LaingBuisson presents
Regulating care
Providing unique insight into the CQC’s new regulation and inspection regime

An inspector calls
Leaders in the sector share their experience of the CQC’s new regulation and inspection regime to date

Legal Eagles
Meet experts Tim Nye and Kyle Holling

Inspecting hospitals
Professor Chris Thompson, national advisor to the CQC, looks at inspection in the independent hospital sector
LaingBuisson presents
Regulating Care

The last 18 months or so has seen fundamental changes to the way the Care Quality Commission (CQC) inspect, monitor, regulate and register services. This has culminated in the introduction of a new ratings inspection regime, new fundamental standards which set minimum thresholds of quality of care and a raft of other statutory requirements, including the duty of candour and fit and proper persons test. Over 2,000 services across health and social care now have first-hand experience of the CQC’s new approach, which assesses whether services are safe, caring, effective, responsive to people’s needs and well-led. According to the CQC, over 75% of those inspections have resulted in a ‘good’ or ‘outstanding’ rating being awarded, something it says it wants all providers to aspire to, but what has been the impact on independent sector providers so far? Experts from across the sector recently gathered together at a roundtable hosted by Trowers & Hamlins, in partnership with Laing-Buisson, to discuss how providers are adapting their approach and their businesses to accommodate the new regulations and the CQC’s emerging inspection regime.

William Laing kicked off the discussion by asking providers to share their experiences of the new inspection regime and whether or not it was tougher than its predecessor. Nicky Cooper felt that Priory had been spared any intense impact because its facilities are reasonably spread across the UK. Barry Lambert said the two inspections Canford had undergone so far went ‘reasonably smoothly’ but added that there did seem to be a tendency to be tougher. Ruth Georgiou agreed, saying the inspections were ‘definitely more thorough’. However, her main concern was the turnaround time between the inspection and getting the report back from the CQC. She said: ‘Our inspection was January and we still haven’t had the report. It’s nice to have the report because it’s something concrete and very measurable. It’s kind of hearsay until you get that.’

Jeanette Blackburn acknowledged that the reports had been taking a long time to produce and said this was due to the new methodology being used and the internal quality audit process. She said: ‘Original-

Round table attendees
Barry Lambert Canford Healthcare
Ruth Georgiou Accedo Care Ltd
Chris Hobbs Care UK
Nicky Cooper Priory Group
Karen Deacon RNIB
Jon Minall Brandon Trust
Simon Mitchell Southwark Council
Karen Lewis Housing and Care 21
Jonathan Sweet Abbeyfield
Jeanette Blackburn CQC
Professor Chris Thompson
Tim Nye Trowers & Hamlins
Kyle Holling Trowers & Hamlins
William Laing LaingBuisson
(see biographies on page 11)
Sector experts gather to discuss the impact of the CQC’s new regulatory regime

Duty of Candour

William Laing moved the discussion onto duty of candour and asked whether the attendees were aware of the need for a deeper understanding of their obligations and if they thought it would improve accountability?

Although most stakeholders agree that openness is a good thing, uncertainty remains over how duty of candour will work in practice and whether it could leave providers open to lawsuits.

Jonathan Sweet said: ‘From our perspective, it is something we’re starting to roll out a lot of training on, certainly on the operational level because it is a slight change of mindset we need to develop. I think it will lead to greater transparency but I’m also slightly concerned it could potentially lead to an increased litigation risk. We have started to talk to families and be more open about certain events but it’s a fine line between having someone who is on the ground and really emotionally involved in the scenario and ends up giving away an issue, which from a legal perspective I’ll be sitting here saying, why did you say that?’

Kyle Holling agreed, saying ‘We’ve been talking to our provider clients about that very issue. When do you go beyond saying ‘I’m sorry about that’ to opening yourself up to potential liability, and how as an organisation can you control what is said and done to avoid it happening while still complying with the duty?’

Larger organisations such as Priory and RNIB, said duty of candour meant cementing existing procedures rather than erecting new ones. According to Nicky Cooper, the NHS, where Priory is active in provision, has always required a ‘being open’
policy. Meanwhile, Karen Deacon said duty of candour just drew together its existing policies in another document. ‘We just want to make sure it’s a document that’s worthy of stature in its own right because we’re part of a much bigger organisation that does more than just providing care,’ she added.

Chris Thompson said that openness was always a good thing but that there was an additional question of what duty of candour places on an already overstretched organisation. ‘There are some words in duty of candour like severe, moderate or prolonged but I don’t think anyone has developed any case law about what those words actually mean on the ground and, therefore, there is a need to have a range of case vignettes of what that might include.’

Corporate Ratings

Professor Thompson was also keen to find out providers’ views on the idea of a corporate rating for providers, which would sit alongside the individual service ratings.

Jeanette Blackburn said feedback from the provider community was that people using services and their families were more interested in how that service performed locally rather than an overall rating for the group. Nicky Cooper agreed, saying: ‘In an NHS trust you want to know in your locality that the healthcare is good but an independent sector provider is so geographically spread out that you only really care about the bit you’re using.’

However, Simon Mitchell thought a corporate rating might be useful from a local authority perspective. ‘We have had some issues with a particular home, it’s just that particular home but it does seem like the upper tier management aren’t that interested in dealing with the issue so if there was some link from high to low, you would start to make the upper tier management take things a bit more seriously down on the ground,’ he said.

Professor Thompson said that in healthcare, the CQC was likely to go introduce a two-stage provider information request. The first would go to the CEO before the regulatory cycle begins looking at individual locations and would ask what they know about the services provided and the level of incidence in each. The second stage would then take place only in relation to the locations being visited. ‘Everyone is concerned they are being asked the same data every time they go to a different site and that is something the CQC is aware of and is trying slim down,’ he added.

William Laing thought it could be very important for providers themselves to have a good corporate rating. ‘We’ve recently done some work for a major investor that wants to broaden its portfolio in care homes and to know the 15 best providers it should be working with. One of the tests was whether the portfolio was compliant with the CQC ratings so it might be valuable from that point of view to have a corporate rating,’ he said.

Special Measures

The discussion then opened up into the CQC’s proposals for a special measures regime for independent sector providers. Jeanette Blackburn said the CQC had recently published a consultation about applying special measures in non-NHS settings, which would apply to all services that are rated by the CQC. Under the proposals, there would be a time-limited framework in which providers of inadequate care must improve or have their registration cancelled. Providers rated as ‘inadequate’ following a comprehensive inspection would enter ‘special measures’ and would have six months to improve. If they then failed to make improvements and were left with ‘inadequate’ ratings in any of the five domains, the CQC would start action to cancel their registration for that location.

Although the CQC already has powers to start cancellation procedure against inadequate providers, attendees were concerned that even the phrase ‘special measures’ would trigger alarm bells at commissioner level and said they would need clarity from local authorities about how far into the process they would seek to decommission services.

Karen Lewis said that even starting the process would spell complete failure for a homecare branch. ‘I think the difficulty is around branch management. To find a good branch manager can take a year, so in my opinion the minute that you’re put in special measures there’s nothing you can do,’ she added, meaning the time period you need to find the right management to improve doesn’t tie in to the time given by the CQC.

Tim Nye said there was a huge amount of difference in what ‘special measures’ would mean to an NHS provider and what it would mean for
an independent sector provider. ‘If it’s the NHS, Monitor comes in and basically drags it through a process to get it out of special measures, whereas in the independent sector it’s a case of ‘you’re failing, you’re in special measures and you’ve got six months to fix it, but you’re on your own’,’ he said.

Jeanette Blackburn said it was true that the onus would be on the provider to improve but insisted providers had to recognise that if they were in special measures it was because their overall provision was inadequate and that impacts on the people using the services.

Professor Thompson said: ‘I think there are two things happening at the same time. One is the clarification of the way the CQC will use its own enforcement powers under certain circumstances around how long you’re going to have to get it right and under what circumstances might you just be closed down as an emergency measure. I would have thought that, inevitably, if you’re given an inadequate rating, local authorities are going to embargo you anyway. Then there is the second question of whether using the word ‘special measures’ is actually confusing the issue and I think the CQC want to have views around that because we now have three types of special measures regime all of which are slightly different: one for education, one for the NHS and one for the independent sector.’

On that note, Barry Lambert asked if the CQC was expecting more cancellations of registrations as a result of the new inspection regime. Jeanette Blackburn pointed out that there had only been 162 inadequate ratings so far meaning numbers were small.

### Market Oversight

Chair William Laing asked how the CQC would fare on its market oversight regime? In particular, what would be the cut-off point for those subject to the regime and whether the CQC had appointed specialist staff to do the work.

Jeanette Blackburn responded that the CQC was in the process of recruiting an in-house team of financial experts with significant expertise, which would look at the financial sustainability of around 40 residential providers and 15 home care providers expected to be captured under the scheme. ‘We very much see that quality and finance are inextricably linked and, therefore, my team will be providing information about the quality of providers based on inspection outcomes and activity across that provider’s portfolio. The quality people are in post but we will procure, for an interim period of about six months, a finance team until we get the permanent team,’ she said.

Residential care groups will come under market oversight if they have more than 2,000 beds or between 1,000 and 2,000 beds but operate in more than 15 local authority areas or have more than 10% market share in five or more local authority areas. Homecare providers will be included if they provide 30,000 hours of care across their portfolio or have more than 800 clients receiving over 30 hours care on average a week. In addition, providers could be nominated if they are so specialist or unique that they would be difficult to replace should they fail.

Jeanette Blackburn said the scheme would be small in terms of numbers of brands but that within those parameters there were many registered services and locations.

Overall, the attendees thought that some market oversight was necessary to prevent service users losing their care provision should a major provider go bust. However, not all thought that CQC was the best body to provide that oversight.
Tim Nye said: ‘When you look at it in the abstract outside of cost, and I know cost is massive, you’ve got a regulator that monitors the quality of care now being asked to determine the financial viability of an individual organisation for which there may be auditors signing off audited accounts, banks checking and confirming satisfaction against financial covenants and investor shareholders monitoring financial performance.

All these people might be comfortable, some of whom have a vested financial stake in the business, but if the CQC isn’t that could have a huge impact on the business through notification of the local authority and the consequential effect on revenues. The question is whether, given all these people are comfortable, the CQC should be able to unilaterally trigger such action and, in any event, if the expertise to do that sits with the CQC or if that role should it be outsourced to a PWC or KPMG?’

William Laing added: ‘I think the key is to make sure a distinction is made between the viability of the organisation and the viability of the individual services. I think it’s perfectly possible for the people in post, or who will be in post, to make that distinction. It should be possible from the management accounts to say we consider all these services to be viable even though there are questions about the umbrella organisation.’

Conclusion

Clearly, the new inspection regime incorporating ratings, the new care thresholds set under the fundamental standards, the Duty of Candour and the Fit and Proper Person Test are all designed for one purpose, to increase the level and quality of care being provided and made available and to enable service users to make more of an informed choice about which services to use or where to send their loved ones. The general consensus was these new changes were a step in the right direction, but they may have little operational impact on those good providers who already adhere to certain of the principles set out under the new Regulations.

However, maybe that is the point. These changes are not necessarily directed at those already providing a good service. Ultimately, only time will be able to tell us the real impact of the new regime, however one immediate concern in respect of the Duty of Candour is the risk of increased litigation with the line between the requirement to provide an apology and admitting liability often grey. The new regime gives the CQC more teeth with the ability to prosecute without giving prior written notice, as does its role in the market oversight regime with its duty to inform local authorities when it believes a pre-identified provider may fail financially.

However, financial failure is something totally different to service delivery failure as was seen in the case of Southern Cross, and there is a real worry that the CQC’s role may simply become one of a self-fulfilling prophecy as Authorities react accordingly. How the CQC uses its new powers and role is therefore fundamental to whether it will be successful and could have a knock on impact across the independent sector including on new investors and entrants to the market. Stakeholders will look forward with interest to see how things develop.
Legal experts Tim Nye and Kyle Holling discuss the rationale behind the CQC’s new regime and look at how it might evolve in the coming months

Why has the CQC decided to adopt these measures now?

Tim: These changes follow a long consultation process that was borne out of a number of perceived failures in the system. You can go back to Winterbourne and Mid Staffs, as well as the failure of Southern Cross, if you are trying to pinpoint why these measures are now being adopted. Of course a regulator should be constantly reviewing and seeking to improve its monitoring and regulatory function, although if you ask the question “but for” - but for Winterbourne and Mid Staffs (amongst others) would these changes now be occurring? I think the answer would be no. You do not fix what isn’t broken.

What do you think the impact of the new inspection regime will be?

Tim: The main difference in the inspection regime is the recently introduced ratings system. I genuinely expect that ratings will allow commissioners and people who use services to make a better informed choice as to the quality of care being provided.

Kyle: The other key point from a structural perspective is that some breaches of the new CQC Regulations are now capable of being prosecuted as criminal offences without having to give prior notice. This has increased the potential for prosecution and conviction where previously notice had to be given. The financial penalties may not be huge in every case but a very real risk is reputational damage and perception in the market and the impact that can have.

Are the new rules stringent enough to weed out those who are unfit to hold senior positions within companies providing health and social care?

Tim: The intention is there, but I am not convinced the Regulations go far enough. There is a Fit and Proper Person Test but that only applies to directors of registered providers, so automatically a parent company who does not itself hold a registration (but who may dictate practice and policy to the subsidiary registered provider) is outside of the scope of the Regulations. Another concern I have is that the test is effectively self-certified or monitored. I understand the rationale for this, primarily being a cost issue. However regulators will often interview registered managers or responsible individuals for the role, so query whether this could have been extended to directors, given it is the directors of a company that control it.

Will the Duty of Candour increase accountability all the way down to workers actually providing the care? Do further regulations need to be put in place?

Tim: For many the Duty of Candour legalises concepts that should already be in existence in a provider’s culture and the way it currently operates, for example the NHS has its Being Open policies. So, it is debatable how much the new Duty of Candour will change things on the ground. It may formalise procedures slightly differently in order to follow the Regulations but good providers will be practising the duty in any event.

Kyle: I think it is key that workers are trained to recognise when the duty of candour arises, they also need to feel confident in voicing concerns, they should un-
understand how to report incidents and they should be aware and made aware of the implications of non-compliance with the duty. Providers will want to maintain control over the process to ensure that apologies given as required by the Duty don’t go so far as to open up liability claims.

What do care providers need to do to prepare themselves for the introduction of the new regulations?

Kyle: The two headline grabbing changes are the Duty of Candour and the directors’ Fit and Proper Person test. In respect of the Duty of Candour, as mentioned a lot of providers will likely have similar concepts already embedded in their culture and so there will – at least for the larger organisations – likely not need to be huge changes. Smaller organisations could be more affected and it will be important that staff members understand their own obligations and roles, understand how to communicate with service users once the duty has arisen, and as mentioned, most importantly, be able to spot and identify when the duty has arisen.

Tim: The Fit and Proper Person test is an ongoing monitoring and audit requirement of the board. As such providers should ensure that they have robust processes in place to gather information, analyse and investigate that information to determine the suitability of a director.

Kyle: One limb of the proper persons test is that providers must not appoint any person who has been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity. This is wide ranging and arguably means if the person knew of mismanagement (but was not responsible) then they are not fit and proper. In practice this could be very hard to monitor, determining what someone may or may not have known at a certain time is always difficult to establish.

What would be the legal position of operators whose existing board members do not pass the test?

Tim: Simply put it would be a breach of Regulations. The Fit and Proper Person test applies to current and new appointments. Therefore providers need to ensure that they have carried out adequate checks on current appointments to satisfy themselves that they meet the requirements of the test and if they find that they do not then they ought to take appropriate and timely action to investigate and rectify the matter.

Kyle: If a provider did not act then ultimately they could suffer a loss of registration. There is no ability on the CQC to remove a director from post however the CQC can make it a condition on the registration certificate that an individual be removed, failure to do so being a breach of that condition that could ultimately mean a loss of registration. I think the CQC hold the ultimate sanction here which is good, but I suspect it will be used sparingly partly as any well run organisation would never let it get that far.

From April, the CQC is responsible for the new market oversight regime. How do you see its role developing?

Tim: I think the CQC will take some time to get to grips with this as financial oversight is a new concept for it. Providers within the regime will no doubt be concerned that the way the CQC handles things could very easily have an adverse impact on their businesses - and the CQC seems to be alive to that fact based on what it has said about information control and release. The big issue there is Freedom of Information Act requests and the extent to which the CQC can lawfully withhold this sort of information. The other question is the approach the CQC will take here – providers within the regime are likely to be subject to financial scrutiny from a range of different sources – lenders, investors, other regulators, landlords. If all of those stakeholders are satisfied with a provider’s financials will the CQC take a different approach and if it does will that put a provider at risk which it would otherwise not be?

Are you confident that the CQC has the
knowledge and the experience to monitor the financial stability of care providers?

Tim: It is unfair to condemn before the CQC have been given a chance to perform in this area. But they were originally established as a regulator of the quality of care provision for regulated services. That has historically been their purpose. Whilst financial standing can impact on quality of care, that is what the CQC should be used to judge, they are not accountants or financial analysts, it is not within their skillset historically as a regulator to review things like accounts, forecasts, covenants and budgets to understand financial stability. It remains to be seen how the CQC will adapt to take on these new responsibilities.

As the success of many care providers is down to the fees local authority commissioners pay, do you think the CQC’s remit should be extended to monitor commissioning practices?

Tim: No, at some point you have to rely on the markets to normalise the position. The constant pressure by local authorities on fees will eventually take supply out of the system by shutting down small providers who can no longer afford to run operations or by seeing larger providers move towards private pay only, or towards services funded by the NHS. The impact of this will be LAs having to pay more in order to secure placements, as placements become less available. This coupled with the projected large increase in people moving into elderly life in the next 20 years and needing care will eventually see a change in the power the local authorities have to set fees so low – although it may also see a change in how much need local authorities will actually meet. It is market dynamics in action.

What can providers do if the CQC identifies their business as being as risk? Can this be challenged?

Kyle: Providers have rights to appeal to an independent tribunal against civil enforcement action, however, there is no such right in relation to criminal sanctions which will perhaps concern providers given the CQC’s ability to now move directly to prosecution for some breaches of the Regulations. There is also no formal right of appeal for those dissatisfied with an inspection rating given under the new CQC inspection and ratings system. Judicial review might be possible in these cases but this is by no means straightforward - a formal appeals process would I am sure be welcomed by providers.

In the light of recent scandals, do you think these measures are enough to restore public confidence in the care system?

Tim: The changes will largely be welcomed, but ultimately what will change perceptions is performance by results. People react to performance change not regulatory change. A major problem for the sector is that at face value that the public lack confidence in the care system. The scandals we have heard about in recent years are unacceptable, one scandal is one to many, but they are the exception not the rule. The vast majority of people receive great care from great providers and we should always remember this.
In the January issue of Healthcare Market News, I set out the CQC’s position on the new regulatory regime, along with some thoughts about how it might be applied to the independent sector in due course.

In the two months since then there have been pilot inspections of both acute and mental health hospitals and a great deal has been learned from those experiences by the CQC, and I dare say by the inspected hospitals as well. Policy work is still going on to ensure that the new regime has the main characteristics that we are looking for:

1. It is robust and focussed on the patient’s experience of care, including safety, quality and effectiveness of the care being delivered

2. It takes into account the leadership of local sites as well as the overall organisation

3. It uses the same approach as that for the NHS so that is fair to all parties - in particular that the rating system uses the same scoring

The latest thinking is that it is becoming clear that it is not going to be possible to create a system identical to the NHS, but there remains an intention to make it as similar as possible so that where there are differences they exist for a good reason. So here is what some of the differences might be.

Unlike the NHS, some independent sector organisations will not have an overall organisational rating. This is for several reasons. The CQC has no legal powers to rate a brand, only the legal entity under which the service is registered. Many large brands are group structures in which there are several companies each containing some of the hospitals. In this case the CQC could rate the companies in which the services are registered but this would have less meaning than ratings of individual sites/hospitals.

Secondly, for very large organisations the logistical challenge of rating all sites in a short enough period of time for them all to be meaningful at the same time in order to inform a corporate rating would be overwhelming. So for both of these reasons it is likely that the final approach will be to inspect, regulate and rate at individual hospital level. Where a company only has one site, by definition their rating will apply to the whole company which is why I said above that this only applies to some independent companies.

There is another difference between the NHS and the independent sector, which is the presence of the registered manager in the latter. The manager is usually responsible for one hospital and in order to register only managers who are fit for purpose it is important to link the hospital’s performance (rating) with the manager, which would not be achieved by rating at company level. So this also pushes us towards location level ratings.

Now, if we accept that this is going to happen there are several consequences for the model of regulation.

First, it will still be important to connect the quality of leadership of the hospital being inspected with the leadership at the centre, including on the board. So systems are being developed to improve the collection of intelligent data from companies to inform inspectors’ views of what they see ‘on the ground’. In this respect, the CQC will be looking for good practice in quality assurance and quality improvement, and will not simply expect to see a replication of an NHS model of board governance. The CQC is aware that this would anyway be impossible in both the ‘for profit’ and ‘not for profit’ sectors because of the other regulatory regimes applying there, including the charity commission.

The key question will be whether the organisation’s quality governance supports
The hospital management and clinicians to provide high quality care as seen by the inspectors during the visit. To get this corporate information we are proposing a two stage Provider Information Request. The first stage will only have to be completed once for the each ‘wave’ of inspections and will relate to the corporate structure, and aspects of quality best provided by company level personnel.

The second stage, to be completed before each visit, will relate only to the services provided at the site about to be inspected. This should cut down duplication and improve the links between ‘head offices’ and the inspectorate. It is also proposed to inform the CEO before each visit, rather than go straight to the site. This process is therefore going to be as similar to the NHS process as possible, bearing in mind the differences ‘on the ground’.

The NHS process involves the rating of core services within trusts, as well as the trust’s overall performance. In the case of relatively small independent sector services, this is challenging as the inspection of every core service is a large endeavour while some of the services in the sector might only have a very few patients. For example, a full core service inspection in the NHS involves a special adviser, an expert by experience as well as an inspector, and the report is almost as large as the main report itself. We don’t want to ignore small core services, indeed they may carry more risk than large ones because of the lack of a critical mass of expertise, but neither do we want to create a disproportionate burden of inspection and unnecessary duplication for both the provider and the regulator.

One proposal is therefore to have one main hospital report and rating, with briefer reports on any core services showing where they depart from the hospital’s overall quality and ratings. This approach of ‘exception reporting’ might achieve the objective of concentrating on the important ‘core’ services, while limiting the regulatory burden for both parties.

Within the CQC a lot of work is also going on towards defining what quality information is needed from independent sector organisations, and how to get it most efficiently and accurately. In addition, in due course, the CQC will formally set out its approach to market oversight and I hope to be able to bring you that in a later issue of Healthcare Market News.

Finally, some of the thinking behind the decision making in specific areas is now being published in the interests of transparency. The publications are in the form of brief guides and are available on the CQC web site.

Getting involved
If you have any comments or suggestions on what you have read here there are several ways you can help. The website contains information about joining chat rooms and feeding back views in other ways. So please do let us have your views.

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**Roundtable - the experts**

**Barry Lambert** - Barry Lambert is chief executive of Canford Healthcare plc, a Dorset-based provider of elderly care services operating five residential homes and two home care services.

**Ruth Georgiou** - Ruth Georgiou is director of Accedo Care Ltd, a growing specialist residential care home provider dedicated to care provision for people with learning disabilities and associated needs.

**Chris Hobbs** - Chris Hobbs is governance manager at Care UK, one of the largest providers of health and social care in the UK.

**Nicky Cooper** - Nicky Cooper is director of compliance at the Priory Group, which has a nationwide network of 275 hospitals, clinics and schools across the country, treating over 70 conditions.

**Karen Deacon** - Karen Deacon is director of social care and further education RNIB, the UK’s leading sight loss charity whose portfolio include the provision of schools, colleges and learning disability services.

**Jon Minall** - Jon Minall is director of operation and development at the Brandon Trust, a charity supporting adults and children with learning disabilities and autism.

**Simon Mitchell** - Simon Mitchell is senior commissioning manager at Southwark Council, one of the most densely populated boroughs in London.

**Karen Lewis** - Karen Lewis is director of homecare at Housing and Care 21, the UK’s largest non-profit care provider, offering a range of care and housing services including Extra Care and Retirement Housing.

**Jonathan Sweet** - Jonathan Sweet is head of legal at Abbeyfield, a charity providing housing, support and care for people at different stages of later life.

**Jeannette Blackburn** - Jeannette Blackburn is Inspector Manager at the Care Quality Commission, which is currently rolling out a new regulation and inspection regime for the independent health and social care sectors.

**Professor Chris Thompson** - Formerly group medical director at the Priory Group, Professor Chris Thompson is a consultant currently working with the CQC on the regulation of independent sector providers.

**Tim Nye** - Tim Nye is a partner at Trowers & Hamlins and specialise in working with investors and private health and social care providers.

**Kyle Holling** - Kyle Holling is a partner at Trowers & Hamlins and works across health and social care on a variety of projects from business transfers to accommodation projects to service provision contracts and structures.

**William Laing** - William Laing is a health and social care expert, economist and chief executive of LaingBuisson, the independent healthcare consultancy, data and information organisation.
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