Ownership of social care provision matters

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Introduction

There's growing concern about the costs of looking after children in the care system and of providers extracting profit from the sector. There's less noise but similar concerns about crucial parts of adult social care. As public funding of care has contracted by just over a quarter over a decade and a half of austerity, the silence about how money is spent within the sector has grown. The new government seeks to argue that public spending remains severely limited but has yet to show whether it is willing to open the debate about where public money is being spent and on what.

Our public dialogue centres around the (in)adequacy of current resources, and within these constraints there are providers of care who struggle to cover costs, let alone make a profit. However, austerity budgets in councils, demographics and the growing levels of need form an attractive proposition for some investors to 'unlock value' usually through the practice of 'financialisation', particularly in companies backed by private equity. There is growing evidence of concern about the quality of services provided by this particular type of 'private equity' sector.

It's worth noting that the Competition and Markets Authority´s (CMA)[1] work on care for older adults found that self-funding adults were weak consumers who lacked information and meaningful choices. In short, this is a warning for those focused on resources, as it's clear that having money does not improve the position.

Of course, the current model of service provision is only sustainable with additional funding. However, focusing on the size of the pot alone overlooks and masks the issue of how scarce resources are being used. For too long, we have shied away from debates about the financial practices of some parts of the sector; we have allowed excessive profit-making and value extraction from a group of providers who deliver poor quality for citizens and low levels of reinvestment into the future of the service.

Every pound of much-needed investment into social care needs to make a difference. Ideally, we would want that money to add value to people's lives through enabling health creation as an added extra to the core investment. At a minimum, we need to stop money from continuing to haemorrhage away from the sector, communities and people who draw upon support for social care. It is time for a comprehensive look and discussion about the money involved in care provision.

This paper is structured in two parts. The first is looking at care and private equity finance before considering why this should concern us.

Part One: Finance in social care

Why does ownership matter in health creation?

In 2024/25, day-to-day spending on health represents 39% of total everyday spending on public services by central government – up from 29% in 2009/10. The Health Foundation argue:

> "Spending on health services is only one part of what matters for health. If the government is going to achieve its ambition to increase healthy life expectancy and 'level up' health across the country, a whole-government approach will be needed – one that places improving health front and centre of all major policies." [2]

With the cost of health, particularly ill health, consuming more significant proportions of public expenditure, we need to focus on improving health to reduce illness; we can do that through health-creating models. We need systems that promote connection, leading to greater confidence that enables people to take control to maximise their contribution to their and their communities´ health, whatever their health status. How we feel about ourselves, the life we lead, and the community around us can benefit our health and wellbeing. We can maintain this even if we are frail, in poor health or terminally ill.[3]

Social Care Future[4] centres on an ambition for good lives as individuals within communities that matter to us. It sets out that stable communities require commitment and long-term interest. Social care has always been this complex blend of the individual and the collective: it's an approach that highlights living independently whilst thriving on the joys of interdependence. The system needs providers committed to the long-term, a focus on outcomes for people and places and whose financial performance supports these values.

Care provision and the purpose of care

Before the 1990s, when councils ´ran´ most of adult social care provision, they struggled to invest capital into buildings to maintain high-quality care facilities. The Community Care reforms of the 1990s incentivised councils to move away from provision. They encouraged new providers to bring finance and investment to the table to develop choices for people who draw on social care and develop modern, efficient services with capital for purpose-built facilities. The creation of this "market" approach rests upon the premise that public/private partnerships that draw upon the best capabilities of both sectors.

In most market models, profit drives reward and reinvestment. A for-profit model should offer excellent services, stimulate business development through reinvestment, and compensate for the risk and skills that make this happen. But too often the theory does not play out in practice: over one hundred and seventy years ago, Dickens warned of adopting Gradgrind's philosophy, where everything about life has to be paid for. Markets are complex beasts (ask an economist!) The political economist Polanyi[5], writing in 1944, argued that markets are embedded in a social and political logic that fails to engage with the tangibles in the form of actual 'finance' by choice. The resulting remoteness of finance means the market will extract surplus value and heighten instability. This apt warning against self-regulating markets has gone unheeded. Since the Community Care reforms began, we have chosen not to explore how money works in the care sector.

The scale of the challenge caused by the market structure is becoming clear. The Nuffield Foundation has highlighted a paradox where consistent underperformance by for-profit providers is accompanied by accelerating outsourcing.[6] In part, we are squeamish about discussing money in care beyond the binary argument "we don't want private provision". Our dominant narrative has been chiefly about the totality of resources available to social care. The squeeze of resources through austerity is deployed to explain the financial instability of providers. This narrative avoids attention to the "predatory financial practices" contributing to social care being a "leaky bucket."[7] The business practices of some providers are, at best, not building resilience in a challenging climate and, at worst, wilfully maximising short-term gains.

Some providers have created complex and opaque structures that make it difficult to track the use of money and who intentionally remove wealth:

> "Within parts of the social care market, local authorities are strongly reliant upon large providers who extract wealth from the care system, wealth that could otherwise be used to provide additional benefits for citizens and the state."[8]

Despite adopting a market model for care in the 1980s, it was 2013 before the collapse of Southern Cross prompted public policy to set out an approach to care markets in adults.[9] The 2014 Care Act finally set out a range of legal duties related to markets for adult care. There has been less attention on children's care, although the current financial crisis has promoted a review of profit models, due to report this autumn.

What is Private Equity?

Private equity (PE) is not the totality of 'private ownership' of services within health and care. Future Care Capital estimated that in 2019, the private sector provided 84% of the 'beds' within adult social care; 13% were provided by the 'not-for-profit sector.'[10] Provision to older adults is amongst the most diverse markets, with the majority run by small private owners. However, the five largest providers comprise 17% of this sector and are private equity backed.

The Competition and Markets Authority (CMA) also reported on the role of private equity in children's care. 60% of the largest children's home operators and the two largest foster care providers are PE-owned.[11] Attention has not been paid to ownership structures in other areas, such as learning disability, mental health, acquired brain injury, children's mental health, eating disorders, children's residential and foster care, etc.

Private equity is an investment into businesses not publicly listed on the stock exchange. A pool of money is built up from investors and invested into a company, which is duly built up before being sold, with the profits distributed in line with the agreements made with investors.[12]. The injection of capital resources and innovation into a business can be a positive force, although notably often within strict boundaries. For example, The All Blacks historically were resistant to private investment and recently opted for private equity to take a 5% share in New Zealand Rugby.[13] The NFL in American Football has also recently allowed private equity to invest by also setting limits of a maximum ten percent stake, trying to find a deal that combines the best of both worlds.[14]

PE is fluid as it targets investment, with current attention appearing to include special educational needs provision ("SEND"). Julian Evans, head of health at Knight Frank, described the market in children's special schools as: "a real focus for infrastructure investors …as there is a real shortage of supply, and the returns are red hot."[15] The state's exit from capital budgets

in the public sector coincided with the potential property investment to achieve the "benefits of the debt-fuelled real estate boom."[16] Consequently, we can see now that capital and revenue can be geared for maximum returns and used for further speculative behaviours. Mazzucato argues:

> "...financial engineering of socially essential services can change the nature of an industry. It is at the very least debatable whether the opaque ownership and excessive financialization which characterize these PE-owned businesses serve their customers more than their owners."[17]

Private equity is involved in social care precisely because it can invest in areas of spending that the state has decided it cannot commit to. Austerity has increased the reliance on other sectors to provide care. Across the breadth of the health and care sector, recent estimates suggest PE firms invested £140bn across 1227 healthcare deals in 2019, 14% of the total deal value.[18] A vacuum in public capital investment and a guaranteed public funding stream for services combine to make this a desirable market.

Why is Private Equity a particular problem?

The Think Tank IPPR describe the dominance of financial interests as a process of "financialisation", which has seen an increasing role for economic motives, markets, actors, and institutions in the operation of economies. This process has shaped the delivery of care:

- An expanding focus on real estate and property rather than quality care as drivers of the business model
- A reliance on borrowing for funding with high levels of debt (There are sometimes complex structures for lending at high rates of interest from within the same group of companies)
- Governance has focused on maximising the business's value to shareholders rather than delivering outstanding services and value to the taxpayer
- "Astonishingly complex corporate structures" with multiple different subsidiaries and the use of offshore companies to minimise tax liabilities[19]
- Horton makes a strong case that this system has extended into the use of labour and the financialisation of property and practices. The willingness of social care staff to work in deteriorating conditions adds value for the investor. However, despite low pay and poor investment into skills, this commitment means that many staff are not as easily disposable as they might be in other investment sectors.[20] Unison's survey of people working in homecare found "a disturbing picture of a system in which the ability to provide some companionship and conversation to an often lonely and isolated client is being stripped away" [21]
- The disconnect between these care models and local communities exaggerates existing inequalities. COVID exposed that inequality bites deep into the workforce. Low wages for people working in health and social care mean they live in the areas called left behind and are overrepresented in deaths[22]

Part Two: Why should we be concerned?

The financial costs of financialisation

The CHPI's research into the costs of care for older people shows how remuneration, rent and loans will have a bearing on costs:

- For 784 small and medium-sized care home companies, £7 of every £100 received goes to profit before tax, rent payments, directors' remuneration, and net interest. The figure for the 18 largest for-profit providers is more than double at £15 for every £100 received.
- The eight largest not-for-profit providers spend £2.34 out of every £100 of their income on rent. Across the 18 largest for-profit providers, rent is £11.07 out of every £100 received. There was an extensive range in the for-profit sector where 7 of the group of 18 spent between 15-32% of their income on rent payments.
- The problem is severe with homes operated by the five largest for-profit care home providers owned or backed by Private Equity. Collectively, their debts amount to £35,000 for each care bed they own, for which they pay interest costs of £102 per bed per week. That means that 16% of the weekly fees paid to these providers by local authorities or individuals for residential care go towards paying off debt.[23]

Differences in the amounts for rent, interest and remuneration aren't paid off the wind. They show in the bills when people pay for care from their resources (meaning they will use up their savings quicker than buying from other providers) and in higher costs paid by the state. These higher costs result from choices made by the provider about the structure of their business, which arguably benefit the company more than the person needing care.

This is visible in the market for care placements for children and young people. Most commentators accept these providers are taking one in every five pounds (20%) in profits, a figure the CMA says is too large. Moreover, the CMA surfaced concerns that PE companies in this market carry higher financial leverage than other providers, which means these providers face more significant challenges in meeting the debts and solvency targets that all businesses have. Changes in market conditions (such as an increase in the cost of credit) would worsen this heightened vulnerability. The CMA concluded that the market is at risk of an unexpected disorderly exit from a provider unable to meet its costs.[24]

Let's think about the implications of what the CMA found:

- Children do not have the choice and quality of places to live that they need, and many children are not cared for close to home.
- If a care provider leaves the market quickly, the most likely consequence is that there will be fewer places for children who need to be looked after. The number of children in an unregulated care setting is already a concern.
- "In sum, there is widespread agreement from stakeholders, supported by the available data, that the market is currently failing to supply sufficient accommodation of the right kind to ensure that local authorities can consistently place children in appropriate placements to meet their needs."[25]
- Councils have sought hard to protect expenditure on children in care and are reducing other services to pay for care. Yet one in every five public pounds is going into profit, not on the care of children, which is not credible to taxpayers.

We can see that this market is failing children, but can we "follow the money?" Evidence points to providers making it difficult for regulators to track impact and compliance adequately. The CMA had to do further work to examine investment and pricing because of the use of complex and opaque structures. Some accounts brazenly show profits, which the recent Independent Review on children in care also called excessive. Less obvious is the evidence of extensive borrowing and practices which reduce yield.

We must deal with the totality of financial practices like these, of which excess profit is a symptom. The Independent Review of Children's Social Care proposal to seek a windfall tax on the profits of opaque companies[26] is a woefully inadequate solution akin to playing hide and seek with the Invisible Man. Watch as companies report losses from their tax haven HQs based on complex hidden company transactions rather than trading.[27]

The Quality Cost of Financialisation: Learning from PE and Adult Healthcare in the USA

The debate about social care in England has hardly been a glorious example of evidence-informed policymaking. Whilst the USA has a very different system, some messages should attract a careful eye from a growing bank of evidence about trends from private equity in healthcare.

- US Healthcare is a serious area of interest for PE investment. In 2018, the valuation of PE deals in the US healthcare sector surpassed $100 billion, a more than twentyfold increase from 2000.[28] American health care is not just hospitals. Projections in the US are that mergers and acquisitions will be high in outpatients and autism service providers and that there will be growth in behavioural health markets.[29]
- In the US, PE investment in nursing care is under scrutiny, with reports and academic evidence finding higher patient mortality, reduced staffing, over-reliance on psychiatric medications and reduced quality of care. The NBER report suggested that 20,150 lives were lost arising from the consequences of PE ownership between 2005 and 2017 [30]

The Quality Cost of Financialisation in England…

We can see concerns about quality and additional costs from financialisation practices emerging in England. Industry commentators LaingBuisson argue that every provider's interests align with high-quality care. They say that the highly regulated nature of the care and health sectors and their media profile mean that PE needs a reputation for good quality of care to sustain the long-term value of healthcare businesses.[31] We have seen how the level of regulation and media attention has not deterred the financialisation of the childcare sector.

There have been warnings in the UK about the "commodification of the care process", presenting severe implications beyond the care of the most vulnerable.[32]. Investments in health care's "outer ring" have moved away from large contracts into individual care packages, which attract less attention. For all the noise about 'privatising' the NHS, there has been minimal public dialogue about the Priory Group becoming one of the UK's largest mental health care providers. With 9000 beds over 400 sites, this is worth some £400m per year to Priory. A Dutch PE firm bought Priory in 2020 for over £1bn.

A few commentators have tracked the apparent over-representation of Priory in inquests into sudden deaths. The charity Inquest has identified more than 20 families grieving for relatives who died with concerns about their care. A recent investigation by the Mail found:

> "The same criticisms at Priory-run establishments crop up again and again…inadequate risk assessments, lack of staff training or expertise, failure to carry out appropriate observations and address known ligature points, mishandled discharges and negligent record-keeping…."[33]

Sure, it's a newspaper article. It's also a reflection on the pain of people's experiences. There are echoes of the USA research finding that PE kills.

CQC data has suggested that not-for-profit providers are more likely to be graded for excellent and outstanding care. Data analysis by Future Care Capital shows lower quality across the private sector. Other research suggests that, on average, not-for-profit nursing homes deliver higher quality care than for-profit nursing homes.[34] This is also affecting equity: the Nuffield Foundation indicate that profit is increasingly focussing upon the self-funder, and related research about closures finds adverse impacts upon the most disadvantaged communities.[35]

Evidence shows that private provision does not deliver better quality. As if that isn't worrying enough, we are also moving further away from the overall outcome of greater equity.

What's the way forward?

A range of commentators have made suggestions:

- The government should introduce a new ethical commissioning charter with conditions relating to the workforce, care quality and provider transparency to drive a change in the provider market. Failing providers would be forced out of the market, encouraging the entrance or expansion of more innovative, socially minded providers. (IPPR)
- Unison has created an Ethical Care Charter aimed at councils to commission to baseline for the "safety, quality, and dignity of care." Unison monitors councils' sign-up.
- A new Ethical Provider Fund worth £7.5 billion over the next decade to enable the creation of innovative new state or voluntary care providers. (IPPR)
- A Care Home Transparency Act to require providers' disclosure of where their income goes. (CHPI)
- The independent review of children's social care suggests a regional approach to commissioning to gain control over the current shape of the market in children's care.
- Thinking about adult social care through the lens of a Green New Deal in which care's reciprocity and collective nature is valued based upon its contribution to wellbeing[36].
- IPPR made a case for Community First Social Care, "anchored in care in the places people call home." This would drive the health and care market to increase support for 'equity goals'[37] as one of the market's prime purposes.
- Providers in the PE sector want to see better-priced and longer-term contracts to create greater certainty of supply whilst seeking to avoid further regulation that could reduce available investment [38]

These practical, technical suggestions have merits but will only work if a new public discourse supports them. What is needed most is the analysis, scrutiny and debate of developing well-informed, evidence-based public policy. It's tricky, complex stuff with no easy solutions. The consequences of not having this debate and scrutiny are our current system.

Health Creation, as described by The Health Creation Alliance, offers a set of values, behaviours and frameworks that can guide us through this complex terrain and help us make choices based

on the outcomes we seek to create. The growing demand for a shift to a health creating society, including health creating models for health and care, could increase the appetite for transparency on what are essentially hidden financial flows and on the consequences for people's care and quality of life. Bringing this into the open could raise the public's demand for better services and for regulatory systems that require providers to contribute to the process of adding to our collective health and wellbeing.

Conclusion

As Polanyi urged, we must engage with finance. Our current disengagement allows space for false narratives rather than face a broader examination of policy choices by granting providers access to the market.

Our disengagement has created a space where PE providers have seemingly come to serve their gain. Based on presently available evidence, the current offers seem set to empty pockets, bleed council coffers, and drain wealth from the future development of the service. These are amongst the worst practices of financial extraction, which do not occur by accident in one of our weakest, neglected sectors. We need every pound spent on England's health system to create more connections, building people's confidence to take control and that have broader gains across our public and community lives.

While social care can be complex, its real accountability should be to those who rely on its services. And this means greater transparency. Is there any reason a great provider wouldn't want a child to know how the organisation works? If people buy care in a frail stage of later life, they might want to know who they purchase care from. People who draw on social care support are being failed by the lack of information, their experience of poorer quality services and worsening inequity. We know this to be a risk of the market system – captured by Dickens so long ago with Gradgrind's philosophy showing in "Hard Times:"

> "...everything was to be paid for. Nobody was ever on any account to give anybody anything, or render anybody help without purchase... Every inch of the existence of mankind, from birth to death, was to be a bargain across a counter."

In a review of Polanyi's work, Block and Summers highlight that progress comes "through conscious human action based on moral principles." In a democracy, the moral choice in public spending is made in the public and political arena. We must tell a story about the reforms we seek for care and what we see when we cast our eyes across those parts of our sector(s) where we have averted our gaze for too long. It's time to make some noise...

References

[1] CMA (2017) Care homes market study" summary and final report. Available at: https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report

[2] Health spending. (2017). *Health resources*. doi:10.1787/8643de7e-en.

[3] University of Birmingham. (2014). *III. Healthy Ageing in the 21st Century*. [online] Available at: https://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/index.aspx

[4] socialcarefuture.blog. (n.d.). *Social Care Future*. [online] Available at: https://socialcarefuture.blog/

[5] Polanyi, K. (1944). *The great transformation: The political and economic origins of our time*. Boston: Beacon Press.

[6] Bach-Mortensen, Dr. A and Barlow, Prof. J Evidencing the outsourcing of social care provision in England, Nuffield Foundation, 2024. Available at: https://www.nuffieldfoundation.org/project/evidencing-the-outsourcing-of-social-care-provision-in-england

[7] Tackling predatory financial practices in the adult social care sector, Briefing note for second reading of the UK Health and Care bill, December 2021, https://cusp.ac.uk/themes/appg/health-finance-briefing-dec2021/

[8] Lloyd Goodwin, T., Burch, D. and McInroy, N. (2020). *A progressive approach to adult social care CLES*. [online] CLES. Available at: https://cles.org.uk/publications/a-progressive-approach-to-adult-social-care

[9] Department of Health, current guidance at https://www.gov.uk/government/publications/adult-social-care-market-shaping/adult-social-care-market-shaping

[10] Future Care Capital, (2019). *Data That Cares,* [online] *Future Care Capital*. Available at: https://futurecarecapital.org.uk/research/data-that-cares/

[11] GOV.UK. (2021). *Interim report*. [online] Available at: https://www.gov.uk/government/publications/childrens-social-care-market-study-interim-report/interim-report

[12] Shaxson, N. (2018). *The Finance Curse: How global finance is making us poorer*. Vintage.

[13] Press, A.A. (2022). *All Blacks sale gets green light after players agree to private equity deal*. [online] the Guardian. Available at: https://www.theguardian.com/sport/2022/feb/17/all-blacks-sale-gets-green-light-after-players-agree-to-private-equity-deal

[14] Mulrain, C.B. and Remmick, B.B.: Private Equity's Time on the Bench Is Over: NFL Owners Allow Private Equity Fund Investments. Holland and Knight Alert September 5th 2024 Available at: https://www.hklaw.com/en/insights/publications/2024/09/private-equitys-time-on-the-bench-is-over

[15] Plimmer, G. and Kerr, S. (2021). Abu Dhabi plans Mid East expansion for UK special schools' provider. *Financial Times*. [online] 13 Sep. Available at: https://www.ft.com/content/51473bbf-69e1-4774-b077-b46ffef2f865

[16] Blakeley, G. and Quilter-Pinner, H. (2019). *Who cares? Financialisation in social care*. [online] IPPR. Available at: https://www.ippr.org/research/publications/financialisation-in-social-care

[17] Mazzucato, M. (2020). VALUE OF EVERYTHING : making and taking in the global economy. S.L.: Public Affairs.

[18] www.privateequitywire.co.uk. (2021). *More than half of PE-backed traditional healthcare providers have yet to reap digital transformation rewards*. [online] Available at: https://www.privateequitywire.co.uk/2021/02/17/296040/more-half-pe-backed-traditional-healthcare-providers-have-yet-reap-digital.

[19] Blakeley, G. and Quilter-Pinner, H. (2019). Op cit

[20] Horton, A. (2019). Financialization and non-disposable women: Real estate, debt and labour in UK care homes. *Environment and Planning A: Economy and Space*, [online] p.0308518X1986258. doi:10.1177/0308518x19862580.

[21] Ethical Care Charter. (2013). [online] *Unison*. Available at: https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf.

[22] Ali, S., Asaria, M. & Stranges, S. COVID-19 and inequality: are we all in this together?. *Can J Public Health* **111**, 415–416 (2020). https://doi.org/10.17269/s41997-020-00351-0

[23] Plugging the leaks in the UK care home industry. (2019). [online] *https://chpi.org.uk/*. London: Centre for Health and the Public Interest (CHPI). Available at: Centre for Health and the Public Interest (CHPI)

[24] CMA at GOV.UK. (2022). *Final report*. [online] Available at: https://www.gov.uk/government/publications/childrens-social-care-market-study-final-report/final-report

[25].CMA Op cit

[26] Independent: Major review calls for windfall tax on biggest private children's home providers, 23rd May 2022: Available here:https://www.independent.co.uk/news/uk/government-social-care-nadhim-zahawi-society-action-for-children-b2084874.html

[27] Martin Barrow (@MartinBarrow)

[28] Appelbaum, E. and Batt, R. (2020). Private Equity Buyouts in Healthcare: Who Wins, Who Loses? *Institute for New Economic Thinking Working Paper Series*, pp.1–115. doi:10.36687/inetwp118.

[29] Bryant, B. (2021). *Top Trends in Digital Behavioral Health Investment*. [online] Behavioral Health Business. Available at: https://bhbusiness.com/2021/03/25/top-trends-in-digital-behavioral-health-investment

[30] Gupta, A., Howell, S.T., Yannelis, C. and Gupta, A. (2021). *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*. [online] National Bureau of Economic Research. Available at: https://www.nber.org/papers/w28474.

[31] LaingBuissson op cit

[32] Player S, Pollock AM. Long-term care: from public responsibility to private good. Critical Social Policy. 2001;21(2):231-255. doi:10.1177/026101830102100204

[33] Bracchi, P. and Marsden, R. (2022). *Damning verdict on student's death amid worrying pattern at the Priory*. [online] Mail Online. Available at: https://www.dailymail.co.uk/news/article-10814929/Is-Priory-fit-purpose-Mail-dossier-exposes-deeply-worrying-pattern-mental-health-clinic.html

[34] Comondore, V.R., Devereaux, P.J., Zhou, Q., Stone, S.B., Busse, J.W., Ravindran, N.C., Burns, K.E., Haines, T., Stringer, B., Cook, D.J., Walter, S.D., Sullivan, T., Berwanger, O., Bhandari, M.,

Banglawala, S., Lavis, J.N., Petrisor, B., Schunemann, H., Walsh, K. and Bhatnagar, N. (2009). Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *BMJ*, 339(aug04 2), pp.b2732–b2732. doi:10.1136/bmj.b2732.

[35] Back-Mortensen, A.M. Goodiar, B and Esposti, M.D. (June 2024) Does outsourcing enable the survival of good care homes? A longitudinal analysis of all care homes in England, 2011–2023, BMJ Available at: https://www.nuffieldfoundation.org/wp-content/uploads/2023/03/Does-outsourcing-enable-the-survival-of-good-care-homes-A-longitudinal-analysis-of-all-care-homes-in-England-20112023.pdf

[36] Stanley, I., Buller, A. and Lawrence, M. (2021). [online] *CLES*. Available at: https://cles.org.uk/wp-content/uploads/2021/03/Caring-for-the-earth-caring-for-each-other-an-industrial-strategy-for-adult-social-care.pdf

[37] Allan, S. and Forder, J. (2012). *. Care markets in England: Lessons from research.* [online] *PSSRU*. Available at: https://kar.kent.ac.uk/76667/1/dp2815.pdf

[38] Submission by Horizon Care and Education Limited in relation to the interim report on the CMA's children's social care study (November 2021) Available at:https://assets.publishing.service.gov.uk/media/61eff363d3bf7f053fd8269a/Horizon_Care_and_Education_Services_IR_response.pdf