week per resident.^{[See [endnote i](#)]}
72. Concerns were reported to us by a number of residents’ relatives following the 40% increase³⁹ in the FNC rate in England announced by the government in July 2016 (which was applied from 1 April 2016). Some residents had expected the FNC increase to result in an equivalent reduction in the amount they contributed to their overall fees (and to be rebated for the backdated period), but we have been told of instances where care homes increased the overall weekly fee by a similar amount to the rise in the level of the FNC rate.

³⁸ Ipsos MORI, CMA consumer research, page 83.

³⁹ The standard FNC rate was increased by £44 a week to £156.25.

Although the resident's net contribution to their fees remained unchanged, they did not benefit from the FNC increase. Independent Age has also told us it had received calls to its Helpline about this specific issue, which it thought were likely to represent a very small proportion of those affected. It highlighted FNC as a particular area where self-funding residents 'seem to have experienced real confusion over what they are entitled to'.

73. 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 practice guidance says that:

The Care Home provider should set an overall fee level for the provision of care and accommodation. This should include any registered nursing care provided by them. Where a CCG assesses that the resident's needs require the input of a registered nurse they will pay the NHS-funded nursing care payment (at the nationally agreed rate) direct to the care home, unless there is an agreement in place for this to be paid via a 3rd party (e.g. a LA). The balance of the fee will then be paid by the resident, their representative or the LA unless other contracting arrangements have been agreed.⁴⁰

74. This could be interpreted as meaning that for self-funders the relationship between the residential care fee and the FNC payment is dependent on the terms in their contract with the care home – so essentially the contract between self-funders and the care home will determine whether or not there will be a reduction in the resident's contribution to their fees when there is an increase in FNC funding. 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 funding, which is reflected in our review of care home contracts. For example, if the FNC contribution was increased then, depending on the contract terms:

- (a) the overall fee might increase to reflect the increase in FNC and the resident's own contribution would remain the same;
- (b) the overall fee might remain the same and the resident's contribution would decrease by the equivalent amount of the FNC increase;

⁴⁰ The National Framework for NHS continuing healthcare and NHS funded nursing care, [Practice Guidance Note](#), paragraph 62.3.

- (c) the resident's own contribution to their fees might be treated as a separate matter to any changes in the level of the FNC payment, so would remain the same.
75. Related to this, we consider there is a lack of clarity about what happens when there is a reduction in the FNC payment or it ceases to be paid, for example if a care home resident is temporarily admitted to hospital or dies. We have seen care home contracts that appear to make the self-funding resident liable for the full gross weekly residential care fees should FNC reduce or cease for any period, or which require the deceased resident's estate to make up any shortfall in the FNC contribution (which we understand typically ceases upon or shortly after death depending on the CCG contracting mechanism) for a period after death.
76. We have also seen some care home contracts with self-funding residents that are potentially ambiguous about FNC or completely silent on it.
77. We therefore think there is considerable uncertainty amongst some self-funded residents about how the FNC payment affects their own contribution to the overall fees, in particular whether the residents' own contribution should decrease or increase depending upon variations made to the amount of FNC paid to the homes.
78. We are also concerned that, in some instances, the contracts we have seen (both the terms directly dealing with the treatment of the FNC contribution, and general fee variation terms which give an overly broad discretion to increase self-funder's fees when the FNC rate goes up) lack transparency and may be unfair under consumer law.

NHS Continuing Healthcare funding and top-up payments

79. 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, to such an extent that the patient can be described as having a 'primary health need'. Where a nursing home resident in England and Wales is eligible for CHC funding, the NHS will therefore pay for their nursing home fees as well as healthcare and personal care.
80. Generally speaking, a CHC package can only be 'topped up' if the resident or their family agree to pay for additional, discretionary services (on top of the services they get from the NHS) which the NHS would not normally fund, as they are not clinically necessary. These additional, private services should be provided by different staff and preferably in a different setting to the agreed

care package. This is not a top up in the same sense as third party top ups to LA fees, but payment for additional, optional services (for example, hairdressing and aromatherapy). Asking residents to pay a top up to cover a shortfall in the cost of the basic agreed care package is not permissible under NHS rules.

81. We understand that in England local CCGs, as the bodies responsible for funding CHC residents, are primarily responsible for overseeing the rules on 'top ups' to CHC packages through their contracts with providers. However, we think there is a general lack of transparency and clarity for CHC-funded residents and their families in England on the applicable rules around top ups and who enforces them, which may mean they are not always being safeguarded against unforeseen or unfair additional costs.

Top ups to cover a 'shortfall' in CHC funding

82. 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, which we understand is not permissible under NHS rules (NHS services must be provided free of charge and fee sharing is not permissible for core NHS services). This differs from the situation with LA funded residents, where third party top up fees are allowed if the resident wants to be placed in a care home that charges more than the LA's standard rate or for superior accommodation in the same home. We therefore have concerns that where care homes are making such charges this may involve misleading or otherwise unfair commercial practices under consumer law.
83. We have also been told by Independent Age that the issue of CHC funded residents being asked by care homes (as well as CCGs) to cover a 'shortfall' comes up fairly consistently in enquiries to its Helpline.
84. The National Framework for NHS Continuing Healthcare and relevant legislation in England sets out that CCGs should be contracting for an appropriate and sufficient CHC package and there should not be a shortfall to be met privately. However, we understand that there are no specific NHS rules that directly prevent or address providers asking residents or their families for a top up to cover a 'shortfall' in funding.

Circumstances in which top ups for 'additional services' may be permissible

85. 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).⁴¹ Therefore we have concerns that providers which make such charges where the additional services cannot be separately identified and delivered may be engaging in misleading or otherwise unfair commercial practices under consumer law.

86. Where such additional services are permissible, the provider may be able to offer these for purchase (which can be contracted for via separate top-up arrangements between the home and resident); but the decision to make an additional payment must always be a voluntary one and not a condition for remaining in the home. Residents who stop any previously agreed additional services payment or contract should not be required to move to another nursing or residential care home (the provider should be able to continue to provide care under the NHS CHC contract).
87. We think there is currently uncertainty around the types of additional private services that are permissible under NHS rules, for example in relation to top up payments for better rooms. This is reflected in the different approaches some CCGs in England appear to take over the extent to which they allow top ups for additional services. For example, from a search of CCG policies on the web we found examples where the CCG's policy was to allow top ups to be paid for 'a more spacious bedroom' or a 'higher specification rooms with en-suite or a private garden', whilst some other CCGs limited examples of additional services to items such as TVs and hairdressing.
88. We think this lack of consistency and clarity, coupled with a general lack of awareness amongst CHC residents and their families about the rules and who 'enforces' them, may mean that they do not benefit from all of the protections they are entitled to against unfair additional costs.

Termination clauses: asking residents to leave the home and visitor bans

89. 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.

⁴¹ 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.

90. Charities including Age UK⁴² and Citizens Advice have raised concerns that care home providers' rights to evict are too broad, making the position of care home residents more vulnerable (whether state or self-funded). Serious concerns have also been raised that some care homes may be unfairly evicting residents by way of reprisal for their families or relatives making complaints (as well as imposing other measures such as visitor restrictions or bans).

Current statutory protections

91. From our review of care home contracts, most care home residents seem to be treated as contractual licensees. We also understand that under housing law in England and Wales, namely the Protection from Eviction Act 1977, there are certain basic legal protections in place for licensees against eviction. Where the Act applies, a care home provider would normally need to give a minimum of 28 days' written notice to vacate the home (or whatever period is agreed in the care home contract if this is longer) and ultimately obtain a court order if they wanted to evict a resident.

Concerns about termination clauses in contracts

92. The care home contracts that we have seen usually set out how the resident and the care home provider can end the contract. Typically, 28 days' notice is required from each side. However, many of the contracts we have looked at give the provider a potentially wide discretion to end the contract, sometimes at short notice, for reasons which the resident may find difficult to question or challenge. Such terms might be unfair under consumer law.

Wide discretion for the care home to ask a resident to leave

93. The contracts we have seen often allow the provider to give notice to end the contract for a number of reasons. These will typically include a change in care needs, violent or disruptive behaviour or late payments, but these may not be clearly defined in the contract and can leave considerable scope for interpretation by the care home. Some contracts may also include general statements referring to the resident being in breach of 'any other obligations under the contract' or 'any of the conditions of the contract'. This means it may be difficult for a resident or their family to understand or challenge a decision to ask them to leave. We think clarity (and due process) is especially important in the care home sector, where asking residents to leave is likely to

⁴² Consultation response, Competition and Markets Authority: Care Homes market Study Update Paper, Age UK, July 2017.

be a particularly stressful and emotional experience, and has a serious impact on their housing situation.

94. Various charities and bodies, including Age UK and Your Voice Matters, as well as the Commissioner for Older People for Northern Ireland (COPNI) have also raised concerns that widely drafted termination clauses can be used by some care homes to evict residents whose families or relatives have made complaints or given feedback (as well as imposing other measures such as visitor restrictions or bans, see paragraphs 102 -106 below) – for example, by citing a ‘breakdown in relations with the care home’. Where such terms have been relied on in this way, the impact on individual residents and their families is likely to be particularly serious and cause them considerable distress. This is likely to raise significant concerns under consumer law (as well as under sector regulations) about not only the use of unfair terms but also unfair and aggressive business practices.
95. 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. This is especially so given there may be a reluctance on the part of relatives to come forward and report it.
96. More generally, it is difficult to get clear evidence about how frequently care homes are asking residents to leave for legitimate reasons. Although the industry has suggested it does not happen very often (and some providers have given us data indicating there are only a small number of notices to quit issued each year), it should be borne in mind that:
- we have been told by some larger providers that their care homes do not routinely record such information;
 - complaints by residents and their families about evictions 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.

Asking residents to leave at short notice

97. In addition to general termination terms, many care homes’ contracts include provisions that allow them to terminate the agreement at very short notice – 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 themselves or to other residents. We have seen contracts that, whilst saying that residents will normally be given 28 days’ notice to leave, allow the

care home to ask the resident to leave either immediately, within 24 hours, or 7 days for a number of reasons. The COPNI has highlighted instances where care home residents have been threatened with only 24 hours' notice of eviction.

98. Some providers have told us that in practice this rarely happens and only in exceptional circumstances, and that they would only do so as a last resort after discussion with the relative and their representatives (and other interested parties) and where alternative care and accommodation had been arranged. We are concerned, however, that such terms may give the impression that residents can be forced to leave without a court order, where this would otherwise be required by 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 serious 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, in particular given the notice protections set out in the Protection from Eviction Act 1977.

Following due process when asking a resident to leave

99. More generally, the 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 (for example, the extent to which a GP will be involved if the care home believes it can no longer meet someone's care needs), and the opportunity for the resident or their family to challenge a decision or appeal or to involve an advocate on their behalf.
100. Although the lack of transparency around the process for asking residents to leave (sometimes at very short notice) is concerning regardless of how the resident is funded, it is likely to be especially so for self-funders as they may not have some of the protections of state funded residents – for example, the LA or NHS placement agreement may set out the steps to be followed (including advance notice periods) in asking a state funded resident to leave and will need the funding authority's involvement in any decision.
101. Failure to operate and communicate a fair process for deciding whether to ask a resident to leave, especially in the context of a care home business, may result in the contract terms relied on being more likely to be found to be unfair, and the home's conduct being found to be unfair or aggressive under consumer law.

Visitor bans

102. Concerns have been raised, for example by Your Voice Matters, 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.
103. Some providers have told us they do not collect information on the number of visitor bans or restrictions imposed, but that they only occur in rare and extreme circumstances, for example if a visitor was harming or abusing the individual they were visiting, other residents or relatives or staff.
104. Visitor bans are a serious interference with residents' private and family life, and we consider that terms allowing bans are unlikely to be in the resident's interest most of the time.
105. At the very least, we consider that the circumstances for banning someone must be narrow and extreme (for example, where a visitor has caused harm to the resident or to other residents, or to staff), and only invoked where there are clear processes in place.
106. Bans and restrictions should never be used or threatened by a care home as retaliation where a visitor has raised concerns about their relative's care or treatment by the home. 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

107. Fees are sometimes being charged by care homes for extended periods after a resident has died, even when the room may have been cleared of the resident's belongings and returned to the care home within this period. Although we have seen examples of self-funder contracts that terminate as soon as the deceased's belongings have been removed from the room or a short time after they have died, others charge fees for periods of up to fourteen days or four weeks after death or for the remainder of the month following death. In addition, 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.
108. We have also seen examples of contracts that may give the care home scope to charge the deceased resident's estate for the full gross fees during the period after death, including any shortfall in fees that had been covered by the state whilst the resident was alive (such as the NHS Funded Nursing Care contribution of £156 a week which typically stops shortly after death).

109. 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.⁴³
110. 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 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).
111. We have also seen examples of contracts which require the deceased's belongings to be removed, within a set period of days, and which for example:
- say nothing about what happens after this period, if the belongings have not been removed;
 - refer to items being disposed of after a certain period of time, without making clear what will happen to any surplus proceeds.
112. We understand from the information received that most rooms are emptied relatively quickly by the deceased's estate. We appreciate that where possessions are not removed, within a reasonable timeframe, a point will be reached where the care home will want to take action to mitigate any potential losses due to the unavailability of the room. In these circumstances, we would have concerns about any terms that are not transparent in explaining what happens if belongings are not collected within a certain timeframe – for example:
- whether items will be stored, how long for and at what charge, if any;
 - do not give the deceased's estate adequate notice of the sale; and/or

⁴³ 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.

- allow for the proceeds to be kept by the home (in circumstances when no money is due to the home).

Overview of complaints systems

Introduction

1. This appendix provides an overview of complaints processes in each nation.

Summary of complaints processes

2. In all four nations, there are statutory obligations for care homes to have a complaints procedure in place and to ensure that it is available to their residents. Care homes must keep a written record of any complaints they receive and provide a summary of every complaint received over the preceding year to their sector regulator if requested to do so.
3. Complaints processes within care homes will vary, but in general, where a resident or their representative (eg family member) identifies an issue, that concern will be raised with a care worker or registered manager in the first instance. Complaints that are not resolved at that level are usually escalated to a more senior person within the care home (eg to corporate management), and sometimes with several stages of escalation. Complaints might also be raised through other avenues, such as where social workers or GPs visit the care home.
4. If the complaint remains unresolved, there are different organisations that the complainant can approach. The route to approaching these organisations will vary depending on whether the resident is publicly funded and who arranged their placement. In England and Wales, publicly funded care home residents can approach their LA (or CCG in England or LHB in Wales). In Scotland, complainants can approach the Care Inspectorate and in Northern Ireland they can approach the HSC Trust if they are publicly funded or the Trust has arranged their care. The Care Inspectorate in Scotland is the only sector regulator that hears individual complaints.
5. In each nation, the Ombudsman is the ultimate and final stage in the complaints resolution process. There is a statutory obligation on care homes in Northern Ireland and Wales to signpost residents to the Ombudsman.¹

¹ Section 25 of [Public Services Ombudsman Act \(Northern Ireland\) 2016](#) and section 33(8) of the [Public Services Ombudsman \(Wales\) Act 2005](#) as amended.

However, as explained in Section 13, private funders in Northern Ireland who do not have access to NIPSO.²

6. In each nation, certain bodies have various general roles in relation to complaints, for example:
 - (a) The Older People's Commissioner for Wales COPNI have a statutory role in respect of older people, which includes powers to review advocacy or complaints arrangements of certain bodies.³ The aim of the Commissioners' review is to ensure that arrangements are effective in safeguarding and promoting the interests of relevant older people in their nation. There is also some existing guidance on complaints handling in the other nations.⁴
 - (b) The Care Inspectorate in Scotland can investigate individual complaints about a care service, including a care home, and periodically produces reports on the complaints received, investigated and upheld.⁵
 - (c) In Wales, the CSSIW has new responsibilities to regulate independent professional advocacy.⁶
 - (d) SPSO has powers to support its role as a Complaints Standards Authority tasked with leading the development and improvement of complaints handling systems in Scotland.⁷ In Northern Ireland, NIPSO, has a similar role, but this section of the legislation is yet to be commenced by the Northern Ireland Assembly.⁸
 - (e) Healthwatch England is the independent national champion for people who use health and care services. Established as a statutory committee of the CQC, it works to make sure those running services, and the government, put people at the heart of care. Healthwatch England supports a network of 152 local Healthwatch.⁹ They gather people's

² See paragraphs 13.31–13.38.

³ See section 5 of the [Commissioner for Older People \(Northern Ireland\) Act 2011](#) and section 5 of the [Commissioner for Older People \(Wales\) Act 2006](#).

⁴ For example, In Northern Ireland, some generic guidance exists on complaints e.g. NIPSO's "Principles of Good Complaint Handling" which providers need to comply with and PCC's "How can we help" guide to making Health and Social Care complaints. The Public Services Ombudsman Act (NI) 2016 includes provision (yet to be commenced) for the NIPSO to take on a role in developing and implementing complaints handling procedures which listed authorities would be required to comply with.

⁵ For example, Care Inspectorate (November 2016), [Complaints about care services in Scotland, 2011/12 to 2015/16](#), where the Care Inspectorate found that one in three care homes had had at least one complaint upheld about them during 2015/16.

⁶ Part 1 of the [Regulation and Inspection of Social Care \(Wales\) Act 2016](#).

⁷ For example, to publish model complaints handling procedures for listed authorities. SPSO also has the power to specify any listed authority to which the model is to apply.

⁸ Part 3 of the [Public Services Ombudsman Act \(Northern Ireland\) 2016](#).

⁹ Healthwatch England was established by the Health and Social Care Act 2012.

experiences, share people's views to make change happen, and provide information about health and care services.

(f) In Northern Ireland, the PCC is a statutory body that aims to provide an independent voice on health and social care issues.¹⁰ The PCC has local offices throughout Northern Ireland.

(g) The Ombudsman in each nation can produce reports on systemic issues of concern.¹¹

7. There are various types of third party who can potentially help someone in a care home understand how and where to direct their complaint:

(a) Advocates: an advocate generally means someone independent of the care home, who will represent the resident or their relative in making their complaint.¹² In each nation, there are certain circumstances in which older people have a legal right to access and be supported by an advocate (a 'statutory advocate').¹³ Some LAs provide advocacy services for complaints relating to social care when there is no legal obligation for them to do so.

(b) Third sector: consumer organisations such as Age UK and Healthwatch England provide general advice, support and information to complainants. Some of these groups will provide advocacy as well as general support and advice. Certain LAs contract with the third sector groups to provide general support to complainants.

(c) In-house advice: although not always independent of the care home, some providers have told us that they offer advice service to residents, their relatives or care homes staff who are managing complaints. Many also sign-post to third sector organisations.

(d) Professionals linked with the resident or the care home: health professionals such as social workers or GPs can be a source of information or advice for complainants, or can raise concerns on their

¹⁰ See the [Health and Social Care \(Reform\) Act \(Northern Ireland\) 2009](#) and [The Patient and Client Council \(Membership and Procedure\) Regulations \(Northern Ireland\) 2009](#).

¹¹ For example, LGSCO (September 2015) [Counting the Cost of Care: the council's role in informing public choices about care homes](#).

¹² DH England has told us that NHS and social care advocacy services assist a complainant in making their complaint about commissioned or provided services. They do not represent the complainant in the way a lawyer would, ie argue the case.

¹³ For example, in England, statutory advocacy is available if a resident lacks capacity to make certain decisions, or is detained under sections of the Mental Health Act. Under the Care Act 2014, LAs also have a responsibility to arrange an independent advocate to assist with a prospective resident's assessment and care and support plan, where the person has 'substantial difficulty' in being fully involved in these processes and there is no one appropriate to support and represent the person's wishes.

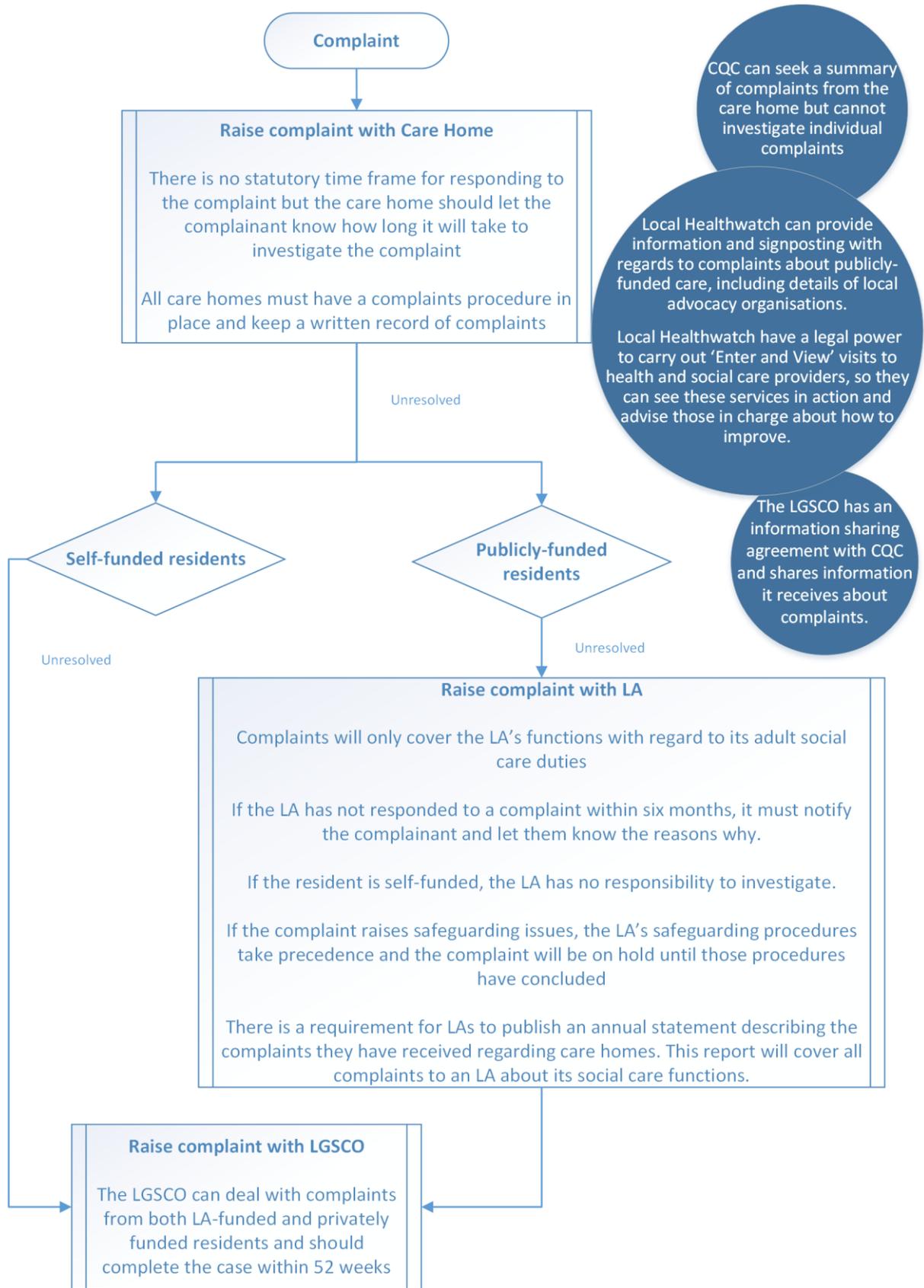
behalf. This is usually ad hoc or informal advice and pressures on these services could affect availability.

- (e) Other third parties: Someone (eg a lay assessor) who can relay concerns from residents and staff to the management of the care home. For example, by running and feeding back from residents and relatives' meetings.

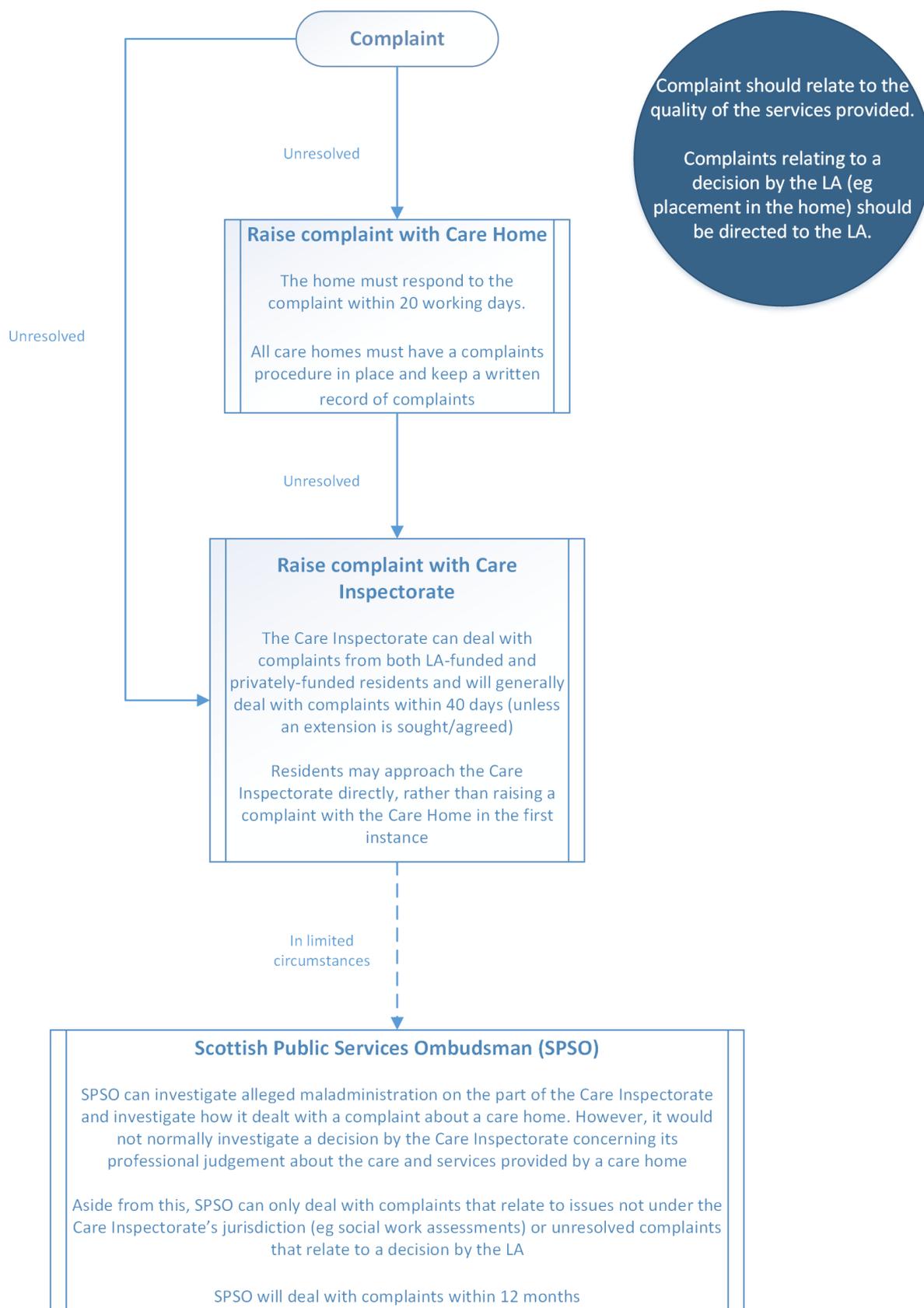
Processes for complaining

8. Below, we summarise the process for complaining in each nation, using flow charts. These are intended to be illustrative only and do not include all elements of the complaints process. In particular, each chart only covers the available route for a person to make a complaint about a care home that relates to social care. If the complaint relates to health care, for example Continuing Health Care eligibility in England, then this would be addressed through a different process.

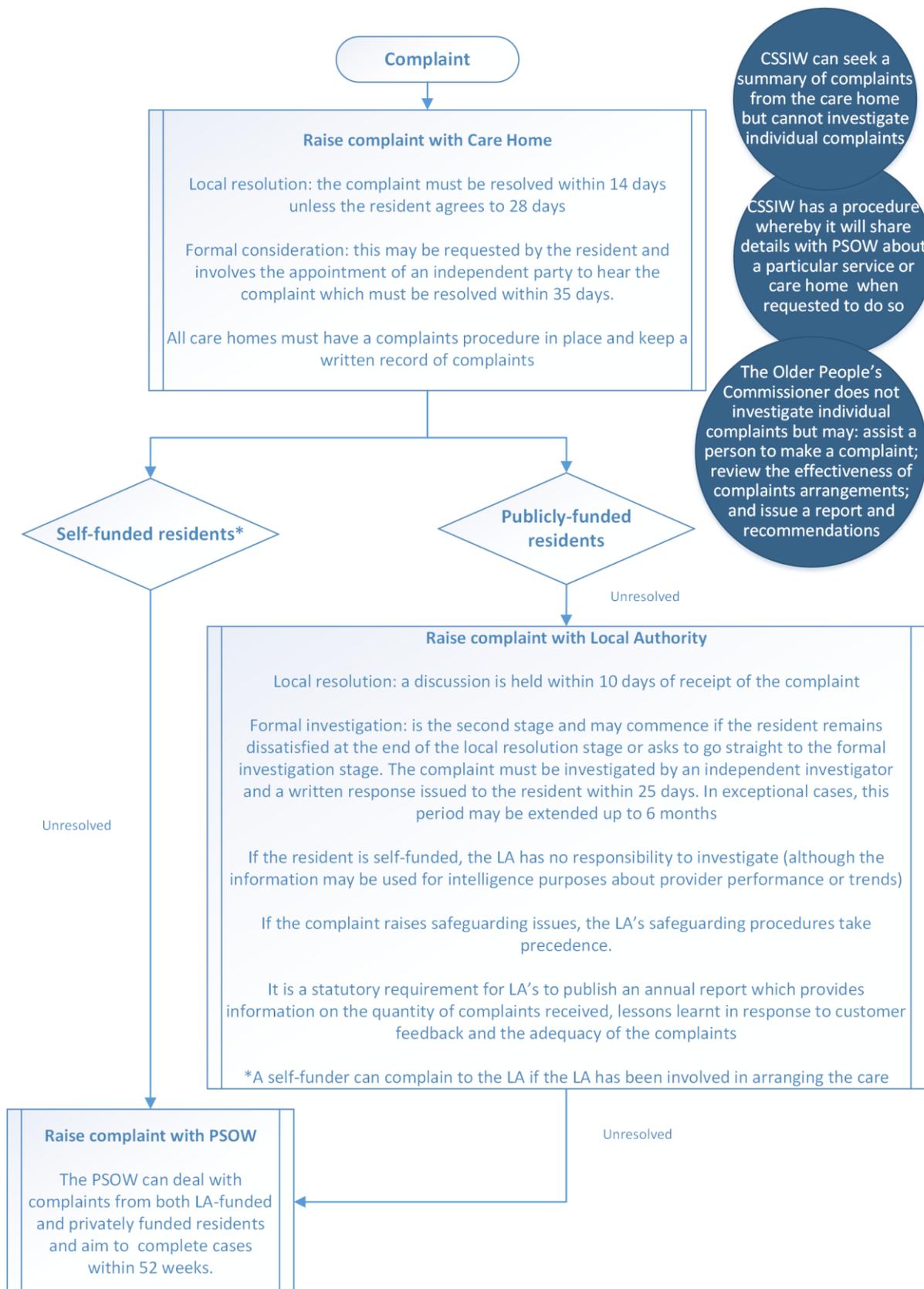
Overview of complaints processes in England



Overview of complaints processes in Scotland



Overview of complaints processes in Wales

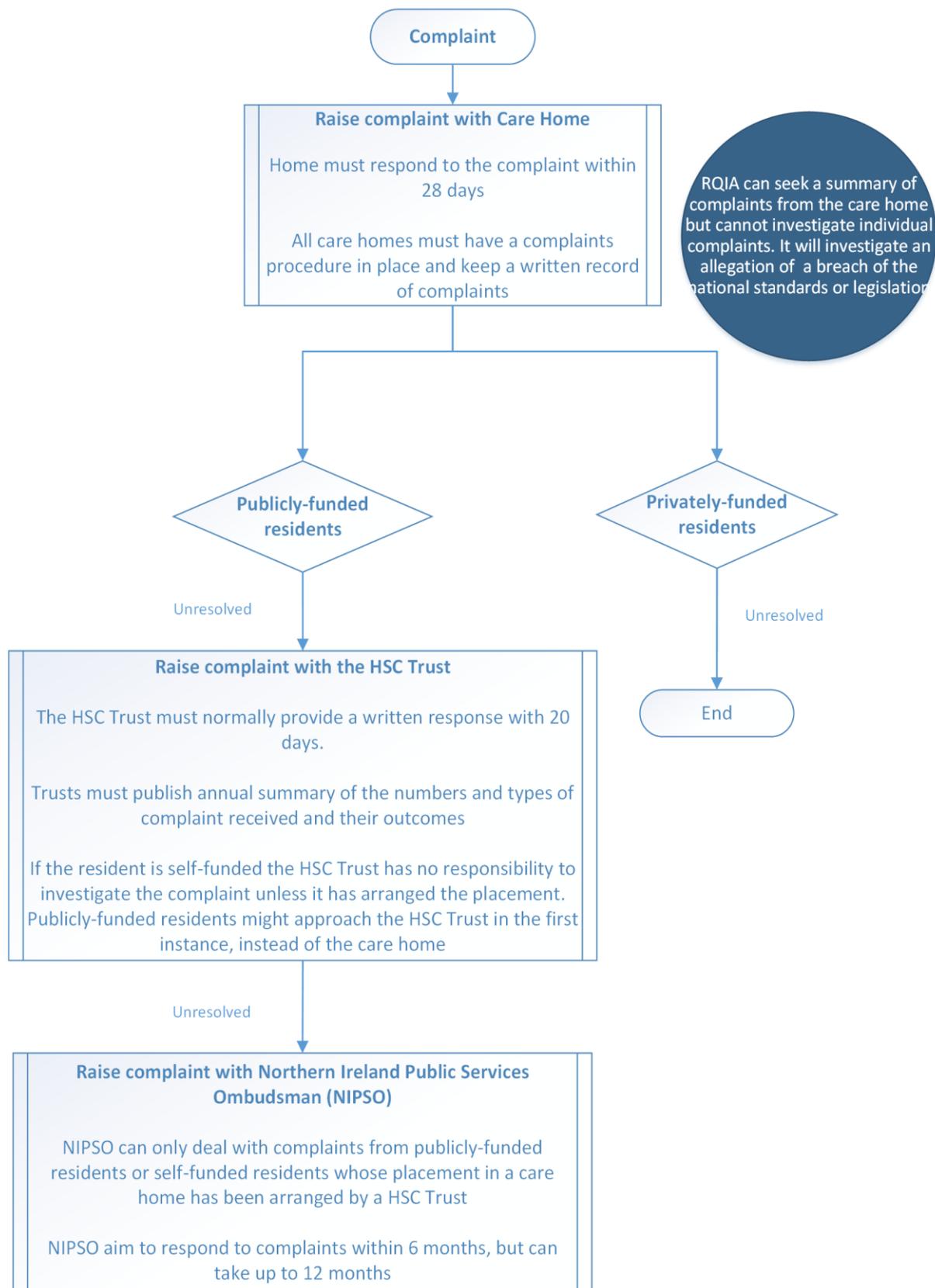


CSSIW can seek a summary of complaints from the care home but cannot investigate individual complaints

CSSIW has a procedure whereby it will share details with PSOW about a particular service or care home when requested to do so

The Older People's Commissioner does not investigate individual complaints but may: assist a person to make a complaint; review the effectiveness of complaints arrangements; and issue a report and recommendations

Overview of complaints processes in Northern Ireland



Glossary

ADASS	The Association of Directors of Adult Social Services in England. A charity that aims to further the interests of people in need of social care by promoting high standards of social care services and influencing the development of social care legislation and policy.
Age UK	A charitable organisation specifically concerned with the needs and interests of older people.
Alzheimer's Society	Alzheimer's Society is a United Kingdom care and research charity for people with dementia and their carers. It operates in England, Wales and Northern Ireland, while its sister charities Alzheimer Scotland and Alzheimer's Society of Ireland cover Scotland and the Republic of Ireland respectively.
Approved Consumer Code	The Consumer Codes Approval Scheme is facilitated self-regulation organised by the Chartered Trading Standards Institute (CTSI). Approved codes of practice go above and beyond consumer law obligations and sets a higher standard, showing consumers clearly - through the right to display the CTSI approved code logo - that code members can be trusted.
Barchester Healthcare Limited	Care home provider.
Behavioural Insight Team (BIT)	The Behavioural Insights Team (BIT), which we commissioned to provide research and advice for the market study, is an organisation that applies behavioural sciences to public services. It is a social purpose company jointly owned by the UK Government, Nesta (the innovation charity) and its employees.
Citizens Advice	Citizens Advice is a network of 316 independent charities throughout the UK that give free, confidential information and advice to assist people with problems and aims to improve the policies and practices that affect people's lives.
Care Act 2014	Legislation which consolidated and reformed the framework for social care in England. It provides local authorities with general responsibilities to provide universal services to

	<p>promote wellbeing; prevent, reduce or delay care needs for individuals who need support; and to promote the integration of care and support. It also provides specific duties in relation to the provision of information and advice and market shaping.</p>
Carer	<p>A carer is anyone who voluntarily cares for a friend or family member who due to illness, disability, or mental health cannot cope without their support. This informal care is in contrast to paid care by care workers and nursing staff.</p>
Care assessment	<p>Local authorities are responsible for assessing individuals' care needs and if they have eligible needs and are eligible for local authority funding, for providing services to meet them. These services can be anything from care in the home to occasional day care or moving to a residential or nursing home. Care assessments – also called needs assessments – are free of charge for those who either need, or appear to need, care or support.</p>
Care England	<p>A representative body for providers of care services in England.</p>
Care Forum Wales	<p>A representative body for providers of care services in Wales.</p>
Care home	<p>Accommodation for persons who require personal care in a residential or nursing home (also see “provider”).</p>
Care Inspectorate	<p>The sector regulator for care services in Scotland which regulates and inspects care services in Scotland.</p>
Care package	<p>Services designed to meet an individual's assessed needs as part of the care plan arising from their assessment. Consists of one or more services, which may be residential and/or community-based. Also known as a 'package of care'. Depending on needs and financial eligibility, the care package may be funded by the NHS, local authorities, local authorities with a contribution from the person needing care or self-funded by the person needing care or their family or friends.</p>
Care plans	<p>An agreement between an individual and those who are delivering care and support to them and is designed to help</p>

	clarify what support is needed and how it should be provided. Care plans enable individuals to have a say in how they want to manage their health and personal care and ensures all health professionals and care and support workers are clear on the needs and goals of the individual.
CARE principles	The CARE principles have been developed by the CMA. These principles should apply to all digital comparison tools (DCTs) operating in any sector and reflect existing law. DCTs should treat people fairly by being Clear, Accurate, Responsible and Easy to use, in order to help DCT websites to comply with consumer law and to support consumer trust.
Care professional	Anybody involved "professionally" in the provision of health/social care and who is an employee of the agents providing care services.
Care team	The health and social care workers involved with the care of the person. This might include staff from the independent, voluntary and private sectors.
Clinical Commissioning Groups (CCGs)	Clinical Commissioning Groups in England were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services in local areas.
Chartered Trading Standards Institute (CTSI)	CTSI is a not-for-profit membership organisation to support and represent trading standards professionals in the UK and abroad.
CHC	Continuing Healthcare. Package of care that is arranged and funded solely by the NHS for individuals who are not in hospital but have been assessed as having a 'primary health need'. CHC packages are funded by the NHS.
Coalition of Care and Support Providers (CCPS)	Industry group of Scottish care providers that aims to identify, represent, promote and safeguard the interests of third sector and not-for-profit social care and support providers in Scotland, so that they can maximise the impact they have on meeting social need.

Complaints procedure	Processes that ensure that complaints about care services are dealt with effectively and within an appropriate timescale. Complaints procedures allow for effective resolution of complaints and ideally include the auditing of any comments and complaints received; categorise the reason for the failure; are open about naming the worker responsible; and encourage collective discussion and problem solving before implementing the solution. Evidence can be presented back to the team so that it can improve future practice. Procedures should include escalation where resolution has not been possible.
Commissioners for Older People	Statutory bodies established in Wales and Northern Ireland. The Commissioner is able to take actions to ensure that the interests of older people are safeguarded and promoted
COSLA	The Convention of Scottish Local Authorities is the voice of Local Government in Scotland. It provides political leadership on national issues, and works with councils to improve local services and strengthen local democracy.
CQC	The Care Quality Commission is the independent regulator of health and adult social care in England. It also has a duty to assess the financial sustainability of those care organisations that local authorities would find difficult to replace (see market oversight)
Citizens Advice	Citizens Advice is a network of 316 independent charities throughout the United Kingdom that give free, confidential information and advice to assist people with money, legal, consumer and other problems.
CSSIW	The Care and Social Services Inspectorate Wales, regulates and inspects adult care, childcare and social services for people in Wales.
Deferred Payment	A deferred payment agreement is an arrangement with the council that enables people to use the value of their homes to help pay care home costs
Dementia Adviser	A Dementia Adviser provides services to people diagnosed with dementia and their families. They provide 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 Friendly Communities	This is a programme run by the Alzheimer's Society and Alzheimer Scotland. They provide training and guidance to various organisations such as businesses, the NHS and government, to help them become more accommodating to persons with dementia. Local communities can also apply for public recognition as a 'Dementia Friendly Community'.
Devolved Nations	Northern Ireland, Scotland, and Wales.
DH	Department of Health. The central government department responsible for the administration of health and social care in England. The devolved nations also have their equivalent bodies.
DHNI	Department of Health in Northern Ireland.
Domiciliary care	Care (also known as home care) provided in an individual's home, normally of a personal nature such help with dressing, washing or toileting. It can be arranged by local authority following an assessment of need, or can be arranged privately by the individual themselves, or someone acting for them. Domiciliary care is outside the scope of the market study.
Extra care housing	Housing designed with varying levels of care and support available on site. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. Extra Care often includes a restaurant or dining room, health and fitness facilities, hobby rooms and even computer rooms. Domestic support and personal care are available, usually provided by on-site staff. Properties can be rented, owned or part owned/part rented.
Family and Childcare Trust	A charity that works to make the UK a better place for families.

Financial Conduct Authority (FCA)	The Financial Conduct Authority is the conduct regulator for 56,000 financial services firms and financial markets in the UK and the prudential regulator for over 18,000 of those firms. This includes some firms offering financial advice to people needing to make decisions about social care.
FirstStop Advice	FirstStop Advice is an independent, impartial and free service offering advice and information to older people, their families and carers about housing and care options for later life. The service is provided by Elderly Accommodation Counsel (EAC) in partnership with a number of other national and local organisations.
Four Seasons Healthcare	Care home provider.
HC-One Ltd,	Care home provider.
Healthwatch England	Statutory consumer champion for health and social care in England that seeks to empower users and influence policy makers.
Health and Social Care (HSC) Board	The Health and Social Care Board is a statutory organisation that arranges or commissions health and social care services for the population of Northern Ireland.
Health and Social Care Partnership	Organisations formed in Scotland as part of the integration of services provided by health boards and local authorities.
Health and Social Care (HSC) Trust	Health and Social Care Trusts are the main commissioners of health and social care in Northern Ireland. See local authorities .
Independent Age	UK charity providing advice, guidance and campaigning to help people live independently for longer.
Integration Joint Boards (IJB)	Joint health and local authority bodies established in Scotland as a result of the Public Bodies (Joint Working) (Scotland) Act 2014 to plan and deliver care services in local areas.
Institute of Public Care (IPC)	A centre of Oxford-Brookes University that has worked with local authorities, providers and governments on market

	shaping, including the development of market position statements, and commissioning.
Ipsos MORI	Market research agency which conducted research for the market study.
Knight Frank	Private research organisation that provides residential, commercial and agricultural property reports and indices, as well as undertaking bespoke consultancy projects.
LaingBuisson	Private health and social care research organisation.
LGA	The Local Government Association (LGA) is a politically-led, cross-party organisation which works on behalf of local authorities in England to influence national government and provides practical support to local authorities.
Local authorities (LAs)	When we refer to local authorities throughout this document, this is being used as a catch all term for the relevant councils in England, Scotland and Wales that have responsibility for adult social care as well as the Health and Social Care Trusts in Northern Ireland.
Local Commissioning Group	Northern Ireland has five Local Commissioning Groups (LCGs) – the Belfast; Northern; South Eastern; Southern and Western Local Commissioning Group. Each LCG is responsible for the commissioning of health and social care by addressing the needs of their local population
LGSCO	Local Government and Social Care Ombudsman.
Local authority/NHS funded residents	Residents in receipt of local authority/NHS funding because they meet eligibility criteria for needs. NHS funding for people with acute medical care needs can be wholly funded through Continuing Health Care (CHC) or a contribution to nursing costs through Funded Nursing Care (FNC) depending on needs. Local authority funding is dependent on a financial assessment with people expected to contribute to their own care costs depending on their assets and income.
Local Health Boards	Created in 2009, seven Local Health Boards now plan, secure and deliver healthcare services in their areas,

<p>Market oversight</p>	<p>Local authorities have duties to ensure that no-one goes without care if their care provider ceases to trade, either out of business failure or voluntary exits.</p> <p>A few care homes do fail each year. Local authorities manage any relocations or keep a watch during the transfer of the failed care home to new owners to ensure continuity of care.</p> <p>Market oversight is a process of assessing the threat to such financial failures, in advance, so that local authorities can implement their contingency plans for any interventions needed. The Care Act 2014 placed duties on the CQC to oversee the financial performance of the largest and most difficult to replace providers in England and to alert local authorities where a failure that would see services cease was imminently likely.</p>
<p>Market position statement</p>	<p>A Market Position Statement (MPS) is a strategic document published by a local authority or other commissioner of services that describes policy and likely changes in demand in an area and helps to encourage the local market of providers to adapt to future needs. It should cover the whole market, including that for self-funders, as well as services which the commissioner will be buying. It is an important part of Market Shaping.</p>
<p>Market shaping</p>	<p>Market shaping is the process where commissioners seek to influence their local market of care providers to encourage an effective pool of quality providers that can meet local demand, now and in the future. The Care Act placed duties on local authorities in England to undertake market shaping and suggested this is best achieved by articulating strategic commissioning policy through a Market Position Statement (MPS).</p>
<p>National Audit Office (NAO)</p>	<p>The National Audit Office (NAO) scrutinizes public spending for Parliament. Its public audit perspective helps Parliament hold government to account and improve public services. NAO periodically reviews and publishes recommendations to improve public services.</p>

National Commissioning Board	A body in Wales that promotes best practice in commissioning and procurement for health and social care with membership from local authorities, Health Boards, providers, the Welsh Government and the CSSIW
National Care Home Contract (NCHC)	National Care Home Contract (NCHC), agreed between the Confederation 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
National markets hub	Web based information on Gov.UK web site that makes available known data and projections, showcases guidance and advice on market issues, and gives local authority examples of best practice.
NHS	When we refer to NHS throughout this document, this is being used as a catch all term for the relevant councils in England, Scotland and Wales that have responsibility for adult social care as well as the Health and Social Care Trusts in Northern Ireland.
NHS Choices	NHS Choices (www.nhs.uk) is the official website of the National Health Service in England. It is the UK's biggest health website accounting for a quarter of all health-related web traffic. It contains information and advice about the social care system including about individual care homes.
NHS Commissioning Board	NHS Commissioning Board is an independent body with executive powers and exceptional responsibilities, established in 2012.
NIPSO	Northern Ireland Public Services Ombudsman.
Nursing care	Care given to those who have been assessed as requiring care to be delivered by a qualified nurse. Nursing care homes, like residential homes, will offer support, accommodation and meals, but in addition will have the specialist expertise on hand to provide dedicated nursing support and care.
Nursing home	Registered residential care home providing nursing care.

Office for National Statistics (ONS)	ONS is the UK's largest independent producer of official statistics and its recognised national statistical institute. It is responsible for collecting and publishing statistics related to the economy, population and society at national, regional and local levels. It also conducts the census in England and Wales every 10 years.
Older people	People over 65 years.
Personal care	The provision of help with basic tasks such as washing, feeding and dressing for people who, by reason of old age, illness or disability are unable to carry out such tasks unaided.
Personal Budget	In England the Care Act 2014 provides that LAs must provide people who are eligible for LA-funding a Personal Budget. This is the amount the LA calculates as needed to meet a person's eligible needs,
Private funder	In Northern Ireland, a private funder is someone who arranges and pays for their own care under a private contract, with no involvement of an HSC trust
Provider	A company or corporate group operating and owning one or more care homes.
PSSRU	The Personal and Social Services Research Unit (PSSRU). A joint endeavour between the University of Kent, University of Manchester and the London School of Economics, PSSRU carries out policy analysis, research and consultancy on social care and related issues.
Publicly funded	Individuals who are funded by a local authority, NHS or Health and Social Care Trust. Most people eligible for local authority funding will be expected to make some contribution to their care costs depending on their assets and income
Quality Matters	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.
RQIA	The Regulation and Quality Improvement Authority is the independent body responsible for monitoring and inspecting

	the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.
Remedies Programme Working Group	We are recommending that a Remedies Programme Working Group (the RPWG) be convened to support and assist cooperation between different individuals and organisations with an interest in improving experiences of people when planning and entering care homes.
Representatives	Friends or family members involved in the decision to find a care home or who may also become involved with continuing decisions, eg raising complaints.
Research Works	Market research agency which conducted research for the market study.
Resident	Person living in a care or nursing home.
Residential care home	Residential care homes provide accommodation, meals and assistance with personal care for people requiring either short term breaks or long term care. Unlike nursing homes, residential care homes do not always employ nurses or other medical staff qualified to deal with complex medical needs.
Respite care	Respite care, (also known as short break or short-term care) is designed to provide support and the occasional break for carers. This may involve individuals using a day care centre to enable their carers a few hours to themselves, or a move into a residential home for a short period of time while carers are on holiday or in need of a longer break.
Scottish Care	Scottish Care is a membership organisation and the representative body for independent social care providers in Scotland.
Scotland Excel	Scotland Excel is the Centre of Procurement Expertise for the local government sector.
Sectoral regulators	The sectoral regulators are the Care Quality Commission (CQC) in England; the Regulation and Quality Improvement Authority in Northern Ireland (RQIA); the Care Inspectorate

	in Scotland; and the Care and Social Services Inspectorate Wales (CSSIW).
Self-funders	People who do not receive local authority or NHS public funding for their care home place and pay from their own income or other resources. See also Part-funders . Most people eligible for local authority funding will be expected to make some contribution to their care costs depending on their assets and income.
Skills for Care	Skills for Care is the employer-led leadership and workforce development body for adult social care in England. It provides practical tools and support to help adult social care organisations in England recruit, develop and lead their workforce, and became the home of the National Skills Academy for Social Care in 2014.
Sheltered housing	See Extra-care housing
Social workers	Professionally qualified social workers support a range of people with challenges and needs, including older people needing care. Social workers for adult social care are employed by the NHS and local authorities and may be involved in assessments, creating care packages, placing people in care homes and monitoring their continuing health and wellbeing. They work alongside medical and other care managers.
SPSO	Scottish Public Services Ombudsman.
Top-up fee	Where someone is funded by a local authority for residential care because of their low income or assets, a friend or family member (a third party) may offer to pay an additional fee (a top-up) to provide the person with superior accommodation or services (eg better room or leisure facilities) either in the same care home that the authority would have placed them or a different care home. The Care Act 2014 makes such top-ups an option for all local authority funded people in England. Top ups must be optional.
Trading Standards	A statutory function based in local authorities that protects consumers, works with and advises businesses, and takes action to enforce aspects of consumer law.

Welsh Local Government Association (WLGA)	The WLGA is a politically led cross party organisation that seeks to give local government a strong voice at a national level.
Which?	Which? is a not-for-profit charitable organisation that seeks to make things better for consumers. It includes the Consumers' Association (a registered charity) that sits at the top of the Which? Group and is responsible for Which? campaigns, policy and the majority of its research.

Endnote

ⁱ This sentence in Appendix E, paragraph 71 originally read: 'Around 50,000 nursing home residents in England are eligible for FNC, which is set at a national standard rate and is currently about £155 per week per resident' and was corrected on 14 December 2017.