

Care Quality Commission

The Stability of the Care Market and Market Oversight in England

Report

February 2014

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Report

1 Objectives and Approach

The Institute of Public Care (IPC) was asked by the Care Quality Commission (CQC) to produce a report analysing the main factors that affect stability in the adult care market and the relationship of this to the forthcoming market oversight regime.

To achieve this IPC has reviewed publicly available data about major providers of care and has engaged in discussions with a sample of major providers, with the Association of Directors of Adult Social Services (ADASS) the Department of Health (DH) and CQC itself.

The report covers the learning disability and older people's elements of the adult social care market. It focuses on the large providers of care but also considers those organisations in the context of the overall shape of the market. Unless otherwise stated, it sets out the position as at the current time (February 2014). It is based on information available at this time.

The report is structured as follows:

- The first six sections provide the context in which the report was commissioned, including some description of the current market.
- Sections 7, 8 and 9 analyse the main factors that may influence organisational and market stability and consider the market oversight regime in relation to market stability.
- Section 10 makes some suggestions and recommendations.
- The Appendix (Section 11) contains a list of organisations interviewed in connection with the report.

2 What constitutes a stable market?

2.1 Assessing markets for stability

What constitutes a stable market in any particular sector is potentially the subject of considerable debate. The Government has stated that a well-functioning care market should match services to the needs and demands of users, efficiently and effectively. Where there is demand backed by a willingness to pay, quality should increase. This is the same for care and support as in other markets.¹ In addition, the Care Bill requires Local Authorities to promote a diverse market of high quality care and support services.²

The National Audit Office in its report “Oversight of user choice and provider competition in care markets”³ suggests that in order to achieve user choice and provider competition the care market needs to balance two elements:

- On the demand side, whether users can engage with the market and can purchase services that help them achieve their care outcomes.
- On the supply side, whether there is adequate competition within care markets to make sure providers are responsive to users’ requirements, and quality of services is maintained.

A characteristic of a stable market is that the relationship between prevailing prices and quality provides signals that prompt market entry and exit which in turn leads to variations in the competitiveness of the market. This was discussed in the 2011 report “Competition in the Care Homes Market”.⁴ For example, a market with low levels of competition may have relatively high prices, but these prices then attract in new market entrants. This in turn results in increasing competitiveness and either lower prices and/or higher quality. The argument here is that markets find their own competitive equilibrium between price and quality. It is quite possible to have companies and organisations entering and leaving markets but for the market overall to be quite stable⁵. Poor performers may be taken over by existing or new organisations. New entrants may bring innovations in terms of products or services and hence encourage existing providers to compete more vigorously.⁶

¹ Impact Assessment for Part 1 of the Care Bill

² Section 5 Promoting diversity and quality in provision of services

³ Oversight of user choice and provider competition in care markets National Audit Office 15 September 2011

⁴ Competition in the Care Homes Market – a report for the OHE Commission on Competition in the NHS by Julien Forder and Stephen Allan, 2011

⁵ Oversight of user choice and provider competition in care markets, National Audit Office, 15 September 2011

⁶ Oversight of user choice and provider competition in care markets, National Audit Office, 15 September 2011

However, few markets operate in such a pure way. Most markets are regulated by Government to a greater or lesser degree. Wages can be controlled, eg, in the care sector the levels at which national minimum wages are set may have a big influence on employment and profitability as may regulations surrounding the use of overseas labour. Price fixing and/or subsidisation may take place, artificially skewing the relationship between supply and demand.

Additional concepts that can help inform thinking on market stability in the adult care market are the viability and sustainability of operators:

- Viability refers to the financial capacity of an organisation to provide sufficient financial return to satisfy the owners operators to the extent that they would be prepared to continue to operate the service both in the short and long term. The determination of the viability of an organisation may be based on its current operational performance. There are a number of tests but EBITDA⁷ is probably the most commonly used, for showing projected return on investment. However, EBITDA is only of limited reliability where businesses have high levels of debt, because the interest paid on the debt would need to be a factor in measuring the businesses viability.
- Sustainability is the combined viability of care services within the care sector, or parts of the sector, to the level that the numbers of providers continuing to operate are sufficient to enable the sector to continue functioning. This may not always mean the same care services, but it does mean sufficient services to a level that will achieve social and financial objectives acceptable to a community or have been agreed.

2.2 Care Markets

Care markets, it is often argued, differ from a textbook competitive market in a number of ways (some of this has been discussed elsewhere in relation to hospitals⁸). Some examples of where this type of market differs are:

- The product is highly differentiated, eg, due to location, different services or style of provision.
- The market in some parts of its operation splits into two with a higher priced element funded by individuals which in turn subsidises a lower priced state funded element.
- The state is still the single biggest purchaser, through Local Authorities, who exert a large influence over the market.
- Information available to consumers is imperfect and people are often making purchases at short notice and in a hurry (distressed purchases).

⁷ EBITDA stands for 'Earnings before interest, taxes, depreciations and amortisation'. It is a means of measuring profitability

⁸ Chapter 6, Competition between hospitals in "Understanding New Labour's Market Reforms of the English NHS

- Government regulation is extensive.
- Apart from the provision of housing, it is probably the only market where; private, not for profit, voluntary and state run providers all 'compete' to provide similar services to similar customers.

There are several standard ways of measuring levels of competition within a particular market. The Herfindahl index (also known as Herfindahl–Hirschman Index, or HHI) does so by measuring the relative sizes of participants in a particular market or industry. The index was used to measure the level of competitiveness of the care homes market in 2010, giving a figure of 123, ie, a market that is not concentrated.⁹ The charts on page 29 show that the market share of the largest providers is similar now to the market share in 2010 so it is likely that the HH index calculation would give a similar figure now.

2.3 Characterising a stable care market

Therefore, what might be some of the characteristics of a stable market?

- Demand and supply would be roughly in equilibrium and there would be neither a monopoly of supply nor a monopsony of purchase.
- Price would be at a level to deliver the quality purchasers demand and to secure future investment.
- Consumers would have good access to information and providers would be readily able to respond to consumer demand.
- Regulatory or legislative change would be planned well in advance with ample warning to the supply side of the market.
- Entry and exit would occur (this divides a stable from a stagnant market) but it would take place in an orderly fashion without consumers being disadvantaged.
- Providers would be able to access reliable information about the market in order to plan for the future and make investments.

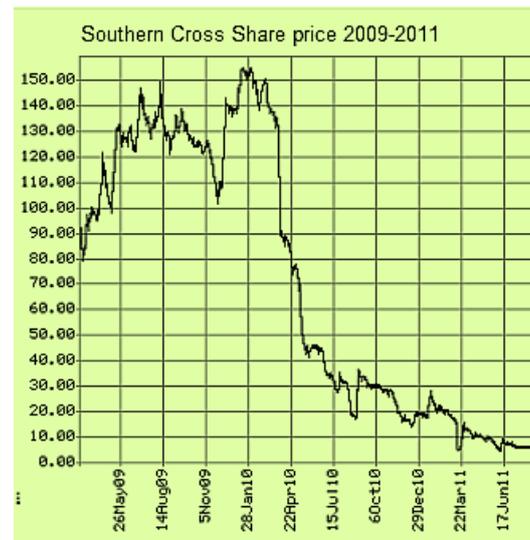
It is concern over stability in the adult care market that has given rise to this report and in particular the two recent examples of provider failure. These failures may in turn have led people to believe that in some way the care market was failing as compared to providers failing. Therefore, a key part of the discussion in developing this paper was whether the recent provider failures were typical of the market and, if so, might that lead to conclusions about the wider stability of the market.

⁹ Forder and Allan, *Competition in the care homes market*, August 2011

3 Southern Cross and Castlebeck – market instability or provider failure?

3.1 Southern Cross

On 11th June 2011 the shares of England's largest residential care provider for older people, Southern Cross Healthcare PLC, were suspended from trading on the London Stock Exchange. Shortly afterwards Southern Cross, which operated 752 homes and looked after 31,000 older people, closed down. The care sector responded quickly to the collapse of Southern Cross and arrangements were put in place to make sure that every client was looked after and that the homes were managed as well, and as quickly, as possible. The situation was potentially disastrous but it was handled swiftly due to efforts from care providers, staff, Local Authorities, Government and landlords. However, much of the care market was subjected to the same pressures as Southern Cross in the period leading up to its collapse so why was this company different?



Source: London Stock Exchange

3.1.1 What led to the problems at Southern Cross?

Southern Cross's failure took place for a number of reasons including:

- A high rental bill, as a result of the terms of its leases. Following sale and lease back of its properties, this amounted to £250 million, higher than its rivals were paying (caused by the annual uplifts to which it had agreed).
- As a result of a drop in income, properties were not well maintained, which in turn led to lower occupancy. Southern Cross's capital expenditure was only £500 per bed each year, compared to an average of £1,000 in the industry¹⁰, leading to a substantial shortfall and under investment in the homes which in turn led to lower occupancy levels and therefore to further pressure on cash and profitability as income levels dropped and the physical condition of the homes deteriorated further.
- Higher interest rates on loans because, having sold its properties, it did not have properties to secure loans against.

¹⁰ Regulatory News Service announcement for NHP, 23 March 2012

- Multiple sales of the company over several years with company funds being used to present the business in a good light rather than reinvesting in the business.
- Rapid and disparate acquisitions which led to difficulties in managing the overall company.
- Increasing loss of market confidence as its share price dropped.
- Poor management.

A year before its collapse, in the summer of 2010, Southern Cross was already in trouble. Its landlords had repeatedly asked it to take action to improve the condition of its properties. One of its major landlords, NHP, had asked it to re-gear the portfolio but Southern Cross refused. The occupancy rates at the NHP properties had reduced from 89.6% in 2009 to 83.5% in October 2010, compared to an industry average for residential homes that fell from 89.1% to 88% in the same period. As occupancy levels dropped, political and media interest increased and occupancy levels dropped further, while key staff left.¹¹

In addition, in late 2011, serious failings came to light at one of the former Southern Cross homes, Orchid View. The coroner investigating said that the problems were from the top down. The deaths of nineteen residents were “unexplained” and the coroner ruled that neglect played a part in five of those deaths. The failings had taken place while the home was being managed by Southern Cross highlighting the connection (discussed later in the report) between poor financial management and poor care.

3.1.2 Was Southern Cross unique?

Some of the factors that led to the collapse of Southern Cross also affected other care providers. For example, Southern Cross’s decision to take on a large amount of debt was not unusual. At the time that the House of Commons Select Committee was scrutinising the care market in the light of the Southern Cross failure other care providers also came under the spot light in the context of debt. Four Seasons Healthcare was mentioned in the report as carrying nearly £1 billion of debt which it was having to refinance for a second time.¹² During 2011 Four Seasons increased its bed capacity by 40% by acquiring the business of Care Principles and taking back the operation of its homes that had been managed by Southern Cross. In 2012 Four Seasons was acquired by private equity firm Terra Firma for up to £825 million which was financed through a mixture of equity and new debt. However, the deal rendered existing shares in Four Seasons worth little or nothing and lenders were forced to write down some of their debts in order to let the deal go through.¹³

¹¹ Regulatory News Service announcement for NHP, 23 March 2012

¹² Oversight of user choice and provider competition in the care markets House of Commons Committee of Public Accounts, 23 November 2011

¹³ <http://www.theguardian.com/media/2012/apr/29/guy-hands-terra-firma-four-seasons>

Similarly, the Priory Group was bought by a private equity firm, Advent International, in 2011, after a failed attempt the previous year to float on the stock market. Like Southern Cross and Four Seasons, the Priory Group was heavily in debt and although the deal valued the business at £925m, its owners, Royal Bank of Scotland, were expected to receive only £133m after its debts had been paid.¹⁴

3.1.3 What has happened to the Southern Cross homes?

The homes operated by Southern Cross are now being operated by a large number of other care providers, under a variety of arrangements. For example,¹⁵

- 241 were taken over by the newly set-up HC-1, (owned by NHP one of the Southern Cross landlords).
- 33 were taken over by Countrywide Care homes (set up by the owner of Maria Mallaband Care Group, Phil Burgan).
- 23 were taken over by Life Style Care (2011) (formed in July 2011 to do this; run by Life Style Care plc alongside its existing homes).
- Some were taken over by Bondcare Nilerace, a subsidiary of Bondcare, which already owned 39 of the homes operated by Southern Cross. Bondcare Nilerace has changed its name to Akari Care. The Akari homes are now managed by Healthcare Management Solutions¹⁶.
- 140 were taken over by Four Seasons. Some of these were homes where the property was already owned by Four Seasons.
- 40 were taken over by Orchard Care.
- 28 were taken over by Care UK.
- 18 were taken over by Methodist Homes.

3.2 Castlebeck

On 5 March 2013, less than two years after Southern Cross Healthcare collapsed, another care home operator, Castlebeck, went into administration. Castlebeck, a learning disabilities care provider, operated twenty facilities, a mixture of care homes for adults with learning disabilities and hospitals, and at that time looked after 214 people. Just under two years before, Winterbourne View (registered as a hospital), had been the subject of a television documentary after a BBC investigation filmed staff abusing vulnerable clients. A national investigation into mental health care providers followed as a result of the programme. Before the Panorama programme Castlebeck was operating profitably. Occupancy levels were high.

¹⁴ <http://www.theguardian.com/business/2011/jan/18/rbs-sells-the-priory-group>

¹⁵ Data taken from company websites and from the Guardian Datablog available at: <http://www.theguardian.com/news/datablog/2011/aug/31/southern-cross-homes-list>

¹⁶ <https://www.akaricare.co.uk/news-2>

However, the programme led to an immediate embargo on admissions. Three of Castlebeck's 28 units were closed promptly and the company's financial position suffered. On 5 March 2013 Joint Administrators were appointed by the directors of Castlebeck enabling it to continue under a trading administration process. In September 2013 the transfer of the business and assets to another provider, Danshell, was completed.

It is interesting to note that Castlebeck's failure was not originally due to poor financial management but to care failings. The care failings appeared to be attributable to board focus on financial matters and operational success rather than on levels of care, and to limited staff training, as well as to the general ethos within Castlebeck. Therefore, it could be argued that the financial failure of Castlebeck was due to too high a focus on financial performance and too low a focus on care.

3.2.1 What has happened to Castlebeck?

In September 2013 Castlebeck was bought by fellow learning disability provider Danshell. The purchase came six months after Castlebeck went into administration having built up debts of over £250m that it could no longer service. Prior to acquiring Castlebeck, Danshell ran 16 services across England and Scotland for young people and adults with learning disabilities, autism or mental health problems.

After becoming Castlebeck's preferred bidder, Danshell had to gain regulatory approval for the acquisition from CQC in England, and the Care Inspectorate and Healthcare Improvement Scotland north of the border.

The arrangement is expected to ensure that the 20 hospitals, care homes and rehabilitation units for people with learning disabilities and mental health needs run by Castlebeck remain open.

3.3 What do these examples suggest about market stability?

In some ways, the two examples provide evidence of a stable market or at least a market which can respond effectively when large or specialist providers fail as well as it does to small local failures of care businesses. Nobody was evicted from their place of residence and other regulated companies were able to take over the operation of the existing businesses and premises. However:

- Most commentators suggest it was a fairly 'close run thing' and that if another major provider had collapsed at about the same time as Southern Cross then rescue may not have been possible, or at least not possible in the same way.
- There were also losers in that both institutions and individuals who had invested in Southern Cross, lost money, which, it might be suggested,

could lead to a disinclination to invest in the care market and hence make future funding more difficult and the market less stable.

- Southern Cross and, to a greater extent Castlebeck, illustrates the relationship between quality and market stability, ie, where the level of care falls to a significant extent then even viable companies are not immune to a loss of public confidence and hence will end up with occupancy levels that are not sustainable.
- In the case of Southern Cross it could be argued, it is still too early to judge whether all the replacement providers have long term stability
- Southern Cross also had a complex web of ownership of its homes and care delivery¹⁷. Whilst this may not have been a surprise to the financial sector, it came as something of a shock to government¹⁸, commissioners of care and adult social care directors as to just how complex it was to trace where ownership, and hence decision making eventually lay.

In large part as a reaction to these problems and in response to a National Audit Office report¹⁹, the Government has proposed, after extensive consultation with the sector, a market oversight regime for the care market designed to deal with potential instances of provider failure.

¹⁷ See for example Caretelization revisited and the lessons of Southern Cross, Peter Scourfield, *Critical Social Policy*, 2012, 32: 137

¹⁸ See Norman Lambs comment in the Care Bill debate Hansard: Care Bill [Lords] Deb, 21 January 2014, c325

¹⁹ Oversight of user choice and provider competition in care markets, National Audit Office, 2011

4 The Market Oversight Regime

4.1 The structure of the market oversight regime

The Government’s discussion paper, Oversight of the Social Care Market²⁰ stated that:

“Over the past 20 years, the development of a market within social care has meant that individuals with a care and support need, and their families and carers, have experienced greater choice over the services that they receive. The Government is keen to see this continue. In its Vision for Adult Social Care²¹, it said that it wanted to support the development of a more diverse and vibrant market. Having a plurality of different organisations offering services should lead to increased choice and better outcomes for individuals, drive innovation and result in improved quality. For this to happen, we want new providers to continue to enter the market, and those offering services that people no longer want, or who offer poor quality services, to exit. This has been happening consistently for many years, and has largely been managed effectively at the local level”.

The framework for the Market Oversight regime is set out in the Care Bill, whilst regulations, made under the future Act, will determine the detail.

The regime provides that in the case of small local providers, if they become unable to carry on providing care because of business failure, then the Local Authority will act to secure alternative care arrangements. The authority does not have to guarantee it will be the same care and may charge for its service and the alternate provision. However, such alternatives should be offered regardless of whether the person was or was not funded by the state.

In the case of other larger providers, the CQC will have increased powers and duties in order to assess and monitor the “financial sustainability” of those providers who fall within the regime. As noted above, the scope of

the Market Oversight regime will be defined in the regulations and these will set out criteria for determining which care organisations fall within it.

However, as the diagram illustrates, the Government has already set out a four stage test for the regime. It starts from



²⁰ Oversight of the Social Care Market, Department of Health, 10th October 2011

²¹ A Vision for Adult Social Care: Capable Communities and Active Citizens, Department of Health 2010

fixing a threshold for entry based on size of organisation, speciality of service provided, and/or geographical reach of the organisation. However, the regulations may specify that certain organisations or types of organisation fall inside or outside the regime. For those that fit within the regime the CQC must assess their finances and may require a plan for continuity of service to be put in place if the organisation fails. Finally if the organisation continues to fail then the continuity plan will be enforced.

4.2 The aims of the market oversight regime

The aim is that providers who would be hard to replace if they cease trading, will be scrutinised more closely by the CQC, so that if they start getting into financial difficulties the regulator can ensure that either they mitigate risks²², and/or that the process of managing the transfer of clients is handled smoothly and sensitively. Overall, the Market Oversight regime is based on the premises that:

- The failure of any of the largest (or most significant) providers would be more likely to threaten the stability of the market than failure of a less significant provider.
- If a “difficult to replace” provider is at risk of failing, then putting in place contingency plans may avoid this outcome.
- Where an outcome of failure is not avoided, then through the involvement of the regulator, the continuity plan can help to avoid distress and disturbance to the service users.

The aim is not to prevent failure but to ensure that, if it happens, arrangements are in place to secure continuity of care.

²² Care Bill section 56(2)(a)

5 The size and shape of the social care market²³

The care market has grown and developed over the last thirty years in England. Prior to the 1980's the vast bulk of care was provided by local government and the voluntary sector and hence there was little 'market'. Since the Community Care Reforms of the 1980's there has been a considerable growth in the private sector to one where it now predominates across all forms of care.

Overall, the key characteristics of this market are its fragmented nature in terms of its wide diversity of providers (although not necessarily of types of provision) the influence held by the state (Government and Local Authorities) in terms of price which influences the viability of the sector, and an increased growth in recent years of private equity and real estate financing. The proportion of residential care places²⁴ purchased by Local Authorities varies across the country, as the table below illustrates.

Region	Total care beds	LA Purchased on a given date	% purchased by LA
South East	84,000	35,000	41
South West	58,000	24,000	41
Yorkshire & Humber	50,000	23,000	46
Eastern	51,000	24,000	47
East Midlands	43,000	21,000	48
West Midlands	46,000	23,000	50
North West	64,000	33,000	52
London	39,000	26,000	66
North East	28,000	15,000	54

Table compiled from CQC 'State of Care 2011/12 Report' and NASCIS data ASC-CAR Table S1. Figures are rounded to nearest thousand

5.1 Overarching trends

5.1.1 Providers

- In 2012/13 the total number of adult social care providers registered with CQC rose by 2% from 2011/12 an increase from 12,429 to 12,670.²⁵

²³ The intention of this section is not to offer a detailed review of the size and shape of the care market which is already contained in a number of documents (not least CQCs own annual review The State of Adult Social Care in England). This material is more a summary of the care market and how recent trends may or may not influence market stability.

²⁴ Residential care and residential care with nursing

²⁵ The number of residential care homes declined from 13,134 at the end of 2011/12 to 12,848 at the end of 2012/13, a drop of 2%. Similarly, the number of residential care home

- Around 92% of care home places are provided by the independent sector across the UK. About 89% of home care hours purchased by councils in England are provided by the independent sector²⁶ The remaining 11% are provided in house by Local Authorities.
- Local Authorities already manage the failure of around 40 small providers each year in their areas.²⁷

Net Total expenditure by Local Authorities in £000's on older peoples care and on learning disability

Net Total expenditure in £000's	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
All older people aged 65 and over	6,853,723	7,001,118	7,106,266	7,391,871	7,607,833	7,554,861	7,005,802	6,860,539
Adults aged under 65 with a learning disability	2,956,949	3,114,008	3,287,311	3,648,400	3,872,810	4,040,043	5,000,348	5,049,114

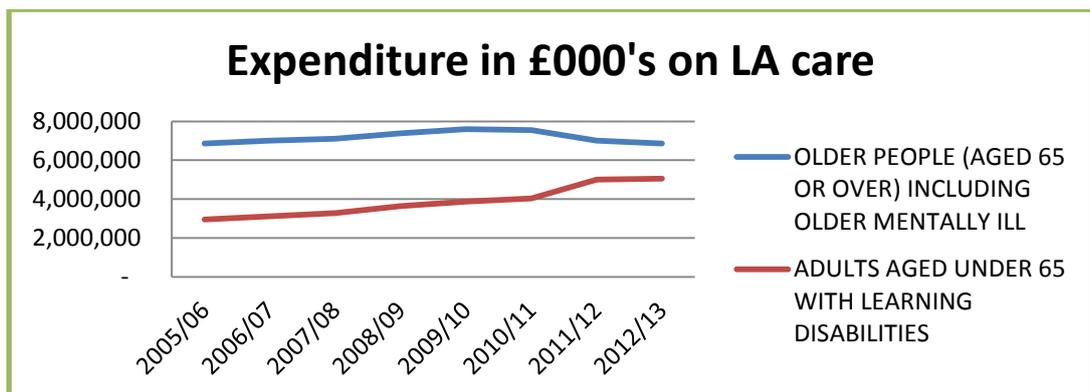


Table and chart derived from PSSEX data NASCIS

5.1.2 Provision²⁸

- The number of residential care homes (without nursing care) registered with CQC declined, from 13,134 at the end of 2011/12 to 12,848 at the end of 2012/13, a drop of 2%. The number of residential care home

beds went down from 247,824 to 244,232. But the number of registered nursing homes was static, with 4,664 homes registered at the year end compared with 4,672 at the end of 2011/12. The number of nursing home beds rose, though, from 215,463 to 218,678. The number of registered domiciliary care agencies was 7,420 at the end of the year, a rise of 9% on the 6,830 registered at the end of 2011/12.

²⁶ LaingBuisson, Care of Elderly People Market Survey 2012/13 (percentage relates to 2011/12)

²⁷ Andrea Sutcliffe quoted in LaingBuisson CCMnews, November 2013

²⁸ The State of Adult Social Care in England 2012/2013

beds (declared at the point of registration) went down from 247,824 to 244,232 (a drop of 1.5%).

- The number of registered nursing homes was static, with 4,664 homes registered at the year end compared with 4,672 at the end of 2011/12. The number of nursing home beds rose, from 215,463 to 218,678.
- In contrast to residential care home provision, home care provision increased by 9% with 7,420 registered home care agencies at the end of 2012/13, up from 6,830 registered at the end of 2011/12. Other community care services, such as supported living, remained almost static, with 2,034 registrations at the end of 2011/12 increasing slightly to 2,043 at the end of 2012/13.
- The combined value of the care market for older people alone (Local Authority funded, voluntary and private expenditure), is estimated to be worth £22.2 billion, of which £13.4 billion is attributable to residential care and £8.8 billion to non-residential care.²⁹

Number of people supported by Local Authorities in residential care, nursing care and adult placements as at 31 March.

Number of Residents Supported	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Learning Disability	39,400	40,040	39,200	39,235	39,185	38,365	40,270	39,025
People aged 65 and over	37,740	33,165	29,190	29,550	25,575	19,825	14,980	14,670

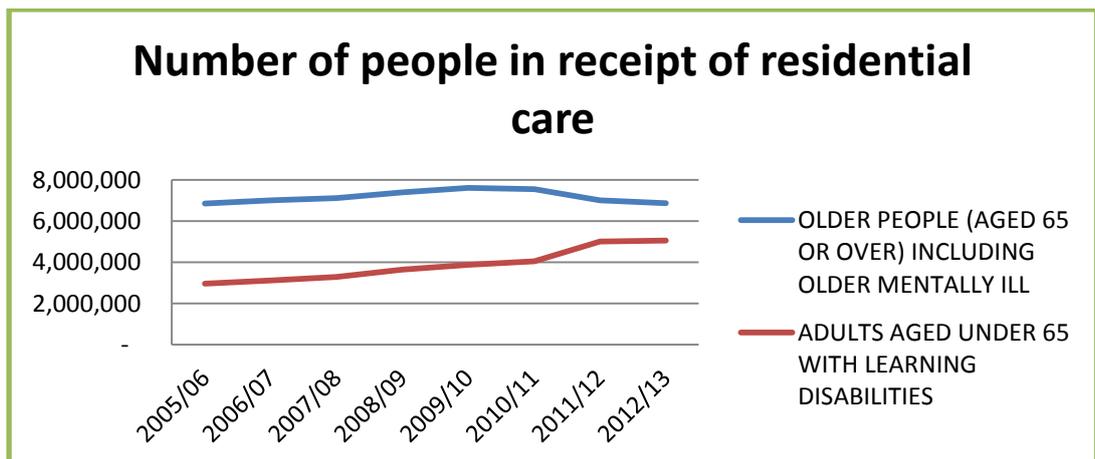


Table and chart derived from NASCIS Table S1

²⁹ Care of Elderly People Market Survey 2012/13, LaingBuisson, 2013

5.1.3 Workforce³⁰

- The number of adult social care jobs in England as at 2012 was estimated at 1.63 million with the number of people doing these jobs estimated at 1.50 million and the number of whole time equivalent jobs estimated at 1.23 million.
- The number of adult social care jobs is estimated to have increased by around 4% between 2011 and 2012 and by 15% since 2009.
- Since 2009 the workforce has continued to shift away from Local Authority services (-15%) and towards independent employers (+15%). Around 72% of the social care workforce engaged in adult care work in the independent sector, 14% for people with direct payments and 9% for Local Authorities.

5.1.4 Consumers

- In England, the numbers of people in receipt of some form of state funded care has declined from 1,748,355 in 2005/06 to 1,328,095 in 2012/13. It is suggested that some of this diminution in the figures may be offset by the number of people who fund their own care either within or outside the regulated care market.
- The proportion of self-funded places in residential care homes is estimated as 39.6% and 47.6% in nursing homes. A significantly higher proportion of self-funded service users were identified as receiving some type of nursing care (76% compared with 43% among publicly funded residents).³¹
- Estimates of the number of people paying for their own home care vary as it is hard to estimate the size of the unregulated market. An IPC review of home care³² included an estimate of 385,663 people aged 65 and over who pay for their own home care. The same paper estimated the number of people in receipt of state funded home care at 329,347.

³⁰ The size and structure of the adult social care sector and workforce in England, Skills for Care, 2013

³¹ Putting People First (2011) Op Cit.

³² Where the Heart is...review of the older people's home care market in England, October 2012

Number of people receiving services, provided or commissioned by the Local Authority for people with LD and people over 65 (there may be some duplication between the two lines of data)

Number of Service Users	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Learning Disability	133,835	137,275	140,400	140,965	141,760	142,455	144,130	144,830
Age 65 and over (inc LD)	1,230,625	1,231,395	1,220,660	1,215,575	1,147,695	1,064,475	991,230	895,940

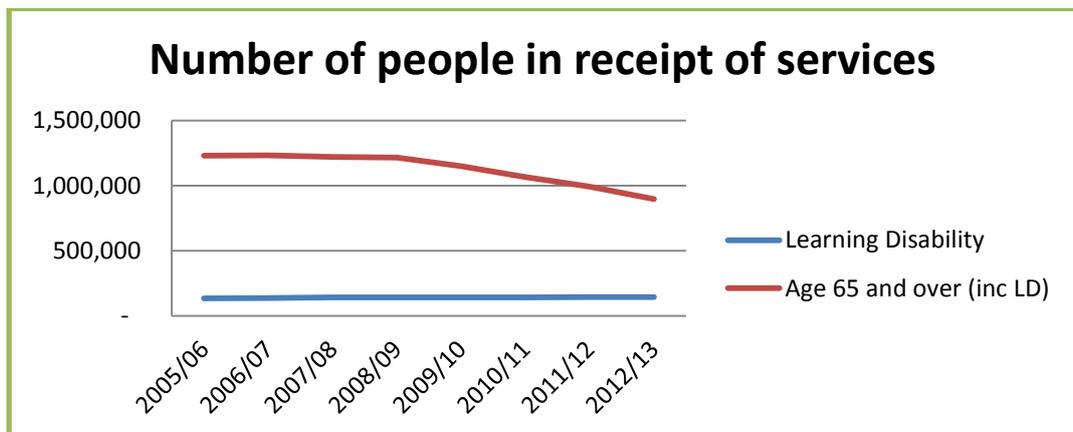


Table and chart derived from NASCIS Table P1

5.2 Older people's care market

Of the one and a half million people using publicly funded social care, just over two thirds are older people (aged 65 years and over).³³ The data suggests that fewer people are using publically funded social care than was the case eight years ago. For all groups, the reduction has become steeper since 2008 and in 2011/12 alone fell by 7%³⁴. There are a number of possible explanations for this decrease, such as the tightening of eligibility criteria and fewer older people being entitled to public funding. As shown above there has been a move away from residential care for older people towards home based services.

The market for older people's residential care in England is almost entirely supplied by the independent sector, a combination of voluntary organisations and for-profit organisations³⁵. Approximately half of this

³³ Adult Social Care Survey Feasibility Study, Picker Institute Europe & The King's Fund, April 2013

³⁴ Adult Social Care Survey Feasibility Study, Picker Institute Europe & The King's Fund, April 2013

³⁵ There remains some LA provided care – approximately 8% of residential care according to the LaingBuisson Care of Elderly People UK Market Survey 2012-13

provision is commissioned by Local Authorities under contract with providers. The remaining section is bought by private individuals who are either self-funding or who use direct payments. There are over 16,000 care homes in England, providing residential care to older people.³⁶

From a consumer perspective, the care homes market for older people has some characteristics of an inefficient market³⁷: entry into a care home is often unplanned and can be made in response to a specific event (such as a hospital admission or the death of a spouse). By definition, switching rates (choosing to switch care home) are very low. Consumer research commissioned by the Office of Fair Trading suggests that it is considered to be a last resort by most residents.³⁸

Several providers have recently been investing in the high end sector of the care home market. For example, Barchester, Sunrise Senior Living, and Maria Mallaband Care. The Anchor Trust has also recently invested in a high priced care home in Surrey. In July 2013 Four Seasons announced its intention to invest in the market for self-funded residential care.

The market for older people's domiciliary care is also supplied chiefly (89%) by the independent sector, consisting of a combination of voluntary organisations and for-profit organisations. The remaining 11% is provided in-house by Local Authorities.³⁹ There are approximately 7,420 home care agencies regulated by the CQC to provide domiciliary care to older people in England.⁴⁰ The majority of domiciliary care is commissioned by Local Authorities⁴¹ but some is selected and paid for by individuals, either self-funders or using direct payments. The number of Local Authority funded home care contact hours dropped by 6% from 3.85m per week to 3.62m during the year 2011/12.⁴² Just over three-quarters of Local Authority funded home care is provided to people aged 65 and over.⁴³

5.3 Learning disability care market

While other areas of the LAs' budgets have been cut in recent years spending on adult learning disability services has largely been protected. Based on NASCIS data, the number of people with a learning difficulty in receipt of state funded care between 2005/06 and 2012/14 has increased by 8% whereas net expenditure has gone up by 70%.

³⁶ Source CQC website

³⁷ Oversight of User Choice and Provider Competition on Care Markets, National Audit Office, September 2011

³⁸ OFT Evaluating the impact of the 2005 OFT study into care homes for older people, page 11

³⁹ Domiciliary Care UK Market Report 2013, LaingBuisson

⁴⁰ The state of health care and adult social care in England 2012/13

⁴¹ UKHCA summary paper, An overview of the UK domiciliary care sector, February 2013

⁴² Domiciliary Care, UK Market Report, 2013, LaingBuisson

⁴³ Not Just a number, CQC Home Inspection Report, February 2013

Further growth in the need for social care services for adults with learning disabilities is argued for in the future. Estimated average annual increases vary from 1.2% (lower estimate, services are only provided to new entrants with critical or substantial needs) to 5.1% (upper estimate, services are provided to new entrants with critical, substantial or moderate needs).⁴⁴

After the exposure of Winterbourne View the Government's drive towards supported living, personalisation and community based support has increased. Residential care now accounts for only 55% of the spending, down from 61% in 2006. Demand remains robust for the core activity of residential care for younger adults with complex needs and/or challenging behaviour. As can be seen from the NASCIS table above in 2005/6 LAs supported 39,400 adults with learning disabilities in a residential setting and in 2012/13 the figure was nearly the same at 39,025.

Growth in community based services for adults with learning disabilities has been reduced by shortages of affordable housing for community based care and because some models of supported living may be too costly. However, some providers of residential care for adults with learning disabilities are diversifying into supported living or other related activities. This is the case for providers who are for-profit as well as not-for-profit organisations. It is a strategy that allows the providers to adjust to the move away from residential provision. For example, CareTech has diversified into foster care and mental health. By 2012 the company was earning only 66% of its revenues from residential and day care services for adults with learning disabilities. This is down from 100% when it listed on AIM⁴⁵ in 2005.⁴⁶

5.4 What does the data tell us about the size and shape of the care market?

- The vast bulk of care is delivered by the private and voluntary sector with only a small section provided by the public sector.
- That there has been a shift towards more people funding their own care. This is down to changes in wealth (with more people exceeding the financial thresholds) as well as more people funding low levels of care as eligibility criteria shift.
- That care services nationally are a significant employer.
- That there has been a shift from residential care to community based provision although this trend appears to have slowed.

⁴⁴ Estimating Future Need for Social Care among Adults with Learning Disabilities in England: An Update by Eric Emerson & Chris Hatton, 2011

⁴⁵ AIM = The Alternative Investment Market

⁴⁶ Financial Times, 6 December 2012

6 Organisational structures

6.1 Introduction

Providers who make up the adult social care market are structured in a number of different ways, which, together with financial performance, may affect their stability. Two elements help to determine how providers are structured; who it is owned by and the ways in which the provider is funded. This section explores how an organisation's structure and governance may affect its stability and hence have an impact on the overall stability of the market.

6.2 Models of ownership and governance

6.2.1 Companies

Most providers, whether for-profit or not-for-profit operate through a company. For-profit providers usually operate through private limited companies, the not-for-profit providers operate through companies limited by guarantee (see below).

Private limited companies may be owned by an individual or by several individuals or by another company (or companies). In turn this other company (a "holding company") may also be owned by individuals or by another company (other holding companies). The way in which a provider's ownership is structured can have a direct bearing on the transparency or otherwise of its financial position. For-profit providers may be structured in particular ways for a number of reasons, for example, for tax reasons (including off shore holding companies), or to maximise their ability to borrow money, eg, by splitting the property off from the business or to facilitate outside investment, eg, by a private equity firm.

Companies that are registered in England and Wales have obligations to file their accounts and their accounts can be accessed by the public, albeit sometime after the period to which they relate. However, companies that are registered overseas are not subject to the same requirements and depending on the territory involved may not be obliged to divulge any information publicly.

If a provider:

- Has an ownership structure that is simple, eg, it operates through a limited company that is owned by only a few individuals, then it is easy to obtain a certain amount of financial information about the provider, provided that it has filed its accounts promptly⁴⁷

⁴⁷ Filing requirements vary, depending on the size of the company. There are exemptions for the smallest companies.

- Is owned by another company, then in order to find out who owns that company, a further search would be necessary to find if the holding company is registered in England and Wales. If the holding company is not registered in England Wales then it may be difficult to find out who the ultimate owners of the provider are and what other providers they own.
- Is owned or partly owned by a private equity firm, then it may still be possible to find financial information. Many private equity firms subscribe to the Walker Guidelines which recommend greater transparency⁴⁸ in reporting. Private equity firms usually list their investments on their websites so it is clear which companies they have invested in. Sometimes they also list historical investments.

6.2.2 Charities and not-for-profit providers

The position for not-for-profit providers is different. Not-for-profit organisations⁴⁹ are subject to restrictions, for example only certain types of company may be registered charities. Not-for-profit providers usually have transparent structures, such as being established as a guarantee company, eg, Anchor, Methodist Homes, BUPA, or as a mutual. Guarantee companies do not have shareholders but they have guarantors. They do not distribute profit to shareholders as a limited company can; instead they re-invest any surplus into the organisation or spend it in accordance with their governing documents. The Charities Commission requires charities over a certain size to file accounts with it very much as companies are required to file information at Companies House. Charities and other NFPs that are structured as guarantee companies also need to file accounts at Companies House.

6.2.3 Listed companies

Very few adult social care providers are listed on the London Stock Exchange. A stock exchange listing means that a company must comply with rigid requirements relating to information sharing about the organisation's financial position and it must file accounts with Companies House within six months of its year end (as opposed to nine months for private limited companies). It is not necessarily easy for an adult social care provider to list on a stock exchange. Health and social care businesses typically grow slowly and steadily, and often that is not what public markets want. LaingBuisson's report, "The Role of Private Equity in UK Health & Care Services" highlighted that the public market is not readily available to healthcare businesses.

⁴⁸ The British Venture Capital Association reported in 2013 that on the whole it had seen high levels of compliance with the regulations.

⁴⁹ Including charities and other providers who are NFP but do not have charitable status.

The table below provides a simple summary of governance, finance and risk for the three main types of organisational structure

	Charity / NFP	Publicly quoted company	Private company
Governance	Trustees/guarantors responsible for the governance of the organisation; they do not own the organisation. They can be sued for mis-management.	Directors are responsible for the governance of a plc. They usually hold some shares in the company. Directors can be sued for mis management.	Directors are responsible for the governance of a private company. They are responsible to shareholders. They usually hold shares in the company. Directors can be sued for mis management.
Regulation (in relation to filing etc requirements)	Subject to requirements of the Charities Commission if a charity. Must comply with filing requirements of the Companies Acts if a company.	Must comply with rules of the exchange on which it is listed and with the Companies Acts and filing arrangements etc.	Must comply with requirements of the Companies Acts and with filing requirements etc.
Funding	Can borrow money and can issue bonds. Usually cautious about this.	Can borrow money, issue bonds, issue new shares.	Can borrow money, issue bonds, issue new shares. Private equity firms may acquire some or all of its shares. May sell property to a third party.
Risk factors (in addition to the risks of poor quality care and the risks involved with a large workforce that apply to all types of provider)	Not extensive: surpluses are re-invested in the business. Usually cautious about taking on debt. Usually operated with a long term commitment to the market.	It must inform the market of developments that might affect its share price. This reduces the risks to investors. Risk of fraud, as large sums at stake.	Over borrowing, incautious expansion, insufficient investment in the company, possibility of short term view when company may be sold, possibility of selling property assets.

6.3 Particular funding mechanisms in the adult social care market

6.3.1 Private Equity funding

There has been a considerable amount of investment in the adult social care market over the last ten years by private equity firms. Private equity investment has several benefits for adult social care:

- Availability (especially at a time when banks are limiting their lending to providers).
- It does not require the business to pay interest, because the investments are normally structured as the acquisition of shares rather than as a loan.
- It brings expertise into a business, eg, advice on how to expand the business and run it efficiently.
- It encourages new entrants to the market who perceive a possible opportunity for selling their business once it has reached a size to be attractive to private equity funds, without having to expand the business to a size suitable for a flotation.

It is often the case that a private equity firm's investment is planned to be short term, such as for three to five years (although in the care market two companies indicated that they thought their private equity funding would be over an eight year period). In that time the private equity firm will want to expand the business as much as possible to increase its value with a view to selling on. This may mean that the business is run in a different way for a short time. It is not necessarily a bad thing but it is worth noting when analysing the business's performance.

Commentators are divided on the question of whether private equity investment has been a benign or a harmful influence on the market. Private equity firms have certainly contributed funding to the market and have introduced some movement at a time when otherwise there might have been fewer exits and entrances. To the extent that private equity firms have also contributed to increased transparency in the market, in relation to financial reporting and ownership, they have also made a positive contribution. However, there are anxieties both about the short term nature of the investment, the potentiality to take resources out of the business and the motives for making the investment in the first place

6.3.2 Sale and leaseback structures

Sale and leaseback arrangements (frequently described as Opco – Propco, as in, Operating company – Property company) are usually driven by a wish to release capital that is invested in an organisation's property in order to invest in the core business. Traditionally, the properties were sold to an

independent real estate investor, including REITs (see below), and the former owner became a tenant under a lease agreement.

However “internal” Opco–Propco arrangements are possible which do not dilute control in the properties. For example, if a care operator which owns properties, usually a residential care provider, wants to raise finance it may decide to set up a separate company as part of the same group to hold the properties (the Propco). The operating company, known as the Opco, continues to operate the care homes but agrees to pay rent to the Propco under the terms of the lease. This will mean that the Propco can borrow money secured against the properties using the rent received from the Opco to service the loans. The Opco may also be able to borrow money separately as lenders of business loans generally concentrate on the ability to service debt rather than comparing the amount of the loan to the value of balance sheet assets.

During the mid-2000’s the values of properties became an increasingly large proportion of the value of providers as a whole. To maximise the amount that they could borrow, companies often imposed rigid lease terms between the Opco and Propco, including increasing rental payment obligations, because the property value and the amount that Propco could borrow depended on the terms of the lease agreement. This was value enhancing at the time but it left the Opco exposed to paying higher and higher rental payments. The strength of the property and financing markets encouraged companies to maximise the amount that the Propcos borrowed.

However, the interests of the Propco and the interests of the Opco are different once the former owns the properties and leases them back to the latter. The Propco will want to set rents at a high level and the Opco will want them to be set at a low level with flexibility incorporated and will not want to pay rents that are above a market rate.

There are ways of using Opco-Propco models which do not put the Opco at undue risk. For example, the lease terms could be aligned with the performance of the operating business. However, this could compromise the value of the Propco, and may not be desired where the Propco is controlled by someone other than the controller of the Opco.

Several care providers have recently used Opco-Propco structures and/or sale and lease back arrangements. For example in 2013; Caring Homes (Myriad), Maria Mallaband (expansion funded by Apache Capital Partners £50million investment to develop eight new luxury care homes) and Barchester⁵⁰ all used this approach.

⁵⁰ Ravenshill, a group of investors, acquired the properties of Barchester in autumn 2013 in a sale and lease back deal.

6.3.3 Real Estate Investment Trusts (REITS)

Another recent trend has been investment in the properties of UK care providers by (predominantly US) real estate investment trusts. For example:

- HCP bought £175m of care provider Barchester's junior debt from Project Isobel in 2013.
- Health Care REIT backed an MBO in Willowbrook from Graphite Capital in 2013.
- Griffin American Healthcare REIT II acquired the freeholds of the Caring Homes Healthcare Group's 44 care homes from Myriad in 2013.
- Health Care REIT began the process of acquiring the stock of Sunrise Senior Living in August 2012.

On a smaller scale, UK-based Target Healthcare, a £46m REIT launched in March 2013 and listed on the London Stock Exchange, acquired the freehold of four new care homes from Ideal Care Homes Group which operates homes from the Midlands to the north of England and is part of the LNT Group.

6.3.4 Bonds

In a climate where traditional bank lending has been hard to come by a number of providers have issued bonds as a way of raising finance. For example, in 2013 MENCAP's housing arm, Golden Lane Housing, issued £10m of bonds to enable it to buy housing which would then be adapted for use by people with learning disabilities. The bond issue was oversubscribed, indicating the potential of this approach as an alternative to bank loans.

Bonds are typically issued as an alternative to bank debt if the issuer wants to borrow more than a bank will lend it or in a market where the banks are reluctant to lend. Bonds are issued for a certain length of time and carry an obligation to pay interest at certain intervals. At the date of maturity the issuer repays the principal (assuming it is able to do so). These bonds are known as "high yield bonds" because they typically offer a high interest rate. They are also known as "junk bonds" or "non-investment grade", because most brokers do not invest in them and they are speculative for an investor because they have a high default risk.

Bonds are a useful way of raising finance other than via bank borrowings. They typically attract a wide pool of investors and allow borrowers to diversify their funding sources. They also allow borrowers to raise debt with much longer term maturities than bank loans. The interest rates that the issuer pays on bonds may be lower or higher than the rates that banks charge for loans. Bond investors are sufficiently confident in the care market to buy bonds even though the spreads paid by high yield issuers are

low relative to the historical average – so bond investors are receiving a lower rate of return for a given level of risk than would have been the case in the past.

Care providers who have recently issued bonds include:

- Voyage
- Priory
- Care UK
- Avante
- Golden Lane Housing

6.4 Conclusion

Based on the evidence above, even in a recession the care market still appears to be sufficiently attractive for investors to invest in, in one form or another. When banks were reluctant to lend providers were able to take advantage of alternative sources of finance by selling properties or by issuing bonds.

Overall there are two key issues from this section for market oversight and stability:

- In terms of organisational ownership, as was discussed with Southern Cross, the more complex, and the more internationally diverse the ownership model then the more difficult it is to gain clarity about the overarching financial position. This complexity may not only be in relation to private companies but also charitable bodies who have a mixture of organisational governance arrangements. The other implication, apart from finances, is that a care company may be in financial difficulties not through their own actions, but through the actions of their 'parent' or holding company.
- Clearly, debt, and the management of debt, is a critical issue for some of the large care providers. Private equity funding, sale and leaseback arrangements and bond issues appear to have become a dominant trend in the funding of debt in the care sector. Whilst there is nothing inherently wrong with these mechanisms, and some would argue they have generated funding and development where other avenues have been closed, they do introduce dynamics that may influence market stability. Short term 'buy and build' approaches to development may do little to enhance the quality of care and in the longer term separating property from care delivery may limit the potential for investment in the latter at the expense of the former

7 Factors that may influence organisational and market stability

7.1 Introduction

Clearly a wide variety of factors can potentially threaten organisational stability and, if occurring across a wide enough range of providers, market stability. This section attempts to isolate those factors and assess the impact that they may have.

7.2 Organisational Structure

From the material presented in the preceding sections, which elements of organisational arrangements are most likely to affect the market adversely? Three issues in particular can be identified:

- Corporate structures that are over focused on taking cash out of the business in the form of dividends.
- Arrangements that reduce the value of the assets, eg, selling the properties in sale and lease back; not maintaining the physical buildings.
- Private equity investment that is short term which only looks to grow the business through the removal of assets or through rapid acquisitions or where it is 'buy and build' but without investing in unifying the organisation.

Conversely the organisations that are most likely to have the greatest financial stability are not for profit, large scale, housing providers who also provide care. They tend to own their assets outright which in some instances are substantial; some have no debt; they do not have to distribute money to shareholders (surpluses are usually reinvested in the business) and they very rarely change hands. In addition, in the case of housing providers providing care, some are monitored by three separate regulators. Clearly, it would take mis-management on a cataclysmic scale or a significant reputational tragedy for any of these larger providers to end up in serious financial difficulties. Even if that were to occur, if public pressure mounted against such organisations then a takeover, secured against the asset base would be the most likely outcome, and care would be secured.

7.3 Ownership

As commented earlier businesses starting and terminating are not necessarily a sign that a market is unstable. Some businesses fail because they are badly managed or have overstretched their resources rather than through any indigenous failure in the market. Therefore, turnover is not necessarily a sign of failure it is the volume and type of change that may be more indicative of market instability.

Within the care market it is noticeable that there is a high volume of private equity involvement. Some providers have described this in recent years as tailing off. However, if REITs are included, then the market still looks dominated by this form of financing / ownership as compared to public companies or not for profit providers.

Comparing the largest ten UK Registered Care Home Providers by homes and beds from 2010-2013

December 2010 / January 2011			December 2013 / January 2014			
Operator	Care Homes	Care Home Beds	Operator	Care Homes	Care Home Beds	Private Equity funded?
Southern Cross Healthcare Group Ltd	732	38,719	Four Seasons Health Care Ltd	510	25,964	Yes
BUPA Care Homes (CFG) plc	303	21,088	BUPA Care Homes	302	21,562	No
Four Seasons Health Care Ltd	353	17,955	HC-One Ltd	240	12,721	No
Barchester Healthcare Ltd	203	11,786	Barchester Healthcare Ltd	216	12,704	No
Anchor Trust (not-for-profit)	96	4,265	Care UK	132	6,710	Yes
European Care Group	93	4,075	Orchard Care Homes	113	5,955	No
Care UK Ltd	77	3,601	Methodist Homes (MHA) (not-for-profit)	92	4,713	No
Craegmoor Ltd	184	3,441	Priory Group (inc Craegmoor)	217	4,413	Yes
Caring Homes Ltd	117	3,422	Anchor Trust (not-for-profit)	96	4,360	No
MHA Care Group	74	3,405	European Care Group	89	4,012	No
Totals	2232	111,757		2007	103,114	

Source: LaingBuisson, *Community Care Market News*, December 2010/January 2011, Volume 17, Issue 8; and December 2013/January 2014. Volume 20, Issue 8.

Comparing the largest ten UK Independent Homecare Providers, from 2010-2013

December 2010 / January 2011			December 2013 / January 2014			
Organisation	Annual Homecare Turnover (£m – estimated)	Market share	Organisation	Annual Homecare Turnover (£m – estimated)	Market share	Private Equity funded?
Allied Healthcare Group Ltd	153	3.0%	Allied Healthcare (Saga, inc Nestor)	335	6.6%	Yes
Carewatch	128	2.5%	Carewatch	142	2.8%	Yes
Nestor Healthcare Group plc	107	2.1%	Mears Group plc	137	2.7%	No
Mears Group plc	101	2.0%	Care UK	113	2.2%	Yes
Care UK plc	83	1.6%	City & County Healthcare	112	2.2%	Yes
Housing 21 (inc Claimar and Complete Care)	74	1.4%	Lifeways Holdings Ltd	105	2.1%	Yes
Enara Community Care	53	1.0%	Housing 21 (inc Claimar and Complete Care)	95	1.9%	No
Lifeways Community Care Ltd	46	0.9%	MENCAP	93	1.8%	No
City & County Healthcare (formerly London Care)	34	0.7%	MiHomecare (MITIE Group)	93	1.8%	No
Sevacare	26	0.5%	Bluebird Care	70	1.4%	No
Totals	805	15.7%		1295	25.5%	

Source: LaingBuisson, Community Care Market News, December 2010/January 2011, Volume 17, Issue 8; and December 2013/January 2014. Volume 20, Issue 8.

The tables above indicate a number of trends:

- The continued involvement of private equity, with organisations often being sold from one group to another.
- The shift in ownership from Southern Cross, ie not all the homes went to the biggest providers.
- The large growth in home care business.
- The increased market share in home care amongst the largest providers.

- A reduction in the number of care homes and beds amongst the largest providers.

7.4 Distribution

Geography is important for care providers. Care homes that are widely distributed are harder and more costly to manage. In home care attempting to cover wide geographical areas without a travel and time premium is equally financially risky for providers. Therefore, companies that rapidly acquire new businesses without geographical coherence may be more at risk than others, particularly if the intention is to rapidly increase turnover before selling on.

7.5 Legislation and Regulation

Clearly increases in regulatory regimes potentially impose increased costs on providers although few would argue that they really threaten stability within the market. Most providers appear to support the proposed new CQC ratings system, arguing that it highlights good practice. Their main criticisms would be the slowness with which CQC recognises and publishes improvements in care after people have received warning notices. There were also comments from providers that if they step in to rescue or take over a company that has been failing, it needs regulatory help and speed of response when making improvements. Slowness to transfer registrations may disincentivise providers and hence put residents more at risk in the case of care homes.

Providers interviewed felt that changes in the regulatory approach were inevitable and involve gains as well as losses. Greater concern about market stability was expressed in terms of the Care Bill and, for older people's residential care providers, the impact that changing the funding basis might have. Concerns focused on the impact that published LA prices might have on self-funders. Currently all providers agreed that self-funders subsidise state funded places and whilst the self-funder market was seen as important, few providers argued that they could survive on that revenue alone. In general, it was felt that the potential impact of the Care Bill on the market was under researched.

7.6 Employment factors

Many of the providers interviewed saw employment factors as one of the biggest threats to market stability. Essentially the argument came in two forms:

- A rise in the National minimum wage level to £7 or further increases in National Insurance etc, would be highly problematic if not fully reflected in the price paid for services. Many providers pay the majority of their front line staff the minimum wage or something close to it. Increases would impact not only on the wage levels of front line staff but would

also have a knock on effect on maintaining differentials. Similarly, a number of Local Authorities wish to use providers who pay the Living Wage, however in many of those authorities providers state this is not matched by an increase in fee levels.

- As Britain emerges from recession, if the private sector lifts off whilst the public sector has a sustained period of price restraint, this, combined with limitations on employing overseas labour, could lead to an inability to recruit staff at any price that would be affordable.

Other issues include:

- Agency staff are more expensive than permanent staff. Most care providers need to use agency staff to some extent in order to cover unexpected staff shortages. Use of agency staff at about 1% or 2% is usual (although we suspect in a number of instances it may be higher than this). Organisations that had higher levels of agency staff might not be managing their staff well and would be paying more for staff than their rivals. Therefore high use of agency staff may be an indicator of a provider that is not well managed.
- Similarly, higher than average staff turnover may be an indicator of a provider that it not well managed. Industry averages are about 25% turnover per annum. NFP providers tend to have lower turnover.
- Finally another reason that staffing levels are crucial for the stability of a provider is that higher turnover of staff and increased use of agency staff is associated with higher risk of poor quality care and of abuse. Benbow, in 2008, identified low staffing levels and/or use of agency staff as a key risk factor for abuse.⁵¹

7.7 Occupancy and take up

Average occupancy rates have fallen slightly over the last few years and are currently about 85-90% in residential homes in the older persons care market. Older people are being admitted to residential care at a later stage, with higher acuity levels than in the past, and living for a shorter period of time once they have moved into a home. This means that average lengths of stay are down to between 12-18 months. This brings with it increased costs because clients tend to cost the provider more at the start of their stay, needing extra help settling in while the staff get to know them.

Some self-funders are charged an extra fee on admission to cover the extra costs but Local Authorities do not pay an admission fee. In addition, higher rates of turnover in residents, means that residential care homes are left with empty beds more often which in turn brings with it lower occupancy. Providers whose occupancy rates fall below an average of 85% for more

⁵¹ 'Failures in the system: our inability to learn from inquiries', The Journal of Adult Protection, vol 10, no 3, pp 5

than a few months may struggle to remain in business, unless they own their home(s) and do not have outstanding loans⁵².

Occupancy rates in residential care for people with learning disabilities are steadier because people with learning disabilities tend to live in a residential care setting for many years. However, because the residential care homes in the learning disability sector are smaller, occupancy is more affected if a single client leaves.

7.8 Fees, pricing and profitability

The profit levels of care providers vary widely, depending on a number of factors, including the services they provide, but chiefly affected by:

- Whether or not they have large debts.
- Whether or not they own their properties.
- The proportion of clients they have who are LA funded.
- The extent to which they provide services to people with learning disabilities (whose funding has not been cut back by LAs as much as services for older people).
- The extent to which they provide services to CCGs⁵³.

In their study of home closures, Netten et al (2003)⁵⁴ found no relationship between the quality of the home and likelihood of closure although (low) price was seen as an important contributory factor.

Since many providers borrowed heavily in the past, interest payments are often an important part of those providers' budgets. For example, Caring Homes Healthcare Group Limited reported revenues at £142.2m for the year ended 31 March 2013. EBITDA was £29.0m. Profit before interest and tax was £16m. But interest payments were £21.5 so overall it made a pre-tax loss of £5.5m. Since then Caring Homes has sold its properties in order to pay off its debts.

By contrast, another provider, Somerset Care Group reported a 3.6% increase in turnover from £77.7m to £80.5m for the year ended 31 March 2013. Operating profit stood at £6.3m (2012: £5.4m) and a profit of £5m before tax was made (2012: £4.3m).

⁵² The breakeven point if the provider owns the properties was 50% in 2011. Source Financial Times, May 30 2011, "Southern Cross run on failed business model"

⁵³ Clinical Commissioning Groups

⁵⁴ Nursing home closures: effects on capacity and reasons for closure Age and Aging Vol 23

7.9 Provider perspectives on pricing

Older Persons residential care

Providers report that for several years the fees that Local Authorities have paid for clients are very low. Often they do not cover the price of the care so the provider needs to use profit from self-funders to subsidise the costs of the Local Authority funded care.

Older Persons home care

Local Authorities' fees are seen by providers as low in this area too. Many providers say they are making very small profits, or even losses, and some are considering moving out of the market. Most providers state that they are rapidly seeking to bolster their organisation by developing the self-funders' market. However, this seems hard to identify and some of the companies that have attempted to do this have reverted back to more traditional markets.

Most providers state that across residential care and community care for older people there are two trends occurring:

- **A move by all providers to develop their self-funder products.** Few providers we talked to suggested that they would ever be wholly supported by self-funders but recognised the gap between state funded and self-funded clients was getting wider, particularly in more affluent areas.
- **Delivering care in high end and more predictable areas of need.** In terms of older people's care this tends to mean more service users with a health care component to their care or where residential care is being used to move people on from hospital at a quicker pace.

Learning Disability residential care

Providers tended to see the learning disability residential care market as more much more stable than the older persons care market. The fees have increased more over the last few years than fees paid for older people although some Local Authorities are starting to reduce increases. Some authorities have used external consultants to drive down prices. Providers feel this has been done without discriminating over the quality or type of care being delivered.

Learning Disability care in the community

Again, the market is entirely made up of Local Authority funded care. This area has been hit more by funding cuts than residential care because it is easier to chip away at care packages that are structured in terms of hours per week than it is to cut back on care packages that are for twenty four hour care. However, providers say that Local Authorities have not imposed such severe cuts as they have with older people's care.

In both areas of learning disability care the more predictable areas of demand are seen as those services which offer care to people with profound and multiple disabilities often involving a health care component. This area of activity is seen as attractive to potential and existing specialist providers because payment is both more certain and predictable and charges are at a higher fee level.

7.10 So what are the key factors that affect market stability?

This section has presented a range of factors that influence provider and market stability. There is agreement between providers and ADASS that there are wide variations in the market around the country, that Southern Cross and Castlebeck have given good reason to pause and consider the way forward, that recruiting a trained and well paid workforce is a major issue for the future and that the older persons care market continues to be fragile.

Very few of the providers and financial advisors we interviewed ruled out the possibility of another Southern Cross style crisis. This view was balanced by the argument that, in the case of failure by a residential care provider if they owned their properties, another provider(s) would step in to take over the business. If a home care provider (which does not rely on assets such as property) were to fail, then the view was that other providers would not necessarily take over the provider's contracts but might take on their staff and look to re-negotiate contracts with the Local Authorities and other clients. The greatest risk is likely to be with the failure of a large care home provider, who does not own the properties in which they operate (leasehold at 50% was felt to be an acceptable level of risk) and where they had a concentration of homes in a limited number of authorities in less affluent areas.

In terms of overall market failure providers interviewed not surprisingly had a strong focus on price and the margins that it might deliver. Many were concerned at their capacity to deliver quality care within the price that many Local Authorities were paying. Alongside this they saw the combined potential of an increase in minimum wage and a rise in interest rates as potentially forcing some out of business and others into a greater concentration on self-funders in the South of England, although perhaps the greater likelihood is towards further consolidation within the care market.

The other factor that was raised concerned smaller, single home providers. A rise in property values alongside the demands of regulation and lower levels of Local Authority funding may well persuade them to cash in their assets and leave the market. They are homes that are unlikely to be taken over by another provider, because their margins only deliver a profit on the basis that their property is already paid for. If this occurred in sufficient numbers then in some parts of the country this could make the care home market less stable.

8 Provider and market stability: Some conclusions

8.1 Introduction

It was commented by more than one person interviewed that government and regulation tend to deal with the crisis that has passed rather than the crisis to come. Therefore, this concluding section reviews the evidence presented so far as to whether there is likely to be further provider failure, and whether, over and above individual failure, there are factors that make providers and/or the whole market less stable. Section nine then looks in the light of those comments at how the market oversight regime may be implemented and Section ten contains some recommendations for consideration.

8.2 Another Southern Cross?

Whilst there may be no company or voluntary provider with the same set of circumstances as Southern Cross, the factors that gave rise to its problems are still present within some providers in the older persons residential care sector, eg, high levels of debt, separation of home ownership from care provision, concerns over levels of occupancy⁵⁵. In the preceding section we argued the most likely characteristics for a provider at risk were a large care home provider, who did not own the majority of the properties in which they operate and where they had a concentration of homes in a limited number of authorities in less affluent areas.

There seemed little evidence, neither did providers suggest, that there was any imminent likelihood of failure in the learning disability sector. In terms of older persons home care then whilst there are clearly concerns about viability of the sector, and some providers felt they could no longer deliver the quality of care to which they aspired to Local Authority clients, there did not appear to be a risk of either imminent collapse or a reluctance of providers to enter and compete in this sector.

This suggests that whilst it is not the job of the regulator to spot financial winners and losers, there is a need to maintain a wider oversight of shifts and trends in the sector and the implications this may have for the likelihood of any one provider failing. Given the ownership models of many providers, simply relying on formal published financial metrics is not the same as capturing market intelligence.

⁵⁵ This view is supported by Company Watch who in August 2013 reported that from a sample of 4,872 care home companies, responsible for an estimated 20,000 care homes operating in the UK, 1,449 care home companies had a financial health rating (H-Score®) of 25 or less out of a maximum of 100. Over the past 15 years, companies with this type of score have had a 1 in 4 chance of needing a financial rescue of some type. Company Watch also suggested that there were 693 'zombie companies', ie, those with a negative net worth. <http://www.careindustrynews.co.uk/2013/08/a-third-of-uk-care-homes-at-risk-of-financial-failure/>

8.3 Another Castlebeck?

There is always the potential for a Castlebeck type failure to occur. As more than one provider stated, this is a low wage, largely untrained, sector where there is a huge number of staff and often thin managerial lines of command. If you employ thousands of people in relatively closed settings there is always the possibility that something will go wrong.

In adult care a Castlebeck type risk is still probably highest in the learning disability sector where poor care can rapidly lead to a loss of confidence in the provider. In addition, because the costs are relatively high in the learning disability sector and the numbers of people cared for in any one location are small, then under-occupancy and hence financial problems can rapidly occur. Losing one client from a four bed home means that occupancy is reduced from 100% to 75%, with viability instantly turning into unviability.

Historically, change in social care has often been driven by a failure of care providers to provide adequate care; from the death of Dennis O'Neill in the 1940's, to the Court Lees Approved School scandal in the 1960's, through to Winterbourne View. In the past this would often have meant the closure of institutions following an inquiry and the creation of new forms of care delivery. Now, given the speed of contagion, a significant failure of care is more likely to lead to a collapse of the care provider and at a swifter rate than change driven by state review. Therefore, there is a strong need for the inspection regime of the CQC to effectively acquire market intelligence if the regulator is going to have the capacity to react to any potential quality driven, provider failure.

8.4 Market strengths and weaknesses

Following Southern Cross and Castlebeck, the perspective has always been that these were provider failures rather than being symptomatic of the market as a whole. Nonetheless it needs to be considered whether there is, or could be, a situation where the market fails.

Barring a national collapse of the economic system, eg, such as hyperinflation in Germany in the 1920's, it is hard to see how the care market could collapse to the extent that provision was not available in some form for people who needed it. Even if state funding dropped to a level that providers exited the market because they could not deliver care, within regulations at the price available, eventually this would lead to the market self-correcting through greater self-funder take up, a rise in prices or a change in quality standard. To some extent this kind of market correction occurs all the time, eg, most new care home builds are averaging around sixty to seventy beds as compared to a market average size of around thirty beds as providers seek ways to optimise their provision.

The more appropriate question is probably what might be the consequences of greater instability within the market. From IPC's analysis we would put forward the following as factors that could make the market more unstable:

- A combination of an increase in the National Minimum Wage, below inflation increases in funding for state funded care and a rise in interest rates could lead to a financial crisis in the sector. This would particularly hit providers that had a combination of three characteristics:
 - A heavy reliance on low paid staff and high numbers of agency staff.
 - High numbers of LA funded service users.
 - Debt that is subject to a rise in interest rates and/or rent increase for care premises at above inflation.
- In older people's residential care a significant indicator of viability is average length of stay. The more this lowers, if care is priced at the same level, then the more vulnerable providers become, as the total amount of time when there are empty places will increase.
- Any further reduction in LA fees or maintaining the current standstill in fees is likely to put pressure on providers⁵⁶. This may encourage a greater use of cost saving such as fewer competent managers, less training, etc.
- We have not explored the full implications of the Care Bill. Some providers argued that instability could be introduced by the increased financial envelope in which LAs make a contribution to people's care.

However, there are also some contrary indications that may make elements of the market more stable:

- An increase in the use of personal assistants offers wider choice and greater diversity and may bring some people to work in the care sector who would otherwise not have been attracted to it.
- There is an increasing involvement in care provision via extra care and a remodelling of sheltered housing by housing providers that is backed by a considerable asset portfolio.
- The diversity of care providers, funding and governance models makes the market more stable.

In the longer term the market may be affected by other factors as well. For example:

⁵⁶ The ADASS budget survey 2013 estimated that 57% of adult social care directors think that providers will be facing greater financial difficulty. 45% of Local Authorities gave no inflation increase to older people's care homes in 13/14. 60% gave nothing for physical disability, 64% nothing for learning disability and 65% nothing for home care.

- As property prices rise, small single home providers may leave the market in order to cash in their property asset, yet because of their size or configuration these homes are unlikely to be taken on by any other provider.
- If managing care businesses becomes harder and less rewarding then it may be difficult to recruit managers at the skill level necessary.
- If the economy lifts off in the service sector long before the public sector, ie, two to three years, then low paid staff may be expected to leave the care sector if wages increase in other forms of employment.
- If financial pressures get greater then pressure to move to an Opco-Propco model, for more providers who currently own their properties, will increase. Such a move needs to be closely watched because if you take the asset base out of the sector it potentially becomes less attractive to further investment and hence more vulnerable to change, ie buildings or land that could be used for a more profitable purpose.

9 Market oversight: Some conclusions

9.1 What is the regime trying to achieve?

As outlined in Section Four, the Market Oversight regime fits within the context of the Care Bill and the Government's desire to ensure that there is a diverse market of high quality care and support. The regime imposes three requirements on CQC:

- To identify providers who fall within the scope of the Market Oversight regime.
- To safeguard the consumers of care by assessing the financial sustainability of providers who fall within the regime and acting accordingly.
- To be proportionate in the expectations it places on companies and organisations.

9.2 What are the issues with the approach?

The first difficulty is in deciding which providers fall within the Market Oversight regime once the regulations have been finalised, taking into account the three categories of size, geographical concentration and specialism.

9.2.1 Size

In relation to organisations which provide residential care, the size of care homes is usually judged by the number of beds they have. However, it would be possible to rank the organisations in a different way, by reference to turnover. This would be true for older people's care homes and for care homes for adults with learning disabilities.

The judgement of size of home care providers is less easy to make. CQC ranks home care organisations by reference to the number of branches that a provider has⁵⁷, or else by reference to the number of services they provide⁵⁸. It might be helpful to rank the size of domiciliary care providers by reference to the number of clients they have. However, some organisations have many clients without complex needs who only need a few hours care a week, while others have fewer clients but their clients need high intensity care. Therefore, if one purpose of counting is to determine the potential for that care to be picked up by another provider, a better measure might be needed.

The suggestion would be to establish a minimum threshold that comprised a number of clients or the number of care hours of delivered.

⁵⁷ For example LaingBuisson's Care Compliance Monitor: Homecare

⁵⁸ For example the CQC report entitled Not Just a Number – home care review inspection report 2013

Here of course size has only been considered in terms of single areas of provision. Some providers provide care across different types of services, eg, older people and learning disability or home care and residential care. The need is for some degree of flexibility on the judgement of size. A complex provider, who provides a range of care services, may be harder to replace quickly, than a provider who only offers one type of care service.

9.2.2 Geographical spread

The issue of geographical spread in determining which organisations should fall within the regime is based on the premise that if an area relies heavily on only one or two care providers, if they fail, then they would be difficult to replace. Therefore, any providers that are dominant in areas without much (or any) choice of care provider should fall within the regime.

However, it could be argued that in sectors such as home care, a provider who has a geographical concentration will be more attractive from a financial point of view because care workers will be able to cut down on travelling time between clients, the organisation has greater potential to be efficient and its geographical concentration gives it more price leverage with Local Authorities.

Some of these arguments would also apply to care home providers. However, as argued before, in that case the greater test may be whether the care home business is asset backed or not. It may also be argued that providers who provide care over a wide geographical area are likely to find it more costly to supervise their workforce and are consequently more at risk of failure due to poor quality care.

Clearly what constitutes a geographical area cannot be a uniform benchmark. Replacing care in a large urban area where providers straddle a range of authorities may well be easier than replacing care in a remote large shire county where that provider is both locally dominant and delivers a range of services, eg, residential care and home care.

9.2.3 Specialism

Specialism, of the three tests, is the hardest to define for this purpose. Some providers provide services that are so specialised that it might be argued that it would be difficult for another provider to take over the services if they failed. However, if a provider has assets and clients, and has failed, eg, due to an operational defect, including poor quality of care, then it is likely that other providers will be prepared to take over the running of the business. Even if it has failed due to poor financial management other providers may still be prepared to take on the business because of the potentially monopolistic position it occupies.

Specialised provision of services tends to be better protected in LA budgets so often the more specialised a provider is the more desirable its business would be to others. In addition, providers which provide specialist services may also provide services to CCGs and so be less exposed to Local Authority pricing squeezes.

9.3 Use of discretion

The Care Bill⁵⁹ currently limits the discretion available to the regulator. It states that the Secretary of State should have regard to size, geography and specialism in framing the regulations (although presumably regard could be given to other factors) and that this determines the boundaries of who is in and who is outside the regime. CQC “must determine, in the case of each registered care provider, whether the provider satisfies one or more of the criteria specified in regulations” and then “must assess the financial sustainability of the provider’s business of carrying on the regulated activity in respect of which it is registered”. Discretion then only comes to the regulator in terms of determining whether, on the basis of that assessment, there is a significant risk to the financial sustainability of the provider’s business.

It needs to be recognised that given this scenario, Southern Cross would undoubtedly have entered the regime, whereas Castlebeck almost certainly would not.

9.4 Assessments of financial stability

Just as drawing boundaries around some of the criteria may be more difficult than it looks on first glance, so assessing the “financial sustainability of the provider’s business” may also not be straightforward.

Every provider is structured in a slightly different way and has different financial (and other) pressures on it. This means that it will be difficult to obtain a clear picture of its financial sustainability using either a “one size fits all” approach, or using a paper based exercise. For example, a provider’s accounts might be difficult to understand fully without also interviewing the Finance Director to establish the basis on which they were written. Financial information may be legitimately presented in a number of different ways depending on how the provider wishes to appear at that moment.

The fact that many providers have large amounts of debt means that standard metrics such as EBITDA are not a good indicator of financial sustainability. At the same time, published accounts are historical documents and are largely backward looking; to analyse sustainability for the future it is necessary to analyse forward looking information such as projections. In addition, it is not just financial information that is needed.

⁵⁹ Sections 53-55

Other factors, as we have seen, can have a huge impact on a provider's financial sustainability from one day to the next. So it is also necessary to analyse the ongoing situation in the market and the factors that may affect it.

The link between quality of care and financial sustainability is crucial to the market. As a provider's financial position deteriorates, for whatever reason, the quality of care it provides tends to be reduced and maintenance is also affected. Poor maintenance can be a sign of financial problems which can lead to lower levels of training for staff and consequently to lower levels of care. Therefore, the data that CQC receives from its inspections needs to be fed into its intelligence capability in order to inform its Market Oversight function.

Finally, it must be borne in mind that the mere fact of identifying a provider as being at risk may itself weaken their financial position. For example, this may be due to it being known that an assessment of their financial stability is being conducted and Local Authorities, who have had prior warning, ceasing to support that provider through not making placements.

10 Suggestions and Recommendations

10.1 Flexibility and Discretion

Even at this late stage it may still be worth considering within the framework of the Care Bill how more flexibility and discretion may be introduced via regulations. Large scale provider failure is still rare despite the arguments presented here that another Southern Cross type failure is a possibility. A light touch and flexibility, which have been phrases much used during the consultation on market oversight, are better delivered where providers may easily enter and leave the oversight regime. Anything more and the danger is that public funds are spent considering formal financial metrics that may reveal little.

10.2 Financial analysis

Analysis of financial sustainability on an ongoing basis also needs to be as flexible as possible but to take into account the large amounts of debt held by some providers as well as the other risk factors discussed. A risk based approach may determine certain parameters for the regime, eg, in the case of franchises, it might not be necessary to include any national providers where more than 50% of their business is franchised, as failure by the parent company would not necessarily produce a local loss of care.

Equally, a risk based approach may mean that financial analysis needs to take into account other group companies of providers, including group companies which do not provide care, if the failure of a group company might affect the sustainability of the provider. Some providers who are stable may face market failure through other forms of business elsewhere in their group.

10.3 Relationship managers

CQC already has a role which allows for discussion between providers and the regulator through its relationship managers. However, from a provider perspective, whilst there were mixed views about the value of this role, most were clear, as was CQC, that it did not include skills to financially assess and analyse company performance or to make judgements about financial sustainability. CQC may wish to consider how this function can best be strengthened.

When companies enter the failure part of the regime CQC needs to look at how it can facilitate the swift transfer of the business. Such actions are clearly in the interests of continuity. This may be helped by having a designated individual to participate in such discussions. Such a role would be similar to an in-house insolvency practitioner or restructuring expert but using CQC's existing mechanisms.

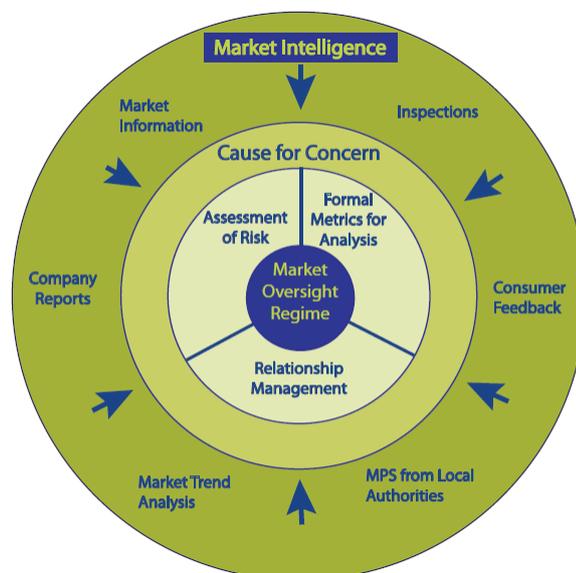
Some of that strengthening needs to come from external sources of help and expertise. IPC would be keen to assist with this as we are sure would other experts.

10.4 A wide or narrow interpretation of market oversight

The Care Bill signals a further step on the road from a state dominated care sector to one where the care consumer has greater choice in a diverse market. The corollary of this is that a lessening of Local Authority control and oversight equally gives rise to the need for better information about the market to be shared by the regulator, with consumers, local government and the market, if care provision is to function effectively. At the time of Southern Cross both the President of ADASS and the Secretary of State emphasised the need for greater transparency and information being one of the best safeguards of the care market.

In this respect does the market only need a regulator that concerns itself with the continuity of care if and when a provider fails or with the wider issues of market stability choice and diversity? Even in the case of provider failure, having created the market oversight regime and appointed CQC as its lead then the public and media may have higher expectations of the regulator than the legislation allows for.

In order to deliver this IPC would suggest a two tier approach: one the formal oversight regime, the second the ongoing capture of market intelligence.



As the diagram suggests, the outer circle of market intelligence should capture and analyse data from a variety of sources; from Local Authorities (Market Position Statements), from the inspection process and from trawling company and organisational information on a regular basis. Some of this material should go into the annual CQC State of Care review and specialist sector reviews. Some should be fed back to benefit the whole sector, to Local Authorities, providers and care consumers.

If Local Authorities are to “promote the efficient and effective operation of a market in services for meeting care and support needs” then they cannot do that without the support of CQC and the information it holds. If this doesn't

happen it enhances parallel and unintegrated systems with CQC acting on quality as the regulator and the Local Authority acting on quality as a commissioner. As a contribution to avoiding this, it should be far easier than at present for all three parties to view an analysis of the availability of local care provision on the CQC website and to integrate such material with NASCIS data.

The second part of the diagram, the cause for concern circle, is in effect the judgement made on the strength of pooling the range of information and then adding that to the formal metrics from the oversight regime. It is a role similar to that of 'Policing the Boundaries' which the Financial Conduct Authority uses.

Finally at the heart of the process comes the formal market oversight role. However, if the wider market intelligence activity is functioning well then that should allow for the regime to be better informed and hence less of a burden on both the regulator and the market.

IPC would see the development of the wider market intelligence role as an important precursor to the market oversight regime and as a part of CQC strengthening its role in the care sector. We feel this is consistent with the aspirations published in CQC's own review⁶⁰ namely:

"We will also draw on our unique sources of data, intelligence, evidence and knowledge, and that of others, to become a more authoritative voice on the state of care." (p6 repeated p14)

"Looking forward over the next three years, we will be more ambitious with our unique sources of information, and the information held by others, to become a more authoritative voice on the state of care". (p15)

⁶⁰ "The Next Phase: Our consultation on our strategy for 2012-2016" CQC.

11 Appendix

Organisations which contributed to this report

ADASS
Allied Holdings (Saga Homecare)
Anchor
Barchester
Barclays
Bupa UK
Care UK
Carewatch
CQC
Department of Health
HC 1
Knight Frank
Lloyds
Mears plc
Mencap
Methodist Homes
Patron Capital
Priory Group
RBS
Savills
VODG
Voyage Care