Response to consultation: market oversight in adult social care

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Summary of key response points:

We welcome the opportunity to comment on the proposals to strengthen the economic regulation of the adult social care market, and recognise the importance of this issue for individuals receiving services. However, we must make clear that it is absolutely essential that if such regulation is put in place then it must also extend to commissioners (LA and NHS) in order that they can be held accountable for their actions, not only to the economic regulator but also to service users and care providers. If this does not happen then the proposals will do nothing to address key weaknesses in commissioning looking instead only at one aspect of the market and we question the wisdom of investing in regulation that is only partial. The main risk to a care home is combination of:

- A high percentage of LA occupants,
- A low level of LA fees and
- Low/ nil LA referrals.

Q1 The perception of local authorities' current effectiveness in managing provider failure is likely to be over-optimistic;

Q2 Further clarification should be given to local authorities regarding their existing obligations in respect of the Choice of Accommodation Directions. Effective oversight and monitoring of local authority commissioning is required, including provisions to manage commissioning failures.

Q3 Registration criteria may need to be reviewed and CQC's initial assessment of financial viability tightened;

Q5 Where local authorities provide insufficient funding for care services, the level of underfunding is typically most profound in respect of services for Older People. This particular group of people may be at the greatest risk of commissioning failure and / or provider failure.

Q6 In order to ensure consumer rights are delivered, many local authorities' commissioning practices will require substantial improvement in order to be compliant with Office of Fair Trading Guidance.

Q7 Whilst all providers should be required to have contingency plans, they should also be proactive in alerting the regulatory authorities to examples of poor commissioning practices;

Q8
- Monitor should be the financial regulator (with additional expertise in social care required and working closely with CQC so that their roles align) and should have its powers reinforced by severe sanctions;
- **we believe a prediction-driven early warning system to be unnecessary;**

– the regulator should focus on protecting service continuity and service users' welfare by ensuring necessary defence measures are in place;

– we suggest an alternative model of oversight, which should also apply to providers of home care services, based on a statutory duty to maintain continuity of service, with a much-reduced requirement for information disclosure;

– local authority contingency plans should be independently verified;

– **we believe all care homes should be exempt from the licensing of providers of NHS services, including CRS designation;**

Q9(A) We have reservations about the reliability of local intelligence;

Q9(C) – Market share, informed by local circumstances, is the most sensitive indicator for setting risk thresholds;

– there are, however, definitional issues in relation to the concept of the "market", particularly "local" market;

– **providers should be able to appeal against an assessment that places them above the risk threshold**;

Q9(D) Information requirements should match those used in Monitor's risk assessment framework;

Q12 There is a need for clarity on the respective roles of local authorities and the regulator in the context of provider of last resort;

Supplementary points

1 The sequencing of consultations has been mismanaged with the result that some providers might have been seriously disadvantaged;

2 Responsibility for market oversight should lie exclusively with the financial regulator; local commissioners should be precluded from intervening in this area;

3 **Monitor should be empowered to exercise a supervisory role on commissioners' commissioning including terms of contracting and pricing**.

Consultation questions

Section 1 Questions	Response
Q1. Are local authorities currently managing provider failure effectively and how could they plan and carry out their plans more effectively?	**ALTHOUGH IT IS IMPOSSIBLE TO ANSWER WITH CERTAINTY, IT IS LIKELY THAT MANY ARE NOT** **Please provide more details:** The Impact Assessment (paragraph 23) acknowledges, "There is currently little available evidence on how well provider exit is managed across the country", thus calling into question the somewhat sanguine view advanced in paragraph 87 of the consultation document. We believe there is a very real danger of complacency in relation to the ability of local authorities to plan for, and subsequently to manage, business failure. Most

	(fortunately) do not have the experience on which a judgement of their effectiveness can be made. While authorities may be familiar with the planned closure of their own homes, a leisurely process that can be spread over years, their experience of unplanned closures in the independent sector has in most cases been restricted to small-scale, and usually single-home, providers. Few, if any, have had to meet the challenge of disorderly closures in the independent sector, involving residential places numbered in the hundreds. That would be the litmus test of their planning. It is questionable if failure on a large scale would be manageable within the resources of any one authority, however sophisticated its plans. That is our cautious view of the current situation. We believe that this scheme should not be taken forward without testing authorities, in a number of pilot areas, on their capacity to manage closures in their own areas on a scale consistent with DH assumptions. We question the statement (paragraph 83, second bullet point) that the "good relationships" authorities are expected to develop with all providers will be sufficient to encourage the latter to share sensitive commercial information, particularly when the authority in question operates its own care homes and is likely to purchase the majority of care home places. We do not believe that local authorities will be able to manage the consequences of business failure effectively without the active cooperation of local providers. As things stand, unless attitudes change radically, unless and until councils prove that they are willing to translate the fine words on the page into action, we fear the hopes invested in the Developing Care Markets for Quality and Choice programme (DCMQC) will come to nothing. In short, local authorities must make greater efforts to engage positively with their provider population on matters of mutual interest (see also under Supplementary points).
Q2. Do you agree with the proposal to clarify and strengthen the duties of local authorities in relation to provider failure?	**YES** **Please provide more details:** This was one of the pivotal points made in our response to the DH discussion paper. However, we are very disappointed to note the absence of any proposals to provide for independent assessment of local authorities' contingency plans. In view of the frequency that local authorities are being found to be in breach of their existing statutory duties (including those under the National Assistance Act 1948 (Choice of Accommodation) Directions 1992) it is evident that they would benefit from clearer guidance in respect of these

	duties. Although commissioning failures may often be a significant factor towards provider failures, there is currently no effective regime in place to oversee and monitor the standard of local authorities' commissioning of Adult Social Care services. It seems that very often, the only mechanism available for providers or service users to hold local authority commissioners to account is through the Courts. This is not a satisfactory arrangement and consideration should be given to extending Monitor's role as economic regulator to cover local authorities' commissioning of Adult Social Care services.
Q3. Are current registration and de-registration powers adequate in cases of provider failure?	**NO** **Please provide more details:** There may need to be further consideration of the criteria against which "fitness" for registration is assessed, to reflect the need for corporate and individual accountability in respect of previous conduct of owners/management in a registered capacity. Equally, CQC's powers under Regulation 13 of the Care Quality Commission (Registration) Regulations 2009 may need to be clarified and strengthened to provide for more robust assessment of the financial viability of sub-threshold providers at the point of registration (see also under Q7).
Q4. Is information sharing and coordination sufficient between local relevant parties such as local authorities, the NHS, CQC and with insolvency practitioners?	**YES/NO** **Please provide more details:** We are not in a position to answer this question.
Q5. Do you think there are any equalities issues that would result from the proposals about oversight of the social care market which require consideration? If so, please provide evidence of the issue and the potential impact on people sharing the protected characteristics covered by the Equality Act 2010[1]	**YES** **Please provide more details:** Where local authorities provide insufficient funding for care services, the level of underfunding is typically most profound in respect of services for Older People. This particular group of people may be at the greatest risk of commissioning failure and / or provider failure. Oversight of the social care market must consider the appropriateness of some commissioners' behaviour towards services for Older People whereby a "one size fits all" approach continues to prevail rather than consideration of individual needs and outcomes.

[1] disability; race; age; sex; gender reassignment; religion & belief; pregnancy and maternity and sexual orientation and carers (by association)

	Were it to compare the number of Older People's placements into residential care which require third party "top-up" subsidies compared with placements of other groups of Adults in residential care settings the DH would likely find evidence of local authorities' discrimination against Older People.
Q6. What further steps to support consumer rights are necessary in the care sector?	**Please provide details:** We have reason to believe that, contrary to the guidance in Building Capacity and Partnership in Care, some local authorities are using their dominant positions in the care market to set unfair terms and conditions including the application of unreasonably low "usual prices". Building Capacity and Partnership in Care identifies that such practices may destabilise the market, increasing the risk of provider failure. These practices also mean that in order to exercise their right to choose their Residential Accommodation, a disproportionately number of individuals are having to subsidise the local authority's funding with a third party contribution. Within its 2005 Report "Care Homes for Older People in the UK- a Market Study" the Office of Fair Trading determined that local authority care home contracts which involved third party "top-up" contributions were consumer contracts and were therefore subject to Unfair Terms in Consumer Contracts Regulations 1999. Local authority contracts are generally not well-drafted and typically place an unfair level of risk upon not only the provider but also the service user. In conjunction with our recommendation that Monitor should have the responsibility of overseeing local authorities' commissioning of Adult Social Care, we believe that Monitor should be assisted by the Office of Fair Trading by way of a full review of the local authority-funded care market in order to establish where, when and how consumers' rights are not being fully and properly supported by commissioners.

Q7. What more should providers do and plan to do, in times of distress and financial failure?	**Please provide details:** The Government has remarked on the need for care home closures to be carried out sensitively to protect the health and wellbeing of their frail residents (paragraph 137). The vulnerability of these individuals exists regardless of the size of the home. While a local authority might find the closure of a home for 5 more manageable than one for 50, it will be no less distressing for each of the 5 residents than for each of the 50. In consequence, we believe that, as a condition of registration, all providers should be required to maintain robust, up-to-date plans providing for continuity of service and the protection of the wellbeing of residents in the event of either business failure or voluntary closure. That might be achieved by amending Regulation 13 of the CQC (Registration) Regulations 2009 to reflect the general thrust of Regulations 13 and 15 of the NCSC (Registration) Regulations 2001 (see also under Q8). Providers should also be proactive in raising an alert where they encounter examples of poor commissioning practice. In order for them to be able do this, an effective regime must be established to oversee local authorities' commissioning of Adult Social Care.

Section 2 Questions	**Response**
Q8. What do you think of the overarching framework the Government has put forward for oversight of the social care market in the future?	**Please provide details:** The question of the identity of the proposed financial regulator has not been put directly, but we the majority view is that it should be Monitor, although we acknowledge that there will also be providers that wish CQC to have the role. Although in outline the framework follows some of the suggestions offered in our response to the DH discussion paper, its scope is significantly different. In our opinion it is weighted disproportionately towards anticipating – that is, taking a view on the likelihood of – business failure rather than the primary duty of protecting service users from its consequences. Once the threshold has been set, we believe the onus should be on local commissioners to nominate which providers exceed the threshold in their areas, presenting evidence-based arguments in support. It would then be for the regulator to scrutinise these nominations before confirming or rejecting them (see Q9(C) for appeal provisions). We believe it would be helpful were commissioners to be expected to take account of the basic principles contained in Monitor's guidance to commissioners on defining services for the purpose of ensuring the continuity of NHS services, particularly the designation framework. It would be better still if Monitor to produce fresh guidance specifically for

	commissioners of adult social care services. The desired ends of oversight could be met, first, by consolidating the principles of current best practice into law, making it an explicit requirement for all providers (see Q7) to ensure continuity of service is maintained. Second, by a rigorous assessment of financial risk carried out by the regulator on all providers deemed to be above the threshold; and then by holding these providers legally accountable for meeting the resulting requirements (see below under Alternative model of oversight). Additional assurances would be available in the contingency plans that all providers should have to draw up, to include means of achieving the objectives set out in paragraph 149. For those above the threshold, plans should also include, as necessary, the remaining requirements in paragraph 121, as enlarged upon in paragraphs 125 to 128. Local authorities should support these efforts with their own contingency plans while the national regulator should be prepared to coordinate information and activities, where necessary. The requirement to submit operational information during the "recovery" phase (bullet point 4, paragraph 121) is unnecessary, since recovery planning is a fundamental element of providers' commercial duties. It must be borne in mind that providers do not set out to fail; they have an interest, and an investment, in maintaining a successful business. And as the consultation document makes clear, "The company, its directors and investors are responsible for the operation of the company and must face the consequences of their decisions" (paragraph 62). We are agreeable to the proposals for action at the resolution/exit stage, that is, subsequent to tests 3 and 4. Far from being "light-touch", the proposed arrangements will be oppressively bureaucratic and, in view of the ultimate objectives of regulatory oversight, totally unnecessary. The concept of the "living will' provides a useful illustration of how advance provisions can be made to deal with business failure. However, we do not believe the approach being piloted in the banking sector need be followed to the level of detail proposed in the consultation document. We propose the following: **Alternative model of oversight** 1 All providers (see under Q7) should have an explicit legal duty to maintain continuity of service in a period of financial distress or during voluntary closure, making all necessary provisions, where necessary through the involvement of third parties (this might be

	achieved by amending Reg. 9(2) of the H&SCA 2008 (Regulated Activities) Regulations 2010; 2 Providers identified initially as being above the risk threshold should be categorised as providers of interest to the regulator and be subject to a thoroughgoing financial assessment; 3 All providers should, as a condition of registration, be required to maintain robust, up-to-date contingency plans providing for continuity of service and the protection of the wellbeing of residents in the event of business failure or voluntary closure. Failure to do so should be an offence. For providers above the initial risk threshold, the contents of the plans should reflect the level of financial risk as assessed by the regulator – they could, for example, include, as appropriate, the measures outlined in paragraphs 125 to 128. These plans should be open to inspection by CQC (for providers below the threshold) and the financial regulator (for providers above the threshold). They should also be available to residents, their family and/or representatives, and to service commissioners; 4 As in the DH framework, local authorities would be required to have plans in place to manage the consequences of business failure. We believe these plans should be reviewed regularly and they, too, should be subject to independent verification; 5 As in the DH framework, the national regulator would be empowered to coordinate information and, where necessary, activities where the provider's business spans more than one local authority area; 6 Following the financial assessment, the providers concerned should have the following legal duties imposed on them: (i) to give notice to the regulator – within a specified period – of any imminent material change in their financial position; and (ii) to alert the regulator to the potential for financial distress in accordance, for example, with a pre-arranged trigger. We believe there is no need for the routine provision of financial and operational information (such as that illustrated in paragraph 105 and Impact Assessment, paragraph 86); 7 On the basis of information supplied in this way, the regulator should have the power to re-assess the provider's risk profile and review its contingency plan to ensure it is compatible with the business's changed circumstances; 8 For the resolution/exit stage, the legal duties on relevant providers should include the actions set out under Tests 3 and 4; 9 Failure to meet relevant legal requirements should be made criminal offences, attracting a schedule of

	severe penalties[2], including disqualification for a specified period from being registered under the H&SCA 2008, and not excluding the possibility of custodial sentences – possibly mirroring the range of penalties being envisaged for failures in safeguarding. Given the serious consequences of a breach of such requirements, these sanctions should apply across all sectors, including services that are subject to Monitor licensing. For the avoidance of doubt, we believe it would be prudent to apply this model to providers of home care services, on the premise that people are no less vulnerable to loss of service continuity because that service does not include provision of accommodation. And they are certainly no less entitled to the security of statutory protection. While we accept the observations made in the Impact Assessment (paragraph 40), transition to an alternative provider would be unlikely to be carried out effectively without a timely disclosure of information on (a) existing service commitments; and (b) transferring staff. This might readily be achieved through the medium of advance undertakings incorporated in an enforceable contingency plan. **Early warning system** Having a facility that is capable of providing early warning in the form of accurate predictions of business failure would be indispensable had the Government intended to secure continuity of service by preventing business failure. But, quite properly, it does not. **The raison d'être of the proposed oversight system is to ensure that, should a provider exit the market through business failure, the consequent process is well-managed, protecting continuity of care and service users' wellbeing**. The Government should make quite clear to the public what the limits of its interest in this issue is. The proposed early warning system is a legacy of the Government's experience handling the Southern Cross case, in which it dealt with a large-scale business failure, crucially, without the time in which to put in place effective management processes. Once oversight arrangements are implemented, however, that situation will no longer pertain. Plans, covering a variety of possible scenarios, will already be in place before the emergency arises. In a sense, the problem(s) that early warning has been designed to deal with will no longer exist. The early warning mechanism is intended to alert authorities to the need to put in place systems and plans to assure necessary protection for service users. But we would argue that if authorities wait for the warning to be issued before

[2] Open Public Services White Paper, paragraph 25

	developing their protection arrangements, or even fine tuning them, it could already be too late. **In our view, necessary measures should be ready to be implemented immediately.** In our view, the resources of oversight should be concentrated on the primary duty of protecting service continuity and service users' welfare, not on the production of dubious, and unnecessary, business forecasts. Put simply: the regulator's priority should be protection, not prediction. We have grave doubts also about the value of challenges from the regulator on the sustainability of providers' business models. In an area in which there are few absolutes, and perceptions of acceptable/responsible financial risk taking tend to be moot, recent history of financial services regulation suggests the expertise of the financial regulator may prove to have no greater standing – and no greater merit – than that of providers' advisors. Given the seriousness of the reservations expressed in paragraph 104 and the risk (alluded to in paragraph 70, second bullet point, and paragraph 87 in the Impact Assessment) that predictions of business failure could prove to be self-fulfilling prophecies, we are disappointed that the Impact Assessment has not examined these issues in greater detail. This **self fulfilling prophecy** point is fundamental and unless the system addresses this, the proposals are likely to fail. There needs to be a period of reflection for all without taking action which might be unhelpful. The word "risk" is used frequently throughout the framework, albeit in different contexts: (i) risk to service continuity for the purpose of threshold setting; (ii) financial risk; and (iii) risk of disorderly closure. As the general connotation of risk is predominantly negative, we are concerned at the potential for reputational damage to those providers whose operations are described in this way and urge that the utmost discretion be exercised. This could result in exacerbating commercial problems, if LA's reduce their placements because providers are seen as having high risks. This was a contributing factor towards the eventual demise of Southern Cross whose situation was exacerbated further by the geographical spread of its care homes (i.e. concentrations in areas of high local authority dominance of the care market) such that the overall level of self-funding service users within the organisation was less than half the national average leaving it seriously exposed to the effects of local authority under-funding. While we welcome the DH assurance that it is working to avoid duplication with licensing under Monitor's regime (paragraph 66), we are not confident that will be enough. In our response to the consultation on licensing providers of NHS services we emphasised that care homes should not be designated for financial regulation according to the funding

	sources of their residents: care homes are units which should be regulated in a unitary fashion. In light of the proposals in this consultation, we have revised the provisional response we gave to the previous DH consultation about Monitor licensing for relevant care homes being initiated by a CRS designation. **We now believe that all care homes should be exempt from Monitor's licensing of providers of NHS-funded services, including CRS designation.** We believe the framework set out in our alternative model would be sufficient to meet the aims of regulatory oversight for **all** care homes, without imposing burdensome requirements on providers. In addition, the roles provided for local commissioners – first, by way of their contributions to setting the risk threshold (see under Q9(C)) and subsequently, in identifying providers that exceed the threshold – would offset a removal of the imperative for licensing NHS-funded services following designation as commissioner required services (CRS). **Answers to the questions that follow have been given without prejudice to these responses.**
Q9.(A) What are your views on gathering greater national and regional market intelligence?	**Please provide details:** Our understanding is, first, that "intelligence" is information that has been analysed – a significant distinction; second, that national and regional market intelligence refer predominantly to the aggregation, to a greater or lesser degree, of intelligence that has been gathered locally. To the extent that it relates to providers' operations and is not in the public domain, the reservations expressed in our response to Q1 are relevant. To be complete, market intelligence must contain elements about the prices (including premiums, if any) paid by local commissioners set against the costs incurred, and the return on capital sought, by local providers (see also under Supplementary points). After all key commercial risks will encompass LA pricing and commissioning. It is essential that intelligence is not contaminated by anecdotal evidence, and that it is thoroughly cross checked. Equally, the collection process should not impose unnecessary burdens on providers.
Q9.(B) What are your views on targeted monitoring of the providers that pose the greatest risk to continuity of care?	**Please provide details:** We believe targeting on the basis of risk to be essential, but, as we have indicated above at Q8, we do not support the extensive regime of monitoring that has been proposed.
Q9.(C) What are your views on how and where the threshold should be set to monitor providers that pose the greatest risk to service continuity?	**Please provide details:** In view of the intention to make the regulator responsible for setting the threshold (paragraphs 97 and 98), we are puzzled by the presence of this question. We would therefore welcome an assurance that the responses gathered on this issue will be passed to the regulator before it considers its own proposals.

	As a general point, and without seeking to diminish the problems associated with a large scale failure, we believe an emphasis on national (as opposed to local) providers as the focus for additional market oversight oversimplifies the issue (see, for example, Impact Assessment, paragraph 35). Regardless of the geographical spread of a provider's estate, the greatest impact of business failure will always be felt locally and the consequences will ultimately have to be managed locally, albeit that co-ordination and support from the national level may be necessary. A number of characteristics – size, scale, geographical concentration (which in our view is not synonymous with market share, despite the implication in paragraph 29) and specialist services – have been identified as presenting significant risks for the continuity of care in the wake of business failure, and thus requiring further oversight. We comment on each of these factors in turn: ○ **Size:** We take issue with the suggestion in paragraph 85 that "small" providers of care homes should be defined as those with fewer than three homes. First, this is a somewhat arbitrary figure. Second, and more importantly, we believe the size component of the threshold should reflect registered places rather than homes or, for that matter, turnover (see, for example, figures quoted in paragraph 47). Given that the object of the exercise is to protect individuals from the adverse consequences of business failure, we believe the more rational course of action would be to count them rather than the establishments in which they are accommodated; ○ **Scale:** While we acknowledge the adverse effects that would arise from the failure of a major player, measured by scale, the relevance of scale, particularly national scale, lies predominantly in the logistical problems it poses for the management of service failure rather than as an inherent risk to service continuity in any given area; ○ **Geographical concentrations:** A geographical concentration in itself may be indicative of a risk to continuity of service; however, it is its standing relative to the market(s) in question that is the determining factor; ○ **Highly specialist services with a wide catchment area:** Since this refers to a service that is commissioned by a number of authorities that are drawn from either a regional or a national market – which itself may be of limited capacity – the risk to continuity of service may have to be assessed at a national level. ○ **Market share:** Understood as a provider's size – in

	terms of registered places – relative to the size (and type) of the market in which it operates, market share becomes a threat to continuity of service when, in the event of business failure, it seriously impairs, if not completely negates, the authority's ability to arrange suitable alternative accommodation from available vacant capacity. This factor has the benefit of reflecting, and being responsive to changes in, conditions in local markets, making it the most sensitive indicator of risks to the continuity of care following business failure. We have concluded that the potential for market share to impact on the ability of the local authority in question to manage effectively the consequences of failure makes it the decisive factor. It lies at the heart of the need for national regulatory oversight. It should therefore be central to the formulation of a threshold. With all factors, rather than imposing an arbitrary figure/percentage share as a universal benchmark, we believe threshold setting should be informed by drawing on the experiences of individual local commissioners (as is implied in paragraph 96), although we emphasise that their views should not be accepted uncritically. It must be acknowledged, however, that there are potential problems around defining "market", particularly "local" market, for the purpose of assessing market share. Regions are particularly problematical. No matter how they are defined – there is no regional tier of government and there are no regional markets *per se* – they are constituted by clusters of different local authorities which may have little in common other than a geographical location. Most importantly in this context, each one of them could have an entirely different experience of market dominance. Having said that, inconsistencies are also likely to arise from basing judgements about where the threshold should be located at the level of the local authority area. The often divergent scale of markets in different areas can produce anomalies in thresholds defined by market share. For example, the market in a unitary authority may be dominated by a single provider – perhaps a "small" provider – whose total capacity would be insignificant in the surrounding shire county. Counties covering large geographical areas are frequently sub-divided not only for administrative purposes but as an acknowledgement that the resulting districts are seen by individuals to represent distinct, recognisable communities. For these people, "local" is defined by factors other than a largely artificial county boundary; they would undoubtedly feel

	even less connection with a region. This is an admittedly narrow perception of "local", but one we would suggest that cannot be ignored when defining markets for this purpose. Even within a local authority's own boundaries, there are likely to be different markets operating in different areas, with the relative affluence of each area being a decisive factor in determining the level of dominance a commissioner is able to exert (for example, care homes operating in affluent areas where there are high proportions of self-funders are far more likely to be financially stable than those in less affluent areas where the majority of service users are financially-supported by the local authority and where the scope for third party subsidy contributions is limited). We look forward to the financial regulator consulting on its views. **Finally, we suggest that providers considered by the regulator to be above the threshold for central oversight should be granted a right of appeal – similar to that enjoyed by providers of NHS-funded services that are designated as CRS.**
Q9.(D) What are your views on what information would be required to assess risk?	**Please provide details:** To be clear, this response relates to financial risk, rather than risk to continuity of service. It is possible that some providers of adult social care services who also provide NHS-funded services will, exemption criteria notwithstanding, be subject to Monitor's requirements to maintain service continuity – for example, having been categorised as CRS. It would seem sensible, therefore, for the proposed regulatory regime to follow the same methodology and use the same metrics as Monitor (the final version of Monitor's risk assessment framework is yet to be consulted upon).
Q10. (A) What are your views on the proposals, for those providers, which are above the threshold in particular relating to recovery plans?	**Please provide details:** See our responses to Q8.
Q10. (B) What are your views on the proposals, for those providers, which are above the threshold in particular relating to enforcement powers?	**Please provide details:** See our responses to Q8.
Q10. (C) What are your views on the proposals, for those providers, which are above the threshold in particular relating to	**Please provide details:** See our responses to Q8.

regulatory functions?	
Q11. Do you agree with the Government's current assumption that a special administration regime would not be appropriate?	**YES** **Please provide details:**
Q12. Do you consider that a supplier of last resort model could offer additional protections without changing the insolvency regime?	**POSSIBLY** **Please provide details:** There needs to be absolute clarity about the respective roles of the regulator and local authorities at this point in proceedings. The proposition outlined in paragraph 140 implies an incursion by the regulator into an area of local authority responsibility. Notwithstanding this point, in consideration of their statutory duties to ensure that individuals can exercise reasonable choice over their residential accommodation and in conjunction with guidance within Building Capacity and Partnership in Care, it is reasonable to expect that local authorities should commission services properly such that there is always sufficient capacity in the market to ensure that the "last resort" scenario never materialises.
Q13. Could you provide any evidence of estimated direct or indirect costs to providers which could arise as a result of these proposals?	**Please provide details:**

Supplementary points

It is our view that the sequencing of consultations conducted by the DH (on market oversight of adult social care and licensing providers of NHS services) and by Monitor (on a wide range of subjects concerned with its new responsibilities) could have been managed more intelligently, and more sensitively. Many providers have been, and continue to be, unsure about whether they should engage with Monitor's consultations. At least as many, we suspect, are completely unaware that Monitor may have a significant role to play in their future operations. To the extent that these providers of adult social care services have not contributed to Monitor's consultations, they – indeed, the sector as a whole – could be seriously disadvantaged. We very much regret that adult social care continues to be treated as an afterthought, confirming the sector's status as the poor relation of the NHS.

Should a national financial regulator be given powers of oversight over the adult social care sector, we urge the DH to ensure that responsibility is vested in the regulator, and the regulator alone. Given their potential conflicts of interest, under no circumstances should local commissioners be allowed to extend their commissioning/contract

compliance duties – as they have already done by duplicating inspections carried out by CQC – into the assessment of the financial and operational strengths of providers (see final bullet point, paragraph 110).

Indeed the proposals when finalised should be extremely sensitive to the need to avoid overlapping roles – especially the Monitor licensing arrangements (with risk pools and contingency plans featuring here) and with the requirements of the HCA (housing regulator). Further there appears to be an apparent contradiction between the thrust of the consultation and the aims of the "red tape challenge". It should be remembered that a self-managed approach by the market was effective when Southern Cross was in crisis.

We want to emphasise that this sector offers opportunities for innovation, and enabling new models of care for people which in turn, will deliver employment and services in a growing market. This should be seen alongside the fact that a great deal of investment has been made in existing services, and investors need confidence that the regulatory burden on provision is not increasing. In addition, there needs to be co-ordination of any new requirements for large providers with the impact of moving to a Dilnot type model.

Based on the experience of our members, without the effective regulatory oversight of commissioning behaviour, we have little confidence that the DCMQC programme (see footnote to paragraph 83) will succeed where so many previous initiatives and guidance issued by the DH have been largely ignored by commissioners – most notably *Building Capacity and Partnership in Care*, published in 2001, which in many respects reads like an early draft of DCMQC. We are particularly concerned about commissioners' reluctance to take a strategic approach to price setting, engaging constructively with their local providers to ensure care prices reflect providers' costs. This despite the existence of independent, authoritative figures published by analysts Laing & Buisson – a source quoted extensively in this consultation document and many other publications from the DH. In consequence, we believe independent oversight – by Monitor – is essential. At a time when it is essential that there is more joined-up commissioning of services, this oversight should extend to considering commissioners' overall *Best Value Judgements* which, rather than perpetuating a "silo" approach should consider how a service can deliver *Best Value* to the taxpayer as a whole rather than just the commissioner in isolation.

Monitor has summarised the rationale of its role in regulating NHS pricing as follows:

> *"Accurate pricing is essential to ensure that hospitals are paid the right amount for quality services they provide to patients. Accurate pricing information helps GPs, commissioners and providers alike to plan and budget to get the right treatment in the right place at the right time to meet people's needs. Pricing can also be used to encourage providers to improve the quality of services for patients. If providers are not properly reimbursed, this can reduce the quality and efficiency of care they offer and threaten the future sustainability of their services."*[3]

The final sentence is particularly apposite in the context of this consultation. Since the same principles self-evidently apply to pricing in the adult social care market (see, for example, Impact Assessment, paragraph 29), we urge the DH to provide Monitor with the powers to oversee this aspect of commissioning, if no other, including prices set by

[3] www.monitor-nhsft.gov.uk/monitors-new-role/regulating-prices-nhs-funded-care

PCTs/CCGs for NHS continuing care.

We would argue that a Monitor power to oversee LAs prices is supported by the following section of the Care and Support Bill:

3 Promoting diversity and quality in provision of services
(1) A local authority must promote the efficient and effective operation in its area of a market in services for meeting care and support needs ...

(2) In exercising that duty, a local authority must have regard to the following matters in particular–

(c) the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not) ...

In our response to the DH discussion paper on oversight of the social care market we argued for independent oversight of commissioners. We were disappointed that our case failed to elicit a response. We do not believe it should be paraphrased, so with apologies for the repetition we reproduce it below.

> The discussion paper's focus on viability/business failure is largely at the level of the provider, whereas we believe it should properly address the whole system, taking into account the impact of all relevant factors. Given that income is one of the cornerstones of financial viability and that the majority of care home residents are supported from the public purse, adequate levels of public funding provided through effective commissioning is one such factor – one that we are disappointed to note has not been recognised in the discussion paper.
>
> It should be noted that, as well as promoting and protecting the interests of service users, local authorities' commissioning activity can also damage these interests, specifically by a reluctance to see beyond budget management to take a joined-up, forward-looking view of the various factors at play in their local health and social care markets. On pricing, for example, many authorities have resisted the idea of an agreed formula for determining fair, economic rates for care homes – taking account of sector costs and allowing for a reasonable return on capital invested – preferring instead to exploit their monopsony power by imposing on providers the lowest possible prices, regardless of the quality of care provided or the prevailing economic conditions. These prices contrast sharply with the unit costs of local authority provision, where it exists. Of the authorities that have at some stage co-operated in such schemes, most, if not all, have since abandoned the agreed model, citing financial pressures from reduced revenues.
>
> Confronted by intransigence on pricing from commissioners, many providers' associations have resorted to judicial review to seek relief; litigation thus becoming negotiation by other means. That is not a sign of a healthy market. Providers who would otherwise have invested in their service are looking instead to cut back. Quality and viability may be casualties of this approach.
>
> As far as the duty of local authorities to shape their local markets is concerned, the findings of the recent NAO study into the social care market,

as cited in the discussion paper, make worrying reading. The report also makes reference to OFT research that revealed that:

"social care providers felt there was a lack of clear strategic direction from local authorities, and a lack of commissioning and procurement skills – which was leading to market inefficiencies and difficulties in planning."[4]

These shortcomings – and there are more – reflect the experiences of our members. We believe they are symptomatic of unwillingness in local authorities to look any further than the immediate management of scarce financial resources; an incapacitating short-termism that is shared by officials and elected members alike. This was recently reinforced at a Caring for our future DH sponsored workshop – http://caringforourfuture.dh.gov.uk/2011/11/21/17-november-workshop-discussion-summary-and-slide-packs/ – where concerns were expressed about the quality of council commissioning: too great a focus on costs and insufficient emphasis on the quality of services.

Since the community care reforms were implemented twenty years ago, the DH has issued countless documents offering local authorities guidance – some of which have statutory status – on working with providers to achieve better commissioning. Few have had any practical effect. In view of the ability of local authority policies and practices to impact on providers' financial viability, with the concomitant consequences for the wellbeing of the health and social care market and, not least, the care of service users themselves, we question whether the Government can reasonably continue its present laissez-faire stance – authorities' democratic mandate notwithstanding. CQC (under its original remit) and its predecessor body, CSCI, both had responsibility for assessing the quality of local authority commissioning of adult social care services. Within that ambit, they had the ability to examine the relationship between levels of public prices for care home services and the quality of care provided – indeed, we urged both to do so. In the event, neither did; a valuable opportunity was lost. The recent Judicial Review decision regarding the decision-making of Sefton Council clearly shows that this council did not assess the impact of its fees policy on providers and service users. Subsequent Judicial Review decisions regarding the respective decision-making processes undertaken by Newcastle City Council and Devon County Council have highlighted issues concerning the irrationality of price-setting and breaches of obligations under the Equality Act 2010.

As the Government contemplates the content of the upcoming White Paper on social care, it would do well to consider the dysfunctional nature of the system into which it is being urged to inject additional resources. We must stress that the problems and inadequacies referred to above are not a direct consequence of the current squeeze on public spending, although they have undoubtedly been exacerbated by it; they are endemic to the system. Since CQC was relieved of the responsibility for monitoring local authority commissioning, there has been no effective oversight of this area of council activity, a deficiency that has been noted in the NAO report:

"Despite having policy responsibility for social care, the Department has few formal mechanisms to influence the way care is delivered locally. For

[4] National Audit Office, Oversight of user choice and provider competition in care markets, para.3.14

example, in evaluating progress of local authorities against the milestones, the Department had to rely on self assessment reporting by local authorities and regional information from the Department's Deputy Regional Directors."[5]

Is the "democratic mandate" of local authorities sufficient reason for central government to permit a situation that would not be tolerated in the NHS? The reformed health service will benefit from the establishment of an independent commissioning board to provide leadership on quality improvement, design financial incentives that reflect quality standards and provide commissioners with detailed guidance on how to meet pre-defined national outcomes. When ministers have been at pains to emphasise the "critical interdependence" between the NHS and adult social care in securing better outcomes for people and the need for consistency of approach across the sectors, we feel bound to ask why comparable arrangements cannot be made to bring some desperately needed coherence to adult social care.

It is for all the reasons set out above that we urge the Government to ensure that financial regulation of adult social care is not limited to providers, but extended to provide oversight of the commissioning of adult social care services – by local authorities and PCTs – a role that should embrace in-house provision. We believe that, subject to the conditions [already] set out, Monitor should be so empowered.

Finally we want to question how these proposals will be implemented when a company has services across borders into Scotland, Wales and N Ireland and would also note that these other countries are not proposing any similar regulatory interventions as we understand it.

ECCA
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[5] NAO report, op cit, para.4.7