Title:
Consultation on oversight of social care markets
IA No: 7056

Lead department or agency:
Department of Health

Other departments or agencies:
Other Departments: Cabinet Office, Department of Communities and Local Government, Department of Business, Innovation and Skills, HM Treasury
Agencies: Care Quality Commission, Monitor

Impact Assessment (IA)

Date: 14/08/2012

Stage: Consultation

Source of intervention: Domestic

Type of measure: Other

Summary: Intervention and Options

RPC Opinion: Awaiting Scrutiny

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£m	£m	£m	Yes	NA

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

Recent events, including the financial distress of Southern Cross (the then largest provider of residential care in the UK) and recommendations from the Public Accounts Committee, have highlighted the need for the Government to review whether current mechanisms to oversee the social care market are sufficient to protect the welfare of service users, and whether additional measures are necessary to support service continuity in cases where a provider of care services fails or chooses to exit the market.
We are considering which options are most effective and where the burdens of any market continuity system could and should fall. To note social care is devolved and this Impact Assessment (IA) relates to England only.

What are the policy objectives and the intended effects?

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

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

This IA sets out the analysis which underpins a consultation on the future direction of travel. In the consultation we outline the proposal which we believe is most proportionate, effective and fair. The IA includes the range of measures we have considered, in many cases these have been dismissed either because i) we feel it is inappropriate for the cost to fall to smaller providers when the risk lies with larger players in the sector or ii) we do not believe the measures are sufficiently robust to offer the public the guarantees they need that their care services will continue in the event of failure.
The 5 options explored in this IA are 1) do nothing 2) sector-led regulation 3) contract clauses 4) targeted regulation 5) special administration regime.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** Month/2012

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** Yes/No	**Small** Yes/No	**Medium** Yes/No	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY: ..... Date: .....

Summary: Analysis & Evidence

Policy Option 1

Description: 1) DO NOTHING FURTHER - CONTINUE WITH THE 'SOUTHERN CROSS APPROACH'

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:**

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

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

The status quo implies if a situation similar to Southern Cross occurred, there may be some costs to the government from having to address the disorderly closure of a company, for example there is a risk of exposure to the cost of moving care users to alternative service provision.

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

Under the current system there is a lack of clarity about the roles and responsibilities of different parties and the protections for care users. Care users are vulnerable people and the closure or change in ownership of their care service can cause significant anxiety and distress. If this is poorly managed, this can cause a deterioration in health and well-being and in extreme cases, death.

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

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

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

Key assumptions/sensitivities/risks **Discount rate (%)**

The do nothing option presents significant risks to users and to the public purse should a future large-scale provider failure occur, where a smooth transition can not be agreed upon.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs:	**Benefits:**	**Net:**	No	NA

Summary: Analysis & Evidence

Policy Option 2

Description: 2) SECTOR-LED REGULATION

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	**Time Period Years**	**Net Benefit (Present Value (PV)) (£m)**		
			Low: Optional	**High:** Optional	**Best Estimate:**

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

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

Relative to the 'Do nothing' option, costs would fall on the providers who choose to be part of the self-regulation schemes (or are required to be i.e. OFT model). This option would place a cost burden on smaller providers and may not offer consistent or high level guarantees to user. If a flat fee were used for all providers, SMEs would face a proportionately higher burden of cost, given risk levels.

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

Providers may find their brand name affected as a result of being part of or not part of a self-regulation scheme. Care users receiving care services not covered by the scheme would still face uncertainty and anxiety in the event of failure.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low				
High				
Best Estimate				

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

There will be benefits for those users who are protected as a result of providers choosing to voluntarily join a regulation scheme, if the scheme is effective.

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

The government's aim is to reduce burdens on business arising through regulation and a voluntary scheme would enable the sector to design an approach that they believed was proportionate and effective.

Key assumptions/sensitivities/risks **Discount rate (%)**

All assumptions stated are pending consultation and may need to be significantly revised based on evidence from stakeholders. However we assume that a self-regulatory approach would not give consumers the protection they need and could place unnecessary burdens on SMEs (consumers may not understand a targeted voluntary approach forcing it to be sector-wide for credibility). The key risk is that there would be no guarantees that the eventual outcome would differ from the 'Do nothing' option.

BUSINESS ASSESSMENT (Option 2)

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

Summary: Analysis & Evidence

Policy Option 3

Description: 3) CONTRACTUAL CLAUSES IN LA CONTRACTS

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:**

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

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

Costs fall to providers from complying with the contract clause requirement. Costs would apply to all providers, excluding those who provide services for self-funders only. If local clause variation were permitted, the costs could be higher for providers serving many local areas. Additional costs to providers are likely to be passed on to commissioners through fee increases. Self-funders (40% of all care home users) face no additional costs.

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

Since this would only cover LA funded residents, there may be anxiety and lack of understanding amongst private funders about protection levels offered by a provider.

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

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

Users who are funded by local authorities would receive additional protection with regards service continuity. LAs would benefit from sharing some of the risk with providers.

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

Key assumptions/sensitivities/risks **Discount rate (%)**

Assumptions are that this protection could only be extended to those who receive local authority funded care and NHS-funded care (totalling 60% of care home users). Market trends suggest the proportion of self-funders will continue to increase. Furthermore, if the pilots testing the extension of direct payments to residential care are successful such mechanisms may not apply to those arrangements. It is therefore unlikely this solution would protect the welfare of service users.

BUSINESS ASSESSMENT (Option 3)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs:	**Benefits:**	**Net:**	No	NA

Summary: Analysis & Evidence

Policy Option 4

Description: 4) TARGETED REGULATION

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	**Time Period Years**	**Net Benefit (Present Value (PV)) (£m)**		
			Low: Optional	**High:** Optional	**Best Estimate:**

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

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

The costs would fall upon all providers covered by the regulation e.g. larger provilders, some specialist providers. Costs would arise from meeting financial monitoring requirments and if necessary, preparing continuity plans. Costs fall to government in establishing the regulatory function to oversee the arrangements. Also it is likely that costs would be passed on to commi ssioners and self-funder through increased fee rates. This is our preferred option and is in the scope of One-in-One-Out.

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

Regulation may impact the terms on which providers are able to raise finance.
The impact of increased costs to providers may be felt by private funders who may see their fee rates rise.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low				
High				
Best Estimate				

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

Care users receiving care from a provider that spans multiple authority areas is reassured that their care needs will continue to be met and the transition process to an alternative provider will be well-managed.

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

There may be some benefits for providers and creditors from better planning for times of distress which should help minimise risks and avoidable failures.

Key assumptions/sensitivities/risks **Discount rate (%)**

All assumptions stated are pending consultation and may need to be significantly revised based on evidence from stakeholders. The consultation process will test all assumptions and risks including: how to set the threshold for organisations covered by this regime; what enforcement powers a regulator would need; what information a regulator would need to assess risk ;and what the costs to providers would be of compliance with such a regime.

BUSINESS ASSESSMENT (Option 4)

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

Summary: Analysis & Evidence

Policy Option 5

Description: 5) SPECIAL ADMINISTRATION REGIME

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	**Time Period Years**	**Net Benefit (Present Value (PV)) (£m)**		
			Low: Optional	**High:** Optional	**Best Estimate:**

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

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

Relative to the 'Do nothing' option, government will face costs from setting up a special administration regime (SAR), the magnitude of which is yet to be estimated depending on the providers in scope. In some SARs a levy may be charged to the market which would increase costs to providers participating in the scheme, which could be passed on to end users. As this system would de-prioritse the rights of creditors, there may be some knock-on costs, for example increased cost of capital.

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

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low				
High				
Best Estimate				

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

The benefits of a special administration regime would be to protect care users in the event of the provider going into administration. As in the case of Option 4, this will ensure that users most at risk will be protected; however this comes with a much higher cost.

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

Reassurance and peace of mind for care users that their interests would be protected on a formal, legal footing via insolvency law, although this does not negate possible negative impacts on health and well-being if transition were poorly managed.

Key assumptions/sensitivities/risks **Discount rate (%)**

This option offers greater protection for users but at a higher cost.

BUSINESS ASSESSMENT (Option 5)

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

Evidence Base (for summary sheets)

A: Policy context / Background

1. This Impact Assessment accompanies the Government's consultation on market oversight in social care, providing further detail of the Government's analysis. It is our intention that the IA and consultation document are read in conjunction with each other.

2. In the Social Care White Paper, *Caring for our future; reforming care and support*[1] the Government committed to consult on the issue of market oversight. The Government believes there is a need to review whether current mechanisms to oversee the social care market are sufficient, and whether additional measures are necessary to support service continuity in cases where a provider of care services fails or chooses to exit the market.

3. The Impact Assessment (IA) sets out the five options considered as part of this consultation: 1) do nothing 2) sector-led self- regulation 3) use of specialist clauses in public sector contracts 4) targeted regulation 5) special administration regime.

4. The consultation document sets out the recommended direction of travel. The recommended approach is option 4; targeted regulation. We believe option 4 offers the best combination of greatest benefits to care users with the lowest cost burden on social care providers.

5. A summary of the indicative relative costs and benefits of options 2 to 5, in qualitative terms relative to option 1, are set out below. We will gather evidence through the consultation to identify and assess the costs, benefits and other impacts of the recommended approach.

		Individuals paying for care (self-funders)	Small and medium providers	Large providers	Taxpayers (Council fees and central government costs)	Total		Care Users (self-funders and council funded people)
Option 1 do nothing	**COSTS**	-	-	-	-	-	**BENEFITS**	-
Option 2 sector-led regulation		1	4	3	1	9		2
Option 3 contract clauses		2	3	4	2	11		1
Option 4 targeted regulation		1	1	4	2	8		3
Option 5 special administration regime		1	1	4	4	10		4

Key	Costs & Benefits*
	Substantially Higher 4
	Moderately Higher 3
	Slightly 2
	Marginally 1
	No cost -

** Please note the best option will have a high score for benefits and a low score for costs*

		Preferred option

6. To note, social care is a devolved policy issue and therefore both documents relate to social care in England only.

[1] *http://caringforourfuture.dh.gov.uk*

The Social Care Market

7. Social care has been operating as a market in England for over twenty years. The 1980s saw the start of the growth in private provision, with the Community Care Reforms of the 1990s providing a major stimulus for growth. Throughout this time, local authorities have continued to be responsible for ensuring that the care needs of their local populations are met.

8. Today, the vast majority of provision is from the private and voluntary sectors. The proportion of services supplied by councils has fallen greatly over the last 15 to 20 years and they now provide less than 10% of residential care places for older people and around only 16% of home care. Furthermore, the vast majority of providers are small businesses; 43% of care home places are provided by operators with fewer than three homes whilst 60% of the 7,145 registered domiciliary care agencies are single agency businesses[2].

9. There are a range of different financial and business models operating within the sector, with providers of all different sizes and purposes. There is significant for-profit activity in this sector, and the corporate providers are often backed by a larger investment group, such as Saga (backed by Acromas) and Four Seasons (backed by Terra Firma). We also know that there are some providers who are highly leveraged and with highly complex capital structures. However, the not-for profit sector also provides a significant proportion of care, and there are a variety of different models of provision – including social enterprises, charitable provision, micro-enterprises, and mutuals – operating within the sector. The Government is keen to encourage this diversity[3]. Of course, the majority of care provision is not from formal services but by unpaid carers, mainly spouses/partners, adult children and other close family. Around 5 million people in England provide such unpaid care.

Policy Framework

10. The Department of Health sets the strategic policy framework for adult social care, working with local government as partners, to provide overall direction and national objectives for adult social care. Delivery is the responsibility of local authorities, in line with their own locally determined priorities. Local authorities can also be a source of advice to support people purchasing their own care; 40% of all those in residential care are now self-funders. The Government has recently published an accountability statement for social care, which outlines this approach in more detail[4].

Market Oversight

11. Recent events, including Southern Cross falling into financial difficulties highlighted the need for the Government to review whether or not current mechanisms to oversee the social care market are sufficient, and whether additional measures are necessary to support service continuity for vulnerable people, in cases where a provider of care services fails or chooses to exit the market:

    – Southern Cross demonstrated that there are specific challenges associated with monitoring and managing failure of very large providers, operating across many geographical boundaries and where there may be highly complex financial structures, which present risks to continuity of service.

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

[3] The Government has set out its aspirations to encourage a range of different models, including mutual models, in the Open Public Services White Paper, July 2011. See: http://files.openpublicservices.cabinetoffice.gov.uk/OpenPublicServices-WhitePaper.pdf

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

- The National Audit Office (NAO) in their report *Oversight of user choice and provider competition in care markets*[5] highlighted that there are no formal arrangements for monitoring, and if necessary intervening in, markets that cross local authority boundaries. The NAO also said that the recent financial problems faced by Southern Cross illustrated the need for Government to develop a system to address serious provider failure.
- Last year, the Government published its *Open Public Service* White Paper[6]. The White Paper included a commitment for departments to develop continuity regimes in cases where a provider exits the market. The Government is clear that should a provider exit, it is not acceptable simply to allow services to cease abruptly or for services to be of a poor quality, because it will be ordinary people who feel the impact of that failure. The White Paper stated that if providers of public services are unable to meet minimum standards "*it is essential that the state identifies these providers and intervenes quickly in order to ensure continuity of service*".

12. Despite the collaboration, which successfully managed the Southern Cross exit arrangements, the circumstances demonstrated the need for earlier awareness of financial risk, mechanisms for intervention if required and clear processes to manage exit and achieve continuity of care during transition. The Government is therefore reviewing its approach to oversight of the social care market.

Engagement

13. As part of the engagement exercise on future reform of care and support in England, the Department published a discussion paper analysing the issue of market oversight and inviting responses.[7] We spoke to key stakeholders including the providers and their trade bodies, banks and professional services firms, local authorities, the devolved administrations, and academics. We received 21 formal responses to the paper, and other organisations and individuals commented on this issue as part of the wider engagement exercise (there were 565 responses to the engagement exercise[8]). Below we provide a summary of the key themes that emerged from the engagement.

Summary of Feedback *to 'Oversight of the Care Market'* and the 'Caring for our Future' Engagement Exercise

All responses voiced concern over the collapse of Southern Cross and the impact that provider failure could have on residents' health and wellbeing. There was widespread agreement that the protection of care users should be the principal concern in such situations – especially as providers are providing both care and accommodation. Many commented on the need for all those reliant on services from an independent provider to be protected appropriately, whatever the size of the provider. Some commented that those with high-level needs who relied on domiciliary care should be given similar reassurance.

We also heard from many that any new measures in this area should take into account the need to continue to encourage private investment into social care and promote a greater diversity of services. Some felt that any measures that weakened the investment proposition risked undermining the wider sustainability of the care and support system. A small number of respondents questioned the role of private equity in the market, believing that this had led to a focus on short-term gains and irresponsible lending decisions –

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

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

[7] *Oversight of the Social Care Market*, Department of Health, October 2011

[8] A full independent analysis of the Caring for Our Future Engagement by Ipsos Mori can be found at www.caringforourfuture.gsi.gov.uk.

incompatible with long-term stability and a focus on the needs of individuals. However, there was widespread acknowledgement that a market operated in social care and that the Government's policy was for this market to continue.

Some providers and professional advisors argued that the successful resolution of the Southern Cross situation, illustrated that the market could cope with such failures successfully. It was also noted that social care had a diverse market with many thousands of providers, which was a powerful way to ensure service continuity. However, others thought that greater regulation and Government intervention was required to protect service users.

On further regulation, some believed that appropriate regulation could bring greater stability and improve the sector's reputation, but said it must be implemented in a proportionate and fair way. Others stated that the sector might be unable to sustain the increased costs and burdens often associated with regulation. A number requested greater clarity over CQC's remit in this area, most notably over the regulator's role in assessing whether a provider had the financial resources to meet its obligations. Many also commented on the likely correlation between quality and financial indicators.

From the wider engagement on markets as part of **'*Caring for Our Future*'**, a common view emerged that local authorities needed to better understand their local market, identify risks to provision and commission in a more strategic and sustainable way. Some, however, raised the issue of whether it was realistic for local authorities always to manage the market effectively, given the size and complexity of some providers. Linked to this were comments about the role of local authorities in purchasing care and fee levels. The Devolved Administrations also raised the issue that that the larger providers operated across the UK and that there were benefits in a co-ordinated response.

B: Analytical narrative

14. The need to support continuity of service is a feature of many markets where there are limited alternative providers or where the loss of the service, even temporarily, can cause a significant reduction in consumers' welfare. For example, the utility sector in the UK (water, electricity, gas) has a continuity of service requirement on the network provider wherever it is a natural monopoly. In addition, retail providers of the same service can be required to act as the provider of the last resort, if one retail company were to fail; for example, the gas and electricity regulator requires that one retail service provider acts quickly to address the needs of the consumers of the failing provider. Implicit in these continuity of service provisions, is the argument that the loss of the service, even temporarily, can cause significant reduction to consumer welfare because the services are considered as essential for carrying out normal activities.

15. Service provision in social care, by its very nature, addresses the needs of people with high levels of need. Social care supports people of all ages with certain physical, cognitive or age-related conditions. Those with a high level of needs and their families, rely on the provider for ensuring their overall health, safety, dignity and well-being. Should the provider close or fail, these individuals and families may not be in a position to be able to find alternative service provision at short notice. However, it is essential that they continue to receive the services to meet their needs.

16. Any intervention needs to be targeted where the greatest risk is posed to care users if a provider exits the market. In the consultation document, we argue that a full risk

assessment would be needed based on key principles to ensure that any intervention is future-proof.

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

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

A) The rationale for preserving service continuity

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

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

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

21. The collapse of Southern Cross raised the prospect of such a risk to individuals' health and well-being. Although in the end, this overall risk was limited only to the closure of one care home in England, during the uncertain period when the company entered administration, some residents, families and cares were caused a great deal of anxiety. The potential for similar risks and potentially of higher magnitude from other providers, remains a concern.

22. The Department of Health ran an engagement exercise on this issue in 2011, and a number of responses highlighted that people could find themselves in a vulnerable situation, should their provider fail and therefore steps needed to be in place to preserve service continuity.[11]

23. There is currently little available evidence on how well provider exit is managed across the country. Through '*Caring for Our Future'* stakeholder engagement, the Government heard that practice might not be consistent or uniform across the country. The evidence suggests that if a move to a new residential care home is managed well, the risks to health and well-being can be effectively mitigated; and indeed, in some cases if a move

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

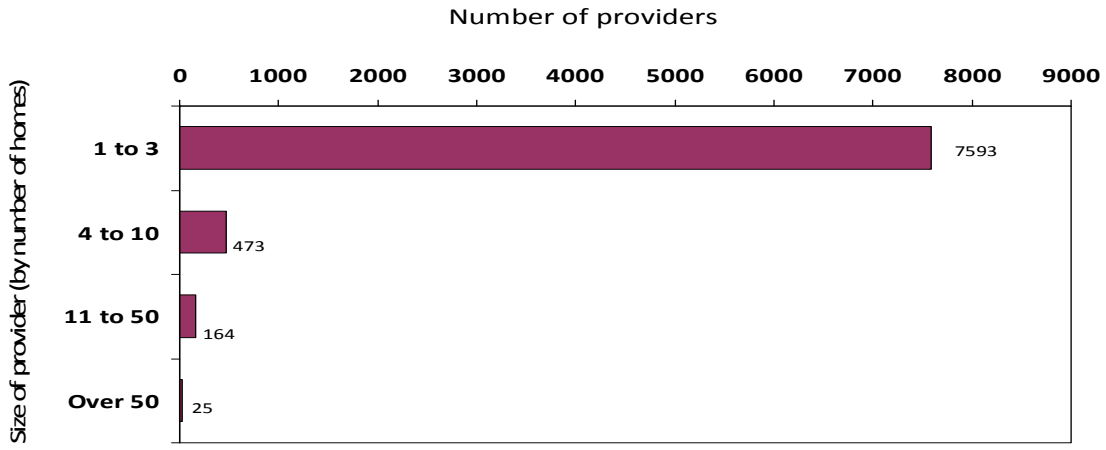
[10] Evidence from the Health Services Management Centre at the University of Birmingham has found adopting good practice limits potential negative impacts on individuals' health and well-being and, for some people, may give slight improvement in outcomes. See: *Achieving closure: Good practice in supporting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

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

leads to improved quality, outcomes can improve. SCIE have published best practice guidance on how to manage the closure of a care home.[12]

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

24. Continuity of care is important regardless of the type of service provision. The data below refers to the care home sector only and is used for illustrative purposes. While the smaller care home operators could span more than one local authority boundary, the vast majority are likely to be operating in very limited geographical areas.



25. Our assessment is that within these local markets, there is generally adequate competition[13] as evidenced by the fact that there has been market entry and exit at the local level for 20 years, without it being necessary for central government to become involved. Evidence shows that the year to April 2011, 114 homes closed (representing a 20 year low in closures) with 182 homes closing the year before. 133 new care homes were registered in the year to April 2011, with 145 new registrations the year before.[14]

26. Given the number of providers and the level of competition in care homes, we believe it is reasonable to argue that there is no significant market failure at the local level, at the current time. The impact of closure of a small provider can be satisfactorily handled at the local level and the well-being of its users adequately protected, without any need for new measures.

Continuity of care at the local level

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

28. We believe it would be too great a burden on business and would not be proportionate, if we were to assess the financial health of these smaller organisations at a national or local level – especially as we want to reduce barriers to market entry and actively

[12] http://www.scie.org.uk/news/mediareleases/2011/080911.asp)

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

[14] Laing & Buisson, Care of Elderly People UK Market Survey 2011

encourage new, innovative providers of care such as micro-enterprises, mutuals and social enterprises.

29. In order for this to continue to be the case, our view is that;
    - commissioners will need to promote diversity and have regard to the importance of market sustainability, particularly through commissioning practices. For example, there could be significant risks, if a single provider develops a dominant position within any local market
    - commissioners and providers have the information to facilitate an effective solution e.g. up to date data on alternative providers and services. If sufficient information is not available, it could become a barrier to ensuring effective service continuity. This points to the need for local market intelligence and relationships to be fit for purpose.

30. Notwithstanding the argument that plurality within the market should act as a powerful safeguard, we do know that if any provider exit is managed badly at a local level, there is a risk that there may be a negative impact on the health and well-being of those individuals affected. However, this process is within the control of the local authority and provider, who can ensure that effective systems are in place and that best practice in cases of any home closures is followed.

31. The Government's draft *Care and Support Bill* is looking to strengthen and clarify local authority duties with regard to the market; more detail is provided in the consultation document.[15]

32. Specialist services may not face the same level of competition as care services for frail older people. Were there to be financial failure of such a provider and disorderly closure, the analysis could be similar to that for a national or regional provider, even if the provider was local.

C) Issues relating to continuity of care arising from larger regional and national provider exit

33. We classify these providers as those with a significant national or sub-national coverage, of a level that would pose significant information and coordination challenges, should they fail. Such instances present risks to ensuring continuity of care.

34. Where a provider operates across a number of local authorities. it is unclear who has complete oversight of that provider's operations – both in terms of the risks to continuity of service and co-ordination should something go wrong. Managing the transfer or closure becomes increasingly difficult when there are many thousands of residents and a high number of stakeholders and authorities involved. Evidence suggests that the sector is likely to see further consolidation over time, meaning provision could become more concentrated in the future and we may see a greater number of larger providers across residential, domiciliary and specialised care and housing services.

35. There may also be risks to continuity of care associated with those providers that have high market concentrations at a regional level or offer dominant care that is highly specialist. The nature of the social care market suggests that local and regional concentrations are just as important as national patterns of provision. Indeed, the recent NAO report highlighted that Southern Cross as a large national care home provider had 9% of the market nationally, but a much greater share in certain regional areas.[16] In parts

[15] Draft Care and Support Bill, clause 3, available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134740.pdf

[16] *Oversight of user choice and competition,* NAO, September 2011, p30.

of the North East, Southern Cross accounted for some 30% of care home places. We know that this may be a particular issue for some specialist services. To note, the Office for Fair Trading consider a range of indicators when assessing market dominance (including market share, the ability to raise prices, barriers to entry) and these all need to be analysed to assess the extent of market power.

36. We are also seeing increasingly complex operating and financial business models emerging in the care and support sector, particularly in residential care, which can make it harder to assess financial viability and be difficult to untangle quickly in distressed circumstances. For example, investors in social care companies can have a wide-ranging portfolio of diverse business interests. We are aware that many providers are carrying substantial debt, which are often structured in complex arrangements and the subject of covenant restrictions. Some of these debts will need to be refinanced over the next few years and, given the current circumstances in the wider economy, this will be challenging. We also know that the care market has close, and complex interactions with other markets, such as the property and financial markets; and we understand that there is appetite from providers to offer services spanning both health and care, and housing and care. Where there are a number of different branches or subsidiaries to a company, there is a risk that problems in a different part of the business could affect their social care provision.

37. Our analysis of the situation for larger players operating nationally or regionally is different to smaller providers. Here, we believe there is a case for a different approach, as the market (which includes commissioners and providers) may not be able to deliver an effective solution on its own. If an organisation providing care to many hundreds or thousands of vulnerable people were to run into financial distress and risk of sudden failure, making arrangements for continuity of care for such large numbers of users, would require a substantial degree of coordination between many councils and potentially many alternative providers. It would be challenging for this to be conducted effectively by individual councils. This is evidenced by the need for central government coordination and information sharing activities during the difficulties with Southern Cross. Moreover, news of the financial distress and risk of failure of such a large provider would cause anxiety and potential significant welfare loss to large numbers of users and their families, even if a solution was subsequently found.

Residential Care

38. In residential care the ten largest providers account for 20% of the UK care home market, by places. The top twenty providers account for 28% of the market, by places. On this basis, Four Seasons and Bupa both have almost a 5% market share, with both having over 20,000 beds. Barchester and HC-One both have around a 3% market share and around 12,000 beds. Care UK has a 1% share, with around 5,000 beds.[17]

[17] Laing & Buisson, Care of Elderly People UK Market Survey 2011/12

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

Home Care

39. In home care, there is a multiplicity of small providers, and fewer, larger providers with SAGA the biggest, following its purchase of Allied and Nestor Healthcare. There were 5,400 registered homecare businesses in England at mid-2011 (including 675 in the public sector). The estimated total market size in 2010-11 is £5.7bn (annual turnover) and the top 10 operators account for 16.5% of the market (by annual turnover). The CQC approves around 500 new domiciliary care agencies in England each year.[18]

40. The Government recognises that there are risks to the individual should a home care provider fail – and these need to be properly assessed and addressed by both providers and commissioners. However, the majority of home care providers are much smaller operations and local authorities are best placed to manage their local entry and exit (as explained above). In considering the risks to continuity of care for individuals if a larger home care service provider exited the market we made the following observations (to be tested through consultation);
    - in the home care sector, users are in their own homes.
    - the core cost component in providing continuity care would be the home care staff themselves. An alternative provider could employ such staff on the same terms or an individual could do so themselves, relatively quickly.
    - there is neither physical infrastructure nor accompanying debt conditions.

Specialist Housing (Housing with Care)

41. There are also a range of models of care and retirement housing, such as extra-care housing. Specialised Housing is a growing sector, however accurate data on size is hampered by multiple definitions and differing methodologies. The Elderly

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

Accommodation Counsel (EAC) data[19] suggests there are 821 extra care housing schemes in England although the Care Quality Commission reports there are 564 Extra Care locations.[20]

42. In such models, the individual will own or rent the home, therefore the risks are closer to that of home care i.e. alternative care services could be quickly arranged. However, it is not clear if there would be additional complexities where homes were on a specific site such as a retirement village, which may have previously offered certain shared, centralised facilities for residents that enabled them to meet their needs for care and support. Furthermore, due to the innovative nature of this provision there is potential for gaps or overlaps, particularly in a crisis situation, where the remits of the Homes and Communities Agency, the Care Quality Commission, the relevant local authorities, the Department if Health and the Department for Communities and Local Government interact. An initial study has been commissioned by the Housing Learning & Improvement Network into lessons from the case of Southern Cross for the specialist housing sector.[21] As this is an emerging market, the Government will engage with providers and experts through the consultation to understand better the risks to users if a provider fails.

Summary

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

Options for intervention

44. In the subsequent sections, we discuss the options for further, new, intervention to ensure continuity of care in the social care market. Options considered are:
    1. Do nothing further - i.e. the Southern Cross approach
    2. Sector-led or voluntary regulation
    3. Use of Local Authority Contracts Clauses
    4. Targeted regulation (preferred option for consultation)
    5. Special Administration Regime (SAR)

45. Each option is presented and discussed below. Although it is not possible to attach costs to options prior to consultation (due to the high number of variables in each case) we have been able to set out which actors will face costs and/or benefits under each option and whether these would be marginal, slightly higher, moderately higher or substantially higher, relative to the do nothing option.

46. We will conduct further work on the costs and benefits of the leading option(s) in light of views and evidence gathered through the consultation.

[19] Statistics on Housing with Care (EAC June 2010]

[20] CQC State of Care Report 2010-2011

[21] James Berrington, 'Managing Risk: lessons from Southern Cross for the Specialist housing with care and support market' at www.housinglin.org.uk

Option 1: Do Nothing i.e. Maintain the status quo and take the approach developed in the Southern Cross case

47. In 2011, the then largest residential care provider Southern Cross, fell into financial difficulties and ultimately failed. Given the size and reach of Southern Cross, there was a high risk of coordination failure among the various commissioners who contracted with that provider.

48. Southern Cross operated c.750 care homes across the UK serving 31,000 residents. However, the impacts were not evenly spread across the country e.g. there were particular regional concentrations in North Tyneside and Sunderland where the operator accounted for some 30% of all are home places. The scale of its operations coupled with the complexity of its business and financial structure, meant that managing its closure was challenging and required close working between different parts of Government, professional advisors, investors, property owners and providers.

49. In resolving the Southern Cross situation, the Government welcomed the commitment from all parties to ensuring that the transfer of Southern Cross homes to new operators was smooth, effective and minimised the disruption to residents. In the end, almost all homes were transferred to new operators and residents did not have to move. Only one home closed in England and two homes in Scotland – all of which were unviable in the long-term.

50. Although the situation with Southern Cross was successfully managed and service continuity was assured, the case has highlighted the risks associated with the collapse of a large provider with a very complex business model, operating across the whole of the UK. We know that during this period of uncertainty, residents, families and carers, felt a great deal of anxiety.

51. Southern Cross was resolved by investors, property owners and advisors negotiating the transfer of Southern Cross's operations to other operators. The Government encouraged the business to reach the settlement, acting in the interests of commissioners and users; however formal powers to compel action by any party or to enforce delay did not exist. The Government and parties involved in this process, reached a resolution because it was clearly unacceptable for people to be left without care services; however there are no guarantees that this successful resolution would be replicated in future.

52. If a provider failed in a disorderly manner the costs involved with continuing with the status quo are unclear. Moreover, it is our view that the approach we took for Southern Cross should not be relied upon alone in the future. This is because;

- the Government does not have formal powers to compel interested parties to reach a resolution and is reliant upon goodwill. Therefore, a resolution that serves the best interests of the service user cannot be guaranteed
- the costs of facilitating such a solution could be substantially higher but the Government does not intend to support a failing private business at taxpayers' expense. The company, its directors and investors are responsible for the operation of the company and must face the consequences of their decisions
- the welfare loss in terms of anxiety to residents could be considerable and lead to a societal dis-benefit
- lenders may be unwilling to negotiate. This could lead to a quicker and more disorderly closure than was the case for Southern Cross – and this could adversely affects users
- this system is highly reactive and does not provide opportunities to proactively manage risks to avoid a disorderly failure, and

– it should not be the role of central government to intervene directly in the operation of the market; this role should be carried out by a relevant and suitable body.

53. We believe that there may be ways of addressing the risk of a disorderly closure of a large national/regional provider that are more effective. We are keen to explore proposals during the consultation process.

Option 2: Sector-led or voluntary regulation

54. Providers across all sectors form their own trade association or bodies, and are sometimes encouraged to set-up a system of industry-led regulation by government.

55. There are examples in other industries of specific self-regulatory schemes set up in case a provider fails. An example of this is the air travel industry and the ABTA/ATOL scheme, which requires all tour operators and airlines to ensure they bring back passengers who are left stranded during holiday or have booked a holiday and cannot avail of it. Although the ABTA scheme was established by government legislation, tour operators and agents have found it in their interest to be part of the scheme as it provided all holiday bookers reassurance that they would be compensated in the event of the collapse of an airline. This also helped the tour operators and agents compete on a level footing. Arguably, once such a scheme has gained a critical mass, those who are not covered are at a competitive disadvantage.

56. The potential benefits of any such sector-led scheme are;
- by definition this would be for the sector, and would need to cover all providers who wished to join
- the opportunity for provision of service delivery or dispute resolution on standardised terms
- greater transparency for care users.

57. There is a case for the social care sector to develop its own solution to the problem of continuity. We have considered some potential options for voluntary or self regulation. These include;
- self-regulatory scheme run by trade association
- OFT approved codes scheme
- transparency through the voluntary provision of financial information (regulator monitors larger providers)

58. We discuss each of these below.

<u>Self-regulation</u>

59. An appropriate trade association could set up a voluntary scheme and encourage its members to join. This could take a variety of different forms, including an ABTA/ATOL type scheme. It could also potentially cover all providers in the market if all sign up to the scheme.

60. Whilst voluntary, the Government could put an expectation on providers to sign up to the voluntary code/ scheme. Furthermore, the Government may take the view that if the voluntary scheme was not effective, a formal regulatory scheme could be put in place (e.g. via a sunrise clause).

61. However, our assessment is that there are a number of potential difficulties in establishing such a scheme, including the costs to small and medium providers, that a voluntary scheme may not offer sufficient reassurance to care users and the risk that anything that was put in place may not be effective.

62. A fuller list of concerns about the application of this model to social care is set out below;

– it would not be possible to test the scheme for robustness until a large provider(s) hits financial problems. This therefore means that there could be a situation where providers

have reassured the Government and care users that they have plans in place, but they turn out to be inadequate and fail to protect care users

- our view is that all care users, regardless of which provider they chose, should have reassurance in this area – given the potential risks to health and wellbeing. Unlike an approach targeted at the larger providers, a self-regulatory approach potentially could include all providers in an untargeted way. It therefore risks being disproportionate and imposing unnecessary costs on smaller providers.
- even if the scheme tried to target providers of larger scale, the sector could perceive such a scheme to be 'mandatory' (risk of losing business if not signed up), it is likely to lead to all providers seeking to join the scheme and incurring additional costs, that could in turn be passed to local authorities or individuals through increased prices. Although option 4 is mandatory, it would be highly targeted by Government.
- those with well-run businesses may also object to having to pay for the consequences of a poorly run company
- smaller providers may also object to having to pay for the failure of much larger businesses
- it is difficult to work out how any financial contributions to the scheme would be calculated and operated – who would contribute and how much would each contribute? The complexity of working out contributions for the members of the scheme, which may be linked to size, geographical location, type of home, risk of failure etc. can be significant and provide little incentive for providers to embark upon such a scheme
- the social care sector has no one single trade body in this area. Since trade associations primarily exist to represent the interests of their members, it could make the process of agreeing a scheme potentially lengthy and problematic, and with no guarantee that ultimately a scheme can be finalised that is acceptable to all parties. Furthermore, many providers are not covered by any association.

Office of Fair Trading (OFT) approved scheme

63. The Office of Fair Trading (OFT) operates a consumer codes scheme, which works in conjunction with trade bodies to offer greater rigour to sector-led schemes. If the protection offered meets OFT's standards, it will approve the scheme. Whilst OFT approved schemes already exist in several sectors, the numbers are however quite limited (OFT website indicates there are currently 14). The OFT also requires that all eligible members of a code sponsor's organisation sign up to the code in order to ensure a consistency of message to consumers.

64. The benefits of such a scheme would be that;

- OFT approval offers greater guarantees that the scheme would be effective
- the scheme would be enforceable and would be mandatory for certain providers based on a set of criteria
- the level of consumer protection would be better than without the OFT approval, and would be likely to include financial protection (though the exact terms would have to be negotiated as part of the scheme's development).

65. However, our assessment is that there are a number of potential negative impacts of such a scheme including the costs to small and medium providers as such a scheme would still need to operate across a significant proportion of providers. Further concerns include;

- that there is no single trade body in social care and not all care home providers are members of the same trade body.
- trade bodies might not feel able to sign up all care home providers (running into several thousands) and be unwilling and lack resources to undertake the onerous task of developing and managing such a scheme.

- current OFT schemes have run into issues and ceased (see below) which would leave care users without the benefits of the scheme.
- establishing an OFT scheme can be a very lengthy process, taking years to design and implement and not offering the same level of guarantees to care users.

66. An OFT-approved scheme with the travel industry (ABTA) ran into problems in 2006, which led to ABTA withdrawing from the OFT-approved scheme after it changed its financial protection arrangements for customers. The new arrangements reduced members' bonding costs and increased control over payment of claims, which in the OFT's view, did not protect consumers' deposits and prepayments to the same extent as the existing approved scheme. Were a similar scheme to exist for care homes and a similar disagreement to arise over 'bonding costs' with the trade body, this could leave the Government exposed and potentially having to step in at short notice in the event of a disorderly exit to prevent residents being left un-protected.

67. In addition the Government's proposals to reform consumer protection has led to the OFT's code scheme being temporarily suspended to new applicants.

<u>Transparency</u>

68. One option is for providers to agree voluntarily to publish information about their financial health. One way of encouraging this could be for providers to sign up to a transparency code that would require its members to adhere to certain commitments.

69. The argument in favour of this option is that there would be more information available to commissioners and individuals purchasing care about the provider, and hence more informed judgements could be made. The costs of compliance to business in terms of publishing financial information should not be onerous, as this should be information that the management of the business could normally be expected to use in running the business.

70. Our view is that there are a number of drawbacks to this approach;
– it would be very difficult for local authorities and the public to interpret and understand complex financial information provided by large providers with complex business models and as such, on its own, this information may not be effective at helping potential self-funders and commissioners avoid care homes that are facing potential financial difficulties.
– transparency alone would not rule out a risk of 'creative accounting', which may lead to poor understanding of the providers' financial position.
– in the light of the failure of Southern Cross and the adverse publicity that was attached to certain business models, capital structures etc, some private for profit providers might have sensitivities around exposing information about their company (such as levels of leveraging, ownership structures).

71. Our view is that transparency may be a useful part of the solution, on which we would be happy to receive views through the consultation. However, transparency measures could only reduce the likelihood of financial failure through pressure from interested parties; however it would offer no protection for care users in the event of provider failure.

Costs and Benefits

COSTS		
Individuals paying for care (self-funders)	**1**	Likelihood of marginal increases in costs of care as providers attempt to cover costs resulting from participation in the scheme. Non-monetised costs: Disillusionment if scheme was ineffective.
Small and medium providers	**4**	Costs would depend greatly on the details of a voluntary scheme. However if the scheme were robust, we would expect costs to be substantially higher for small and medium providers. In all modes of sector-led regulation, the costs would have to be met by small and medium sized providers despite the risk relating primarily to larger providers. 90% of social care providers are small or medium businesses or voluntary organisations.
Large providers	**3**	Costs are likely to be moderately higher for large providers as they fund such a scheme, although as they meet some costs of ensuring continuity of care currently, these would be slightly lower in relative terms than those facing smaller providers.
Taxpayers (Council fees and central government costs)	**1**	It is likely providers would try to pass on some costs through increased LA fee levels, however given the buying power of LAs this is likely to be a marginal increase only.
BENEFITS		
Care Users (self-funders and council funded people)	**2**	The benefits to care users of a sector-led approach to regulation would be highly variable. If the system was effective and widespread benefits could be high, however they would offer little reassurance until tried and it could be confusing for users. We do not believe it is likely the scheme would be successful due to the shape of the market and provider representation.

72. We believe that there is little likelihood in the care sector of any type of voluntary regulation emerging to deal with provider failure. This is due to the nature of the service and the shape and structure of the market (e.g. the majority of providers being very small, localised operators, but with a small number of major providers). It is also not clear that, as a non-regulatory option, the costs to business would be lower than a regulatory approach given the lack of targeting. Crucially, we regard this approach as inadequate to protect the welfare of users. For these reasons, we currently reject this approach.

Option 3: Use of Local Authority Contracts Clauses

73. The Government could work with local authorities to strengthen contractual requirements on providers. These could include specific guarantees about notice periods of closures and mandate that plans be in place to ensure quality is maintained should the provider fall into financial difficulty and fail.

Benefits

74. The benefits of such a scheme could include;

- contract clauses have more teeth than a voluntary, self-regulatory scheme
- providers would need to sign up to contracts in order to win business
- keeping market management at the local level, negating the need for central oversight.

75. However, there are a number of drawbacks that have led us to reject this approach;

- residential care is commissioned by local authorities (51%), individual consumers (41%) and the NHS (8%), so this would only offer partial protection. In particular this would not provide any protection to self-funder-only services where individuals were independently purchasing their care, as Government would not mandate clauses in private contracts. From a policy and political perspective, these differentials in the level of care home residents' protection would be difficult to justify or be understood by care consumers
- given the market trends towards more self-funders and towards personal budgets for local authority care, it is unlikely this solution would be future proof
- this would again place burdens on small and medium providers as well as larger providers, which may result in increased fees thus passing on cost to NHS and local authority commissioners and self-funders
- it is unclear whether in cases of provider failure, especially if the company goes into administration that contract terms would be upheld and users may not be protected as was envisaged
- there would be a question over whether the contract terms should be standard, to ensure the same protection across the board, or whether each local authority should take this forward themselves. There would be a difficult trade off between allowing local flexibility (to respond to specific local circumstances) and protection. For example, in an area where there is lots of provision and potentially over supply of beds, there may need to be different contractual terms compared to areas more heavily reliant on a single provider.
- a contractual approach is likely to impose significant burdens on business, particularly if local flexibility were permitted
- finally, a contractual requirement on providers may include an element of sharing the risk between purchaser and provider; this can increase the cost of purchasing beds, even in areas where the risk may be low. Conversely it may also be construed as over-regulation because not all providers would carry a risk and imposing a contractual requirement on all of them could be disproportionate.

Costs and Benefits

COSTS		
Individuals paying for care (self-funders)	**2**	Individuals paying for their care would likely face higher fees as providers attempt to cover additional costs associated with LA contract clauses compliance. They would not benefit from these arrangements if they were in self-funder-only care services. Non-monetised costs: Confusion regarding two-tier protection, stress and anxiety for self-funders.
Small and medium providers	**3**	Small and medium providers would face moderately higher costs due to compliance with contract clauses, particularly those that supply different LAs.
Large providers	**4**	Large providers would face a substantially higher cost burden given they deliver services across a high number of local authority areas.
Taxpayers (Council fees and central government costs)	**2**	Local Authority fees would probably increase due to increased contractual requirements.
BENEFITS		
Care Users (self-funders and council funded people)	**1**	There would be marginal benefits to those funded by LAs who would have greater reassurance that their needs for continuity of care would be met in an orderly way. However, contract clauses may not hold if a provider passed into insolvency, furthermore no self-funders (159,000 of which are in residential care)[22] would be covered.

76. For these reasons, we currently reject this approach.

[22] Laing & Buisson, Care of Elderly People UK Market Survey 2011

Option 4: Targeted regulation

77. This option is the Department's preferred option and is the basis of the forthcoming consultation, although we welcome views through the consultation on the other options outlined in this Impact Assessment.

78. This option is based on the premise that local authorities continue to oversee the smaller players in the local care market and to put effective plans in place to ensure continuity of care, should any provider exit the market in their local area. This is based on our assessment, outlined earlier in this document, that there is no market failure amongst smaller providers to warrant central Government intervention.

79. The Southern Cross case illustrated among other things that the Government did not have sufficient early knowledge of the financial situation and hence intervention was more protracted. In order to avoid such a situation in the future, we believe some early knowledge of the financial situation of those providers whose potential financial failures is likely to cause the highest adverse effects, is needed. This knowledge would help in a resolution appropriate to the level of risk posed by the financial failure of these providers.

80. Based on the risk profile of these providers, our assessment is that further regulation may be required to ensure that any potential financial collapse of these providers does not result in adverse effects to users. This could happen if the provider were to close in a disorderly manner. It is important however that any regulation is kept targeted and proportionate to the level of the risk.

81. The consultation proposes new targeted regulatory interventions;
    - enhanced intelligence of a group of providers above a certain threshold e.g. a certain size
    - enforceable contingency plans developed by providers posing higher levels of risk to service continuity
    - measures to manage provider distress and failure. The consultation suggests the approach could be based upon recovery and resolution plans i.e. the 'living wills' approach currently being piloted in the banking sector

82. The regulatory powers would be used to;
    - require the submission of financial data from a targeted set of providers to a central body. This will provide an early warning system and aid in the planning of large-scale market exit. In the consultation, we put forward this as our preferred approach to oversight of the major providers.
    - have some power to coordinate information and possibly activity, in cases where a provider's business crosses more than one local authority area. As discussed earlier, there is a risk of an information or co-ordination failure in such instances. In the consultation, we argue that addressing these failures would require a national level response and some coordination powers.

<u>Coverage of the regulation</u>

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

84. It could be argued that this may seem unfair to the larger providers and that might impact upon their ability to compete effectively; however we are of the view that choosing those providers whose failure could cause the largest adverse effects on residents is a

proportionate response to the risk they carry and which a competitive market should recognise. In the work that follows this consultation, we will be considering the appropriate thresholds at which this should apply to providers.

85. We are of the preliminary view that the following types of providers may need to be monitored, regardless of their financial stability;
    - providers that are large by number of care homes
    - providers that have significant geographical concentrations
    - providers of specialist services, where alternative care provision may be difficult to secure.

Information requirements

86. Under our proposals, a targeted set of providers would be required to provide regular financial information based on certain metrics that would be set out. This will provide the Government/regulator with an understanding of the risk profile of the providers. The information could be required at specific time intervals, could include profit and loss statements, details on debt structure, and financial metrics e.g. level of gearing, the liquidity ration, unsecured debt, contract lengths etc.

87. We believe that such knowledge can only effectively come about through a regulatory solution, making it incumbent on providers to make available information at regular periods that would enable an understanding of the level of risk faced by the provider. This may lead to further information requirements, but the requirement needs to be proportionate to the level of risk posed. At the appropriate time, this information could be shared with commissioners (thus also addressing the information failure), whose main duty will be to ensure continuity of services in their own area given this information. In sharing such information, however, the regulator will need to be sure that there is no risk of precipitating an unnecessary exit.

Contingency Planning

88. In addition, we believe that there should be a requirement on providers to have contingency plans that outline the manner in which they would assure quality of care for their residents for a specific period until alternative provision is available. These plans would need to be agreed with the regulator, and the plan will be invoked upon the provider reaching certain trigger points as specified by the regulator/Government. This plan would need to be capable of being implemented, even if the provider were to go into administration. We envisage the process to be similar to that used in the banking sector where ‘living wills’ have been proposed – see Annex A for further details.

89. The details of how this could be designed, funded and implemented is an issue that we would explore in the next phase of this work, if the consultation supports this model. The Department would rely upon expertise from existing regulators. We are mindful that the design options will have different cost impacts for providers and these would be assessed fully in a future impact assessment.

Responsible body

90. If analysis of consultation responses and available evidence support this option, then the Government would take forward work to determine the appropriate regulatory body who can undertake this function. The work will involve a more rigorous analysis of the scope of the regulation, the providers to whom it will apply, any legal framework necessary to facilitate this and the costs of doing so. Work would then continue to design the precise regulatory measures with the chosen body.

Costs & Benefits

91. Our preferred option is to introduce targeted regulation of the major provider (based on a risk assessment and carefully defined thresholds). Such measures should lead to;

    – potential risks to service delivery, resulting from a provider falling into financial difficulties, being identified early, so that appropriate action can be taken and quality maintained, and
    – the resolution process (when a provider does have to exit the market) being effective, well managed and carried out in a way which prioritises the protection of individuals' health and well-being.

92. This should offer benefits to;
    - care users who will be assured of continuity of care and an orderly transfer of care, if their provider should fail.
    - small and medium providers (private and not-for-profit) who will mostly not have any additional burdens imposed upon them

(A) Direct costs to providers

93. Costs would fall to larger providers and those who were required to comply with the scheme. For the majority of providers this would be the cost of providing financial data, managing the ongoing relationship with the regulator including meetings as required. Whilst this should not be burdensome, as the providers will hold such data, there will be an administrative fee associated with providing data in the format required. Costings for this element will depend upon the consultation responses on:
    - where the threshold should be set to capture the providers whose failure would pose the greatest risk to service continuity
    - what information would be required [through central oversight] to assess risk levels
    - internal discussions with CQC, Monitor and other relevant bodies

94. For some providers who were judged to pose a significant risk to service continuity in the event of failure, they would also face costs associated with developing contingency plans. Preparation of recovery and resolution plans ('living wills') - could be a one-off cost to produce their resolution plan and agree it with the regulator, with some additional cost to review and update when necessary. The costs would depend upon:
    - the number of organisations assessed as 'high risk' by the regulator
    - consultation responses relating to the information that would be needed to be included in contingency plans (for example recovery and resolution plans)?
    - the detail of individual contingency plans (determined by the provider and approved by the regulator) which may have cost implications

95. Finally, there would be a further cost associated with compliance with recovery plans. These costs would depend on the nature of any regulation (which has yet to be designed). For illustrative purposes only, if providers had to set aside some specific funding to ensure the quality of care was maintained during any period of financial distress, we would need to consider the opportunity cost of the funds they were setting aside or assets that they were locking in. Regulations might also be factored into the cost of borrowing. These costs will be worked up in detail in order to understand market impacts and would be set out in a future Impact Assessment, if the consultation supports our preferred direction of travel.

(B) Direct costs to the Government/regulator from conducting financial oversight

96. Costs would also fall to the taxpayer via the Department of Health (DH). DH would be required to fund the regulator to meet the costs of setting up structures for monitoring provider financials with staff who have the required skills i.e. expertise in scrutinising complex financial organisations. It may also include the costs of employing professional financial services for expert opinions and advice regarding the financial health of the providers. It could also include the costs of setting up any necessary legal framework to ensure monitoring and implementation of the targeted regulation. As this would be in addition to any existing regulatory body's functions this would be an additional cost to the department. The precise magnitude of this cost will be determined based on;
    - the consultation responses to 4 (i) (ii) and (iv): 4(i) What are your views on the proposal for those providers which are assessed as posing the greatest risk to the continuity of quality services to develop specific contingency plan e.g. recovery plans? 4(ii) What information would need to be included in such plans? 4 (iv) What enforcement powers would be required to establish this system? Is regulation required to achieve this?
    - evidence from regulators about the resource they would require
    - costs would also be subject to Ministerial decisions on affordability.

(C) Indirect cost to the Government

97. It is possible that some of these costs will be passed on to commissioners and self-funders through higher fees and prices. However, any rise would only be for those providers who fall under the regulations – it would not be across the whole sector (as might be the case under option 2 sector-led regulation or option 3 local authority contract clauses). If the consultation supports this direction of travel, the impact assessment following the consultation will explore all the costs and benefits in more detail.

COSTS		
Individuals paying for care (self-funders)	**1**	Self funders may face increased costs as a result of compliance with the scheme. However, this would affect a smaller number of self-funders than increased costs in less targeted schemes. Therefore we believe increases would be marginal.
Small and medium providers	**1**	Normally, no cost would fall to small and medium providers. There may be exceptional circumstances where they were judged high risk due to specific specialisms or regional concentrations. Therefore we believe cost increases relative to option 1 (do nothing) would be marginal.
Large providers	**4**	Large providers would face substantially higher costs arising through the cost of compliance with the regime; there may be a risk of increased cost of capital (to be explored through the consultation).
Taxpayers (Council fees and central government costs)	**2**	Council fee rates may be marginally impacted, although LA market buying power may resist pressure from providers. There would be set-up and running costs facing central government.
BENEFITS		
Care Users (self-funders and council funded people)	**3**	We consider this option presents moderately higher benefits to all care users whether state funded or self funded. This may decrease the likelihood of failure through regulation and would ensure smooth transition for all users in the event of failure.

98. Costs and benefits will be assessed and set out in a further impact assessment if the outcome of the consultation supports this approach.

Option 5: Special Administration Regime (SAR)

99. The final option that we considered was introducing a special administration regime for social care, which would mean that should a provider enter insolvency, specific rules would apply which prioritised the needs of users over those of creditors (in insolvency law, insolvency office-holders must act in creditors' best interests).

100. In the healthcare sector, the Government is considering a special administration regime, in order to ensure the continuity of essential health care services. There are 'SARs' in other areas such as water, energy, rail and banking to ensure continuity.

Costs and Benefits

101. The benefits of extending such a regime to social care are:

- It could operate on a targeted basis, so only the largest and riskiest providers were covered.
- This offers greater legal protection for all care residents over and above creditors
- This meets our objective to ensure continuity of care

102. The Government recognises the advantages of having a clear legislative requirement to prioritise continuity of care. Furthermore special administration regimes ensure that any costs of continuity are met until alternative provision is secured. These costs could be met either by provider(s) or the Government.

103. However, the Government currently does not propose a special administration regime because we believe the likelihood it would be used is low due to competition levels, system incentives, the ability to move individuals as a last resort and the potential negative impacts on the whole social care system if such a regime is introduced. These impacts are set out below;

- such a regime could require money to be set aside by providers, which would take money out of the system for providing quality care services
- - any additional cost to providers would be likely to raise the cost of care for individuals and local authorities
- the change to creditors' rights could limit investment in the sector and cause existing investment arrangements to be changed which could precipitate failure
- the case of Southern Cross was resolved by all parties acting responsibly to find a solution and preserving continuity of care. This is in the best interests of all parties, which could be altered by a special administration regime. The system for resolving the commercial aspects of failure should sit with the market, and
- whilst the Government should have measures in place to protect people's care Government should not be intervening in commercial procedures unless there is a need to continue use of the asset.

104. There is general agreement that actions upstream such as intervention before a possible failure are better and cheaper for all parties. Dealing with the problem upstream should also mean minimal impact on the market.

105. The cost of setting up a special administration regime can not be estimated by the insolvency service given the high number of variables including the number of providers covered, whether a market levy is included etc. However, it is thought to be the most expensive intervention for both providers and the taxpayer through set-up costs. It is likely to lead to providers incurring additional costs that could in turn be passed to local authorities or individuals through increased prices.

COSTS		
Individuals paying for care (self-funders)	**1**	There may be a marginal increase in the cost of care associated with scheme compliance; we assess this as marginal although it could be greater depending on the schemes model.
Small and medium providers	**1**	It is likely the scheme could be targeted to pose marginal costs on small providers who we would expect to be largely excluded, as in option 4.
Large providers	**4**	Large providers would face substantially higher costs of compliance with a formal regime. We would assume that such a scheme would mean providers faced increased costs as investors offered less favourable terms given the subordination of their rights in insolvency.
Taxpayers (Council fees and central government costs)	**4**	These costs are rated as substantially higher given the high cost to taxpayers through central government set-up and running costs. It is likely providers would attempt to recoup some costs through increased fee rates.
BENEFITS		
Care Users (self-funders and council funded people)	**4**	Care users would be offered reassurance of continuity of care and a smooth transition on a firm legal basis. Whilst this may not be a 100% guarantee it would have the most teeth out of all the options.

106. We do not believe that such an option is proportionate or balanced in relation to the market failure that we have described. We therefore reject this option.

Costs Summary

107. Our cost assumptions are set out in the table below. These costs are indicative, as much would depend on the details of the schemes.

		COSTS						BENEFITS	
		Individuals paying for care (self-funders)	Small and medium providers	Large providers	Taxpayers (Council fees and central government costs)	Total			Care Users (self-funders and council funded people)
Option 1 do nothing		-	-	-	-	-			-
Option 2 sector-led regulation		1	4	3	1	9			2
Option 3 contract clauses		2	3	4	2	11			1
Option 4 targeted regulation		1	1	4	2	8			3
Option 5 special administration regime		1	1	4	4	10			4

Key	Costs & Benefits*
Substantially Higher	4
Moderately Higher	3
Slightly Higher	2
Marginally Higher	1
No cost	-

** Please note the best option will have a high score for benefits and a low score for costs*

Summary – rationale for preferred option

108. The policy aim of any intervention is to ensure continuity of service for individuals requiring care and support, in the event that their provider exits the market.

109. However the guiding principles for any approach, which are set out in the Government's White Paper; Caring for our Future are;

- local authorities should continue to oversee and manage continuity of care in local markets, which they have been doing effectively for decades
- providers must be primarily responsible for those in their care during transition, taxpayers money will not support a failing company
- any regulatory measures should be proportionate and targeted and should align with Government principles of better regulation[23]
- any reform should take account of Government's wider objective to promote a diverse and vibrant care market and to encourage new investment.

110. Taking into account our analysis of likely cost pressures and the policy principles set out by Government for any approach to oversight, we have eliminated options 1,2,3, & 5 as:

- **Option 1:** We believe that there may be ways to address a disorderly closure of a large national/regional provider that are more effective. We are keen to explore proposals during the consultation process.
- **Option 2** We are not confident that this scheme would offer adequate protection to care users. Such a scheme would probably only be effective if small and medium providers were able to contribute financially to a sector-led scheme. This

[23] http://www.bis.gov.uk/policies/bre/principles-of-regulation

would place unjustifiable burdens on small providers who do not pose the same level of risk to continuity of care in cases of failure.

- **Option 3** would not offer any protection to people in self-funder only services. Self-funders comprise 41% of those in UK care homes (159,000 residents[24]). It is not clear that this would be effective and that clauses could be implemented in insolvency. If the system were ineffective, it would offer no benefits to care users.
- **Option 5** The prevalence of competitive market forces suggests this level of intervention is disproportionate. However, it would create a firm protocol for continuity.

[24] Laing & Buisson, Care of Elderly People UK Market Survey 2011

Wider Government Policy Considerations

Further considerations in taking forward option (4) targeted regulation if the consultation supports this approach

Consideration	Description
The Coalition Agreement	The recommended option is in line with Coalition proposals on proportionality of regulations, as it is highly targeted.
Government policy on regulations i.e. the 'One-In-One Out' rule	This policy affects One-In-One-Out as it involves regulation. If we proceed with this approach, further consideration will be given to the Department of Health's regulatory and deregulatory programme.
Government policy to exclude micro-business from all new regulation	The recommended approach would place no regulatory burden or add any conceivable indirect costs to micro-business. This is also the case for small businesses (providers) in this sector.
Consideration of the impact on civil society organisations	The consultation includes a set of questions about how to identify the organisations who pose the greatest risk to continuity of care. There are three not-for-profit organisations in the top ten largest care homes. It will be necessary to take into account a range of factors, which may include their legal status in deciding whether they would fall within or without this regime.
Could a sunset clause apply to this approach	The issue of continuity of care is such that we do not believe it is advisable to put a less robust system in place and risk lower protection to vulnerable users of care services.
Equality Analysis	Equality Analysis has been prepared in parallel. As this intervention is designed to target vulnerable people, we will ensure our proposed approach promotes equality in line with legal duties.
Specific impact test on wider business	The consultation will gather further evidence to test the impact of our proposed approach with care providers (including large and smaller businesses) and with investors (including banks and private equity houses). It is likely that any action, which meets our policy aim of ensuring continuity of care in the event of provider failure, will create some burdens on business. However, we are keen to develop a highly targeted, light-touch mechanism, which balances a light-touch approach with effectiveness.
Specific impact test on competition	The social care market is highly competitive,[25] which is a necessary condition to support user choice. Engagement with providers through the consultation may draw our attention to further evidence. However, at the current time we do not believe the proposed approach would have an impact on levels of competition in the care market.

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

Annex A: 'Living Wills' Model: Recovery and Resolution Plans

The market oversight approach that we are proposing in the consultation document comprises two distinct but closely related aspects;

- the first relates to improved market intelligence and the monitoring of key financial metrics of high-risk care providers.
- the second aspect is modelled broadly on the concept of 'Living Wills' currently being piloted in the banking sector. This approach requires the regulated entity to prepare *Recovery and Resolution Plans*[26]. Regulated entities in the case of social care will be high-risk, usually larger providers identified following a risk assessment (based on the probability of risk of failure and the scale of adverse impact, for example).

Recovery Plans

The purpose of a Recovery Plan is to enable firms to plan how they would try to recover from severely adverse conditions that could cause their failure. It would set out in advance a firm's 'menu of options' for dealing with a range of severe stress events.[27] In a stress scenario, the deployment of a recovery plan should enable the providers to better deal with the cause of financial stress and delay or potentially avoid failure. In any event, it would allow commissioners and residents valuable additional time for continuity of care.

As such, a Recovery Plan would be an internal document prepared by the management on behalf of the Board of the entity. It should be prepared in a 'business as usual' environment and presented to the regulator for approval. It would need updating in a regular and timely manner for emerging risks, significant events, changes to the market dynamics, funding landscape, among others. In the banking sector, these plans are prepared by the banks in discussion with the regulator. The plans are not published and have a very limited circulation to avoid exposure to financial markets.

Resolution Plans

These plans aim to ensure that should there be a failure, there is an orderly resolution, carried out in a way that preserves or facilitates continuity of care. A resolution plan therefore, includes key information that a regulator or the administrator would require for an effective resolution of the provider entity.

In the case of banks, triggers for Resolution are set out in legislation and Resolution plans are prepared by the authorities (Bank of England). It should be noted that in the banking resolution regime the resolution authority also has the powers to intervene to effect transfers of businesses and/or to apply for the appointment of an insolvency practitioner. A Resolution Plan would need to be prepared by the authorities (regulator and/or administrator) based on a compendium of updated information and documentation (which the FSA define as a 'Resolution Pack'[28]) provided by the entity management in a 'business as usual' environment. A decision on who holds the Resolution Plan would need to be made during detailed design of the regulation.

[26] Further information on Recovery and Resolution plans can be found on the FSA website: http://www.fsa.gov.uk/library/communication/pr/2011/070.shtml

[27] FSA Consultation Paper CP11/16: Recovery and Resolution Plans, August 2011. Feedback statement setting out the approach being taken by FSA to ensure firms develop appropriate recovery plans and resolution packs, published May 2012. http://www.fsa.gov.uk/library/policy/dp/2012/fs12-01

[28] FSA Consultation Paper CP11/16: Recovery and Resolution Plans, August 2011. Feedback statement setting out the approach being taken by FSA to ensure firms develop appropriate recovery plans and resolution packs, published May 2012. http://www.fsa.gov.uk/library/policy/dp/2012/fs12-01

Equality Analysis
Consultation on Oversight of the Social Care Market

Policy objective

Care and support services can be critical to the health, well-being, safety and dignity of individuals and carers. It is not acceptable for people with care and support needs not to receive the services that they need because a business fails or chooses to close. Should a provider exit the market, it is critical for the process to be well-managed to avoid undue stress and anxiety on individuals, their families and carers. This is particularly the case if a service has to stop completely (rather than be transferred to a new operator).

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

The Government is therefore proposing to improve the system of oversight of the social care market. Under this system, providers posing significant risk to service continuity of service will be required to disclose information to a regulator, and have robust plans in place in case they fall into distress. The regulator will oversee and enforce this process, and ensure that in the event of exit, there is co-ordination and information sharing between all parties, supporting the work of commissioners. As a result, every person receiving care and support will continue to get the care they need if a provider exits the market, regardless of whether they are state funded or privately funded.

Public Sector Equalities Duty

The Equality Act 2010 created the general equality duty. In developing policy, we are required to have due regard to eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act; advancing equality of opportunity between people who share a protected characteristic and those who do not and fostering good relations between people who share a protected characteristic and those who do not.

Protected characteristics are: disability, race, sex, age, gender reassignment (including transgender), sexual orientation, religion or belief, pregnancy and maternity and carers 'by association' with people sharing some of the characteristics e.g. disability and age. It also applies to marriage and civil partnership, (in respect of the requirement to have due regard to the need to eliminate discrimination)

We are taking the following steps to abide by this duty;

- consulting on our proposals
- publishing this Equality Analysis alongside the consultation document
- holding specific discussions with relevant stakeholder groups to identify and avoid any negative impact of this policy upon individuals who share a protected characteristic. We expect these groups to include the Race Equality Foundation, LGB&T Partnership, Faith Action and Age UK.

Who will be affected?

These proposals will affect:

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

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

- elderly: the median age of entry into a residential care home is 82
- women: as they live longer
- adults suffering from a mental or physical disability
- unmarried people: men were three times as likely, and women eight times as likely, to be in a care home if they were unmarried (2001 census)[29]
- disabled people

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

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

Impact of our proposals on protected groups

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

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

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

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

Ensuring protected groups are considered in the policymaking process

Despite our belief that our proposals will benefit protected groups, the evidence below demonstrates that those groups identified above (religious people, LGBT people, those from BME communities and carers) require specific consideration. This is especially the case given that contingency plans will only affect systemically important providers.

We will therefore;

[29] Laing & Buisson, p. 150.

- include questions in the consultation requesting specific input on the effects of our proposals on these groups, and how our proposals might be altered to offer greater protection to these groups in the event of provider failure
- meet with relevant organisations to discuss these issues in greater detail.

Evidence of potential impact on people sharing protected characteristics

Summary

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

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

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

LGBT

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

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

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

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

Race, Religion and Ethnicity

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

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

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

Carers

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

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

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

References

'As We Grow Older: A Study of the Housing and Support Needs of Older Lesbians and Gay Men', Hubbard, R. and Rossington, J., commissioned by Polari (1995).
'Developing Anti-Oppressive Empowering Social Work Practice with Older Lesbian Women and Gay Men', Langley, J., *British Journal of Social Work* (31), p. 917 (2001).
'Facts About Carers 2012', Carers UK (2012).
'Gay and lesbian perceptions of discrimination in retirement care facilities', Johnson M.J., Jackson N.C., Arnette J.K., Koffman, S.D., *Journal of Homosexuality* (49), p.83 (2005).
'International migration in later life: social care and policy implications', Blakemore, Ken, *Ageing and Society* (19), p.761 (1999).
Lesbians, Gays and the Empowerment Perspective, Tully, C.T., Columbia University Press (2000).
'The health and social service needs of gay and lesbian elders and their families in Canada', Brotman, S, Ryan, B, Cormier, R, *Gerontologist* (43), p. 192 (2003).
'The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: a review of the literature', Addis, Samia, Davies, Myfanwy, Greene, Giles, MacBride, Stewart, Sara and Shepherd, Michael, *Health and Social Care in the Community* (17), p.647 (2009).

'"We are not blaming anyone, but if we don't know about amenities, we cannot seek them out": black and minority older people's views on the quality of local health and personal social services in England', Manthorpe, J., Iliffe, S., Moriarty, J., Cornes, M., Clough, R., Bright, L. and Rapaport, J., *Ageing and Society* (29), p. 93 (2009).