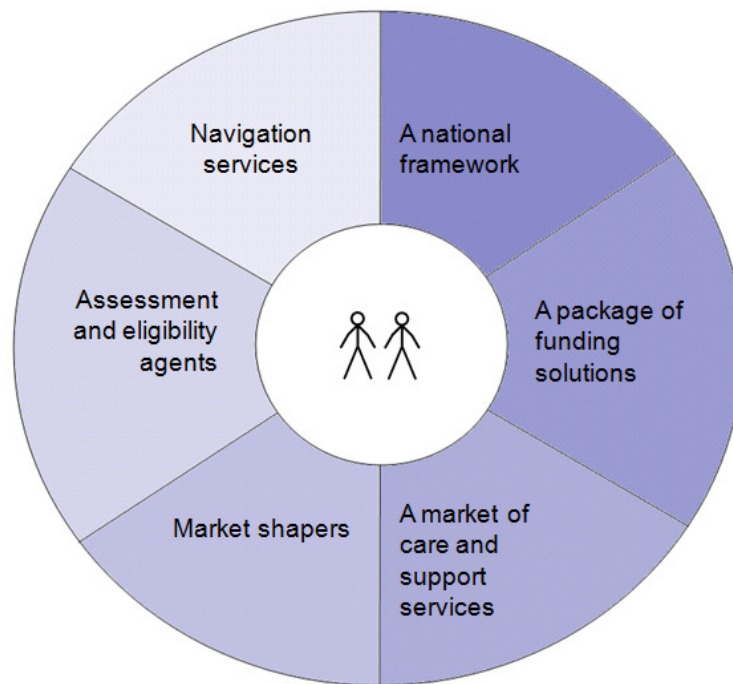


**Redesigning Social Care – a summary of Expert Group
Discussions hosted by the Resolution Foundation
October 2008**



Executive summary

This report summarises the discussions held by four expert groups on the issue of *Redesigning Social Care for older people*, hosted by the Resolution Foundation in October 2008.

The Resolution Foundation is an independent research and policy organisation set up in 2005, which is currently undertaking a programme of work on redesigning social care for older people. As part of this work, the Foundation invited five groups of experts, each with their own specialist perspectives on care, to come together to discuss the vision and architecture for a future care system in July 2008. Each group was tasked with designing a new architecture for a care system for older people, which would be able to achieve a better vision of care, based on principles such as independence, choice, clarity and consistency, wellbeing and prevention.

In October, the Foundation brought these experts back together in four larger mixed groups to present the elements of a *Vision for Care*, which the Foundation created based on the original groups' discussions, and research carried out over the summer. These elements are:

1. A national framework
2. A package of funding solutions
3. A market of care and support services
4. Market shapers
5. Assessment and eligibility agents
6. Navigation services

Experts were asked to consider the *Vision* in general terms, and discuss its value as a concept and framework for care reform. Two key issues emerged:

- The *Vision* had transparency at its heart, but that this had fundamental repercussions for the delivery of personalisation. This was because clarity of entitlement and responsibility could require care users to be “boxed” into groups of qualification for different entitlements.
- That the *Vision* had to improve how the “social market” of care functioned, if the goals of personalisation and choice within a mixed market of provision were ever to be achieved.

The experts were also asked to consider more specifically the question of who might have responsibility for each of the elements in a future care system. There emerged a number of potential conflicts and synergies from this discussion:

Conflicts

- The agent assessing eligibility for state funding **should not** be the source of that funding *If the agent assessing eligibility for funding also provides that funding, they may have an incentive to restrict funding, as demonstrated by some local authorities' tightening of FACS eligibility criteria.*
- The provider of navigation services **should not** also be a source of care funding

Better information and advice can improve the take up of services and benefits that people are entitled to. A navigation service may have an interest in not stimulating demand for services that it will subsequently have to pay for.

- The provider of navigation services **should not** also be a provider of care services
A navigation service might be biased towards recommending the services it also provides.

Synergies

- The agent carrying out needs assessment **could** usefully carry out a market shaping role
Needs assessments could potentially be a valuable source of information on older people's needs (including self funders and informal care users). This could be passed to care providers to help them identify new opportunities and niches in the market.
- The agent carrying out needs assessment **could** act as a first point of contact for a navigation service.
Needs assessments could also be the starting point for entry to navigation services. Older people could be informed of their advice and guidance options during their assessment.

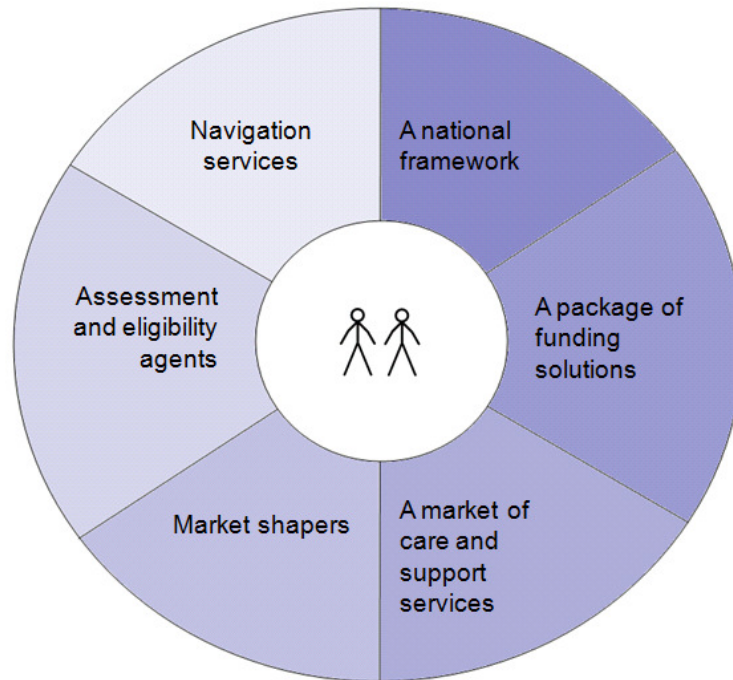
The Foundation also presented the findings from its summer research programme, which explored four of the six elements of the *Vision* in more depth, and invited experts to comment. Key points included:

1. *Local market shaping*
 - a. It was unlikely that there would be one “market shaper” of the future
 - b. Local authorities were likely to have *a* role, but not *the* role
 - c. Care markets were influenced by a range of external factors which made strategic shaping a challenge
2. *Funding*
 - a. A two-stage funding approach would be needed to cater to imminent care users and the possible less asset-rich future generations
 - b. A range of products would be needed as there would be no one size fits all solution
 - c. There was a need for a product which provided for extra or one off costs in later life more generally, that care (or many other events) might generate.
3. *Navigating the care system*
 - a. A single point of contact was needed to explain people's advice and information options as a first step
 - b. First stop shop approaches were more viable than one stop shops, given the complexity of care and wellbeing
 - c. There needed to be a balance of local and national advice services.
4. *Innovation and efficiency in care*
 - a. There were a number of short term practical steps that could be taken to improve efficiency in the market
 - b. Market analysis and information were crucial for generating new and innovative practice
 - c. The sector was critically undermined by a lack of business skills and recruitment and retention problems

The following note summarises the discussions held and comments expressed by the experts in all four groups, and as such does not represent the opinions or conclusions of the Resolution Foundation.

A vision for older people's care – general thoughts

Each of the four expert groups were asked to give their thoughts on the overall “Vision” of the future care system for older people. Each of the six elements of the Vision were explained, and the following graphical representation was distributed to show how the individual (care user, carer and family) would be at the centre.



Reactions to the six point Vision were generally positive, with most of the experts suggesting areas to be considered in more detail, or identifying factors the Foundation must ensure are included, rather than questioning the concept or component elements. Comments fell into four general areas:

1. Points to consider regarding specific elements
2. The structure of the vision
3. Underpinning factors
4. Missing elements

Points to consider regarding specific elements

Market shapers: it was suggested that “market shaping” should actually be a broader function within the Vision to encompass “place shaping” and the involvement of the voluntary sector and wider community. Market shaping is an important function within this wider role.

Navigation: similarly, some experts wanted to ensure the Foundation had considered the need for navigation services to provide information and advice on a broader range of issues than care (such as housing and finances). The Vision was also viewed by some as a good opportunity to introduce

more consistency and standards within the provision of care advice and guidance. However, the issue was also raised whether placing such high priority on navigation of the system might divert precious resources away from actual care provision – understanding the system would be fairly meaningless if there were no resources to provide services, which was already the case in some areas due to such scarce resources. This was countered by those who raised the point that self funders in the care system were critically lacking advice and guidance. In the south of England self funders make up 50 per cent of the market, and these large numbers of older people cannot be left without any support.

The national framework: there was a considerable amount of discussion as to what a national framework ought to include and provide clarification on. Key issues raised included:

- The framework had to emphasise individual responsibility: it had to act as a means of re-educating people regarding what the state would pay for, and what the individual would have to take responsibility for regarding care. This was linked to a need for greater definitive clarity between free health and means tested care services.
- A related point was the critical need for a minimum entitlement. The national framework had to clarify exactly what the individual should expect from the state as a minimum (whether this be care, funding, or simply support to prepare for and navigate the care system).
- The framework also had to clarify the integration of care with the wider concept of wellbeing and related services, e.g. answering questions regarding the role of housing in care.
- There were, however, doubts as to whether there was sufficient political will to construct a national framework along these lines, as this would involve answering hard questions (such as where services fell between the free NHS and means tested care services, and how much individuals would have to contribute to their care), as well as standing up to vested interests when defining roles and responsibilities within the system. The example was given that local authorities would be resistant to the national imposition that a Framework would represent, and it was doubtful whether there was sufficient political will to therefore push this through.
- It was felt that a national framework would also need some form of national resource allocation system (where people received the same amount for their care even if they were assessed and attributed points at local level), but that local authorities would be resistant to such a scheme. The point was raised that national allocation systems were inherently flawed and would still generate local variation and unfairness.

Funding: the general point was made that the Vision should consider “resources”, not just “funding”, as individuals might not contribute funds in the future as much as their own time and commitment. The wider definition of “Resources” took into account the fact that care users, families and the wider community can provide much toward achieving the Vision, in terms of informal care and volunteering. Regarding funding specifically, it was suggested that younger generations would be very resistant to paying more tax, and the real challenge was to get people to prepare for their care individually. The fundamental problem remained that people still felt the government could

afford to pay for care, and would not be inclined to prepare for care given that they only had a one in four or five chance of needing it in the future.

The structure of the Vision

Two key points were raised regarding the graphical representation of the Vision. The first was that the national framework ought to be “wrapped round” the other elements to demonstrate how it actually clarified and specified the roles of the other elements and actors within the Vision.

The second point was that the representation still suggested passivity on the part of the individual – i.e., that a lot was being “done to” the care user, rather than the care user interacting with and/or controlling elements of the Vision to be an active participant in defining their own care and support. The Vision needed to depict the concept of co-production with people at the centre of each element.

Factors underpinning the Vision

Some experts felt the Vision had not taken into account of how capacity in the system would be increased to meet demand, given the limited resources currently available. Adequate resources to deliver the Vision and care in the future had to be found from somewhere, and this needed to be acknowledged within the Vision itself.

Another issue which created much debate was that of personalisation and transparency. It was felt that the Vision had transparency at its heart, but that this had fundamental repercussions on the delivery of personalised care and support services. This was because clarity and transparency of entitlement and responsibility could require care users to be “boxed” into groups of qualification for different entitlements. This potentially conflicts with personalisation, where each user’s needs and circumstances should be weighed up and the care they need provided accordingly. It was felt transparency was vital for “buy in” from the public, but that this could imply means testing “cliff edges” so that people knew where they stood on the dividing line of entitlement. The only alternative was universally free care provision, with consequently no cap on resources. Personalisation, on the other hand, could generate a far more opaque system where eligibility and entitlement was a case by case issue.

Regarding personalisation more generally, some experts warned against giving personalisation a standard definition and then imposing this on care users. They did not want to see a scenario where an older person was told “this is what you have to do because this is what personalisation means.” For example, personalisation was often conflated with a care user controlling their care funding, however personalisation could mean an older person having the ability to direct how the time during a care visit was used. Indeed, concerns were voiced that some older people might find the implied responsibility of financially managing a personal budget too much of a burden and felt the roll out of personal budgets represented an imposition in itself. Others argued that these concerns were overstated, and that older people would have the option to take as much or as little control of their personal budgets as they were comfortable with.

Missing elements

It was felt two areas ought to be brought out more clearly within the vision:

- The care workforce – the Vision needed a mechanism to ensure that the people behind the six elements (i.e. delivering the Vision) were competent and trustworthy.
- Standards – although standards and regulation were envisaged by the Foundation as part of the national framework, it was felt that this concept needed to be more explicit within the six elements.

A vision for older people’s care – delegation of roles and responsibilities

The expert groups were asked to consider more specifically who ought to discharge the key functions of the Foundation’s Vision.

Market shaping

Many experts suggested that the local authority was best placed to carry out a market shaping role, specifically regarding the “mapping” local markets and commissioning services accordingly. However, there were concerns that local authorities currently lacked the capacity to carry out such a role on behalf of all older people (i.e. self funders), and would be unable to shape markets in a more nuanced way in the future once blunter shaping tools (such as purchasing care and actively “managing” the market) became less viable. Others experts also suggested that in the future service users, or groups of users, would also have a role in shaping markets.

Assessment and eligibility and funding

It was felt that assessment of need could be a universal entitlement, with means assessments representing a second stage in a two stage process for those whose needs were sufficient to potentially entitle them to state funded care. It was widely agreed, however, that assessment of eligibility and the funding of care ought to be separated to resolve the inherent conflict of interest that currently existed.

One suggestion was that Assessment could be carried out by local authorities, with funding distributed centrally. This idea was the subject of much discussion, with some pointing out that such a system would remove budgetary control from local authorities and would be resisted, whilst others felt that local authorities would welcome having this responsibility lifted from them. Such a system would require a national resource allocation system, whereby local authorities awarded points to individuals who would then claim them from a central “pot” of funding. This would improve the portability of care funding, but there were concerns that this might still lead to local variation and unfairness. This was qualified by the acknowledgement that different local authority budgets currently made a consistent service impossible to deliver in any case, and that at the DH Green Paper engagement events the majority of participants voted for national rather than local solutions.

An alternative idea, which would still separate funding from assessment, was for social workers to carry out assessments, whilst funding came from local authorities. It was pointed out that social workers were experienced at providing high quality, holistic needs assessments already, but would

often feel demoralised at having to “fight” for the resources required once they returned to their (local authority) offices. However, social workers did not actually have to be part of the local authority, and independent practices already existed. Divorcing social workers from the local authority would remove the conflict of interest between assessor and funding gatekeeper, whilst making the most of existing expertise in the social work profession.

Navigation

Concerns were expressed by a number of experts that a conflict of interest might arise if local authorities provided information and advice to help people navigate care, given their role in assessing people’s eligibility for state funding. Providing information may increase the demand for services which local authorities may have to pay for, for example. It was felt that unless the local authority’s role as funder, assessor and/or provider of care services changed, the provision of advice should remain outside of its sphere of influence.

A vision for older people's care – four elements in more detail

The second half of the expert group sessions looked in more detail at four of the six elements of the Foundation's Vision. The four elements had been the subject of the Foundation's research programme during the summer, and the groups were presented with the objectives, key questions and findings of each project and asked for their comments. These are summarised below.

Local market shaping

The Foundation presented the concept of market shaping within the context of care as a "social good". The research had identified a range of tools that might be used by market shapers of the future to achieve sufficient volume, diversity, quality and affordability in care services. Experts were asked to reflect on market shaping more generally and who might carry this out in the future.

1. The concept of market shaping

There was a broad discussion regarding the concept of market shaping itself, and whether the care market (or indeed any market) should or could be "shaped" at all. There was a diverse range of opinion on this, including those who believed that the care market would not naturally shape itself to meet reform agendas such as personalisation – as a "social" market, it could not be left to grow naturally but had to be aligned to social policy priorities. Others felt this was simply not feasible and that markets could fundamentally not be controlled, and would always respond to market forces. This was duly countered by those who pointed out that the care market does not develop in a vacuum – it is already influenced by a range of factors (see point 2 below), and the activities of a "market shaper" would simply be one of these factors.

The question was raised, by those who believed markets were uncontrollable, whether personalisation could be delivered simply by giving money directly to service users and letting them shape the market themselves. However some experts argued that many service users would be unable to express their demands effectively (see point 5 below) and supply would not be able to respond - thereby leaving the market uninfluenced by service users' preferences.

2. Who currently shapes the care market?

It was felt that whilst local authorities currently have a role in shaping local care markets, they did not have *the* role. Many experts suggested other market shapers and external factors brought their influence to bear on the development of the market. These included:

- Charitable grants (such as Big Lottery funding). These could have a significant impact on stimulating new and innovative service developments. The third sector applies for this funding based on local need, so its delivery is essentially responding to demand. As the third sector have such a large role in delivering care and related services, the influence of charitable grant funding on local care markets is very important.

- The care regulator can influence the market directly by driving up quality, but also by influencing local authority and consumers' purchasing decisions (according to quality star ratings, for example).
- The largest care providers, who can influence relatively small local market areas according to their own objectives (e.g. with investments and strategic business decisions).
- The political culture of local authorities, regions and sub-regions, and public service culture on the front line. It was argued these cultural differences could create market areas that were very geographically diverse

3. *The role of the local authority*

As mentioned above, it was acknowledged by most participants that local authorities did have a role to play in the shaping of future care markets. However, there was a general consensus that local authorities were not carrying out this role effectively in the current system, and would probably lack the capacity to be a key market shaper in the future. A common criticism was that local authorities did not consider the needs of self funding individuals when commissioning services, and generally knew little about the private market in their areas (either from the point of view of self funders, or the providers delivering their care). Market shaping for all older people in the future was seen as too considerable a challenge for local authorities to take on as sole market shaper – particularly given the growing influence of other agents and external factors (see point 2 above).

4. *How to shape markets in the future*

Leaving questions of who should discharge the market shaping function to one side, some points were raised regarding *how* should be done in a future care market. These included:

- The importance of Joint Strategic Needs Assessments and joint commissioning with the NHS in the future, to ensure the market delivered compatible and mutually reinforcing care and health objectives.
- The need to implement a more nuanced shaping strategy – as blunter tools (such as purchasing on behalf of older people) become less viable, market incentives to influence provider behaviour become more important.
- Using the concept of “place shaping”, and understanding the role of market shaping within that. Market shapers would in fact have to create a “place” in which a care market could flourish, which included looking at a wider range of services (e.g. housing) as well as the local community and informal care.
- The elements of volume, diversity, quality and affordability (as presented by the Foundation) were received positively by the experts as key market shaping outcomes, but it was pointed out that these had to be considered simultaneously, otherwise it would become too easy to sacrifice one in order to achieve the others.
- Although market shaping in the current system is thwarted by a lack of information regarding the private care market (i.e. no one knows where private funds are being spent), it was suggested that if the future Vision of care had a universal assessment/entitlement

system, this would act as a valuable means of collecting information regarding a larger number of older people who might go through this “gateway”.

5. Brokerage

One of the suggestions made by the Foundation as part of the market shaping research project was the creation of a new “intermediary” function within the care system, akin to Independent Financial Advisers for older people. There was a mixed response to creating a new agent in the care system, with some experts suggesting brokers might take this role, other suggesting care managers carry this out, though many felt that care managers did not have the skills for this function.

Although creating a new position was not universally accepted, most experts did agree that intermediary functions were very important for both personal budget holders and self funders. The point was made, for example, that the latter group were under-utilising domiciliary care and going prematurely into care homes, mainly because they were not being given sufficient guidance. Other experts linked intermediaries to the broader functioning of the market: pointing out that in the care system, people rarely expressed their needs and tended to simply use what was available, thereby not effectively shaping supply. Care users also did not have a collective voice, so their demands were not often heard. Intermediaries would help remedy this situation and help shape the market on behalf of care users.

6. Clear guidance

Some expert groups discussed the childcare market and how this was shaped in comparison to care for older people. What stood out for many was the clarity of guidance provided to local authorities from government on how to balance priorities and shape the childcare market for a set of clear outcomes. It was pointed out that this was possible because the childcare market operated within the very clear framework of *Every Child Matters*, which lays out a set of specific objectives working towards a defined set of outcomes for children. In older care, local authorities had to balance competing priorities without a unifying goal to work towards, and many felt this hampered strategic market shaping. For example, there was a very clear steer towards prioritising efficiency above all else, even when government rhetoric placed so much emphasis on choice, prevention and personalisation. Some experts also explained that there was no incentive to fund care for older people, unlike in childcare where childcare vouchers and the focus on getting parents back into work helped drive up the quantity of provision. These factors combined have led to the rolling back and rationing of care services for older people.

Funding

The Foundation presented a range of funding models that could be used to help individuals pay for their care in the future, based on the understanding that a future care system would need to be funded by both the government *and* the individual to a greater degree. Options included variations of equity release, insurance and savings products, and private and state sponsored/managed

products. Experts were asked to consider the viability of these options and other potential alternatives:

1. Equity release

It was pointed out that if housing wealth was removed from current discussions regarding funding, then the options presented would be very different. As such, it was important not to premise all future planning regarding care funding systems on the fact that current and imminent care users have been able to take advantage of unusual economic and political circumstances to accumulate very large amounts of housing wealth. It was felt that such circumstances were unlikely to occur again and that an equity based funding system was therefore unlikely to be viable in 30 to 50 years time. A house in the 1970s was unlikely to buy much care, for example. As such, a possible “two stage” approach to funding, catering to baby boomers and the generations that followed, might be more appropriate (see below).

There was some debate as to whether attitudes to debt and inheritance were changing, making equity release a more palatable product for baby boomers compared to today’s older people. One expert cited a recent survey which found 46 per cent of baby boomers reported their biggest concern in old age was whether they would be able to continue with their current lifestyle – not whether they would be able to leave their house to their children. This was countered by others who cited focus groups which still showed a clear aversion to capital based products and support for collective tax or social insurance models (see below). It was also questioned whether people’s aversion to being in debt, which has always been viewed as declining given a generation of cheap credit, might be turned around given the more recent changes in the economic environment.

It was felt that decumulation of assets could be made more palatable with better education, if people understood that although decumulation might reduce their children’s inheritance, it might also lead to their children having lower taxes and a reduced care bill themselves in the future. The idea of state-sponsored products (be they decumulation or prefunding products) was also well received, though it was pointed out that they would be unlikely to improve public confidence in their private counterparts unless these were also seen to be value for money and have transparent pricing systems.

The products available for decumulation of assets were compared unfavourably by the wider and better promoted products available to help people accumulate assets (such as shared ownership and right to buy schemes), and it was discussed as to whether the two might be linked somehow. It was also suggested that decumulation should also be tax deductible, in that paying tax to both accumulate and then decumulate assets was quite unfair.

2. A two stage funding scheme

Given the significant housing wealth available to current and imminent care users (i.e. the Baby Boom generation), compared with the much less certain financial situation of the generations which may follow, there was general support in all expert groups that a two stage funding system. This

would allow for equity release type products to be used for imminent care users who have significant housing wealth, and contributory schemes to be used for younger generations.

Indeed, it was pointed out that if equity release and other decumulation products were used effectively by baby boomers, then the following generations would be far less likely to inherit – so non-equity based funding vehicles were important for the future. In addition, if imminent care users were to make use of equity release, there might also be a reduction in taxes for younger generations, which in turn might make it easier for them to use more savings-based products (such as care insurance). There were concerns, however, that with changes to the pensions system and difficulties in securing a house (if they are less likely to inherit), younger generations would have to save a considerable amount from their incomes in any case, and still may not be able to afford to pay into a scheme to prepare for care costs.

It was also suggested that instead of a two-stage scheme, a rolling scheme shifting from equity based products to insurance based products would remove a cliff edge and reduce the chances of those on the cusp paying twice. More generally, it was felt that a one size fits all scheme (i.e. equity release for older generations, insurance for younger generations) was not suitable in any case, given the diversity of people's circumstances. People have different income and savings sources (house, savings, pensions, family) and a range of product options will be needed to suit different people's circumstances.

3. Long term care insurance and savings

Experts felt there ought to be more differentiation between pre-funded care insurance, for which there seemed to be little public appetite due to the cost of premiums, and immediate needs insurance, which was more popular. Expanding the risk pool was seen as the only way to make the former product more affordable, which required either better education of the need to plan for care costs, or some form of compulsion. A parallel was drawn with pensions, where soft compulsion (auto enrolment) was used as a result of a failure of education to encourage more pensions saving.

However, experts agreed the government faced an even bigger challenge to get people to plan for care compared to pensions, as the level of hyperbolic discounting (i.e. people not seeing the value of saving for a future eventuality) was even worse in a care context. This is because everyone needs a pension or some form of saving to help them live through retirement, unless they die. Pensions pay for general "living" costs, which everyone needs. Care, on the other hand, is a risk which many people will not be exposed to (in that there is a 1 in 4 or 5 chance of needing residential care in old age).

Suggested solutions to this included a role for government to improve public awareness of the need to pay for care costs and therefore save for them in advance (see below), but also to potentially link the saving for care with more general savings for a wider range of needs in later life. It was suggested, for example, that a broader retirement product could be introduced which paid for *any* cost in old age, and that products already existed in the US for this. A product had existed for this purpose in the UK – an annuity was paid at 65 which would double if a person went into care.

However this product was withdrawn due to regulatory problems, and so a change in regulation would be required if such products were to be reintroduced.

Some experts were concerned that such an approach would still be problematic, as there would be a level of uncertainty regarding when an older person ought to spend their pensions/care savings, given there would be no knowing when (if ever) a person would require care. There was a debate as to whether people ought to be able to spend their savings on prevention and wellbeing earlier on, or wait until their needs escalated and costs increased. Nevertheless, treating care as an “extra” cost to the resources needed in later life was seen as a valuable means of overcoming people’s resistance to preparing for care as a distant possibility.

The care bond scheme, used in Australia, was also given as a positive example of a different approach to annuities – individuals would pay a bond to a care provider to secure a care place with them. Providers would be able to invest it for a fixed return, and return this bond when it was needed to pay for care, minus a fee.

4. Tax and other collective funding options

Some experts felt that social insurance and national insurance/taxation models of care funding should not be ruled out too early, given that they were being successfully used in other European countries and that these methods were consistently the most popular with the public. It was discussed that whilst the public (particularly younger generations) were always resistant to tax increases, when the issue of care and care funding was discussed in more depth, a collective method to pay for care always seemed to have the most support. Unlike individual contributory schemes (such as LTCI), people were less concerned with getting an equal return on their contribution to collective risk pooling schemes (the example of the NHS was used, which enjoyed high levels of acceptance that people pay in to the service and may not ever need it).

5. Raising awareness of the need to fund care

It was suggested by some experts that the popular misconception among the public that the government paid for care, and that care was often conflated with free NHS services, had actively been encouraged by the government. The government had put out “misinformation” from the 1950s implying that paying national insurance amounted to protection in old age, with no distinction made between health and care. The popular sentiment that people are “entitled” to care in old age due to their tax and national insurance contributions is understandable, therefore. Furthermore, many experts felt there was little political appetite to rectify this situation by making a distinction between NHS and means tested care, and raising awareness that care needed to be paid for in old age. It was also pointed out that it was not just politicians who were reticent to make this clear – the media too were not particularly interested in this issue unless it involved a scare story.

Nevertheless, a public debate regarding the need to pay for care was vital if the government ever expected people to prepare for their care costs without compulsion. The example was used of Oregon, where the state government had held a state-wide engagement programme and public debate to allow the citizens to decide exactly what health services the state would pay for and which

would be paid for privately. The expert groups agreed that the public had to accept responsibility for their care costs, and it was the government's job to present a stark choice – prepare with care insurance or other savings product, or use equity release at the point of need. The government could also no longer avoid the issue regarding exactly what people had to pay for (e.g. hotel costs).

Navigating the care system

The Foundation identified a number of key weaknesses in the current provision of information, advice and advocacy to help people navigate the care system, and presented a range of options to address these weaknesses (including “first stop shops” to coordinate a range of advice services) to the expert groups for comment:

1. *National versus local services*

Expert groups were divided as to whether navigation services should be provided at mainly local or national level. Some experts believed the local diversity of care systems (in terms of entitlements, fees, and services available) made a local advice service more useful for older people, whilst others emphasised the importance of national consistency and standards of advice. Those in the latter group believed a nationally branded “pointing system” needed to be created, which would have local representatives, but would not be based at local level. Some experts suggested the first point of contact for this national pointing system might be, in a future care system, part of a universal entitlement to an assessment of need.

2. *A starting point*

The importance of a first “point of contact” was a consistent theme in most expert discussions. It was suggested that the equivalent of a tourist “information point” was needed to provide an overview of the help and support available, before that help and support to navigate care was even provided. This would then point people in the right direction for information, advice, advocacy, brokerage, and so on, depending on their needs and preferences.

Some experts felt there was no currently recognisable first point of contact for older people, like there was for children (where schools acted as the most visible, recognisable single point in the community where children's needs are dealt with). To remedy this, experts discussed automatic trigger points for when people reached 65, similar to a Bounty Pack or a DVLA check up at 70. Whilst some felt 65 would be far too early for many older people to be given information about care choices, this was countered by those who suggested information could be more generic to encompass wellbeing and social/community opportunities and wider entitlements (e.g. free travel) rather than a focus on care services. As mentioned above, some suggested a universal entitlement for a needs assessment could act as the “starting point” for many older people to be informed of the range of information and advice available. Others emphasised the importance of the internet in the future as a national first point of contact, directory of providers (a “caresupermarket.com” was mentioned) and gateway to local advice.

3. *Who should provide navigation services?*

Many experts agreed that variations in local authority budgets would lead to inconsistency in the range and quality of information and advice if it were provided or coordinated by local authorities. It was felt that the potential creation of a new “navigation service” would be an important opportunity to introduce standards and a guarantee of independence to care advice, and this was not necessarily compatible with a local authority role. Concerns were raised as to whether the local authority ought to act as a local coordinator of information and advice sources, give its existing roles as gatekeeper to funding as well as providers of some services. A conflict of interest might arise if providing information led to older people demanding services which the local authority had to then pay for, and similarly, local authorities might be inclined to advise people to use the services they provide rather than independent providers. It was felt that unless the local authority’s role as funder, assessor and/or provider of care services changed, the provision of advice should remain outside of its sphere of influence.

However, this concern was not just related to local authorities – it was also pointed out that a growing number of third sector organisations were providing information advice and advocacy (IAA) services, as well as a variety of care services. Some experts felt that a charitable organisation’s “advice branch” might recommend services from its own “care branch” and exclude other providers.

4. *Concerns*

Some experts felt that the Foundation’s suggestions for a new navigation service maintained a “dependency model” whereby older people passively received advice and support. There needed to be more of a focus of peer support and actively encouraging older people into the delivery and dissemination of care advice and information.

Concerns were also raised that current care reforms risked “the imposition of choice” (with personal budgets being used as an example), and that a complex navigation system, with several different methods of providing help (information, advice, advocacy, brokerage) risked adding to the choices available and the complexity of the system, rather than improving it. It was for this reason that some experts suggested a “tourist information point” to give an overview of help available (see above), and also why it was felt that the separation of information, advice and advocacy from professional brokerage or intermediary services risks over complicating the system. Help to navigate the care system had to be as coordinated and simplified as possible into a seamless service of “help”.

In addition, it was felt that the advice sector was full of good initiatives, but that there lacked a proven model to be universally adopted. Getting “everyone in a room” (i.e. all interested practitioners and stakeholders) to define a successful approach was seen as an important way forward.

5. *The content of information and advice*

Some experts felt there needed to be a differentiation between advice on what an older person was entitled to (covering benefits and welfare rights), and what was then locally available regarding care

and support services. It was unlikely advisors would be expert in both, and it was discussed whether the former could be provided nationally whilst the latter provided locally (see above).

Other points raised regarding the content of advice needed to help people navigate care included:

- The need for a range of information (including housing, transport, benefits and community services) to be provided
- The importance of financial advice
- The need to target families, carers and care staff, who all need information and advice too
- The need to explain the risks of making bad care decisions and the consequences of care choices

6. Improving take up

Several experts emphasised the need for local referral networks within communities and pro-active case finding to ensure older people knew about and were put in contact with navigation services. A first stop gateway or universal entitlement could not be relied upon to catch harder to reach older people (who were more likely to need information and advice in any case). The importance of “entry points” to the care system was also discussed in this context, with hospitals, GPs, and care providers themselves seen as important channels to bring people into the sphere of navigation services. However some felt that the need to refer people “in” to a system could be removed altogether by embedding information and advice, and engaging people, in their daily lives. This would both normalise the seeking of advice and raise awareness of the care system before people actually needed care. However, there was some debate as to how early we could expect people to start thinking about their care options.

Innovation and efficiency in care

The Foundation presented a range of factors which care providers had identified as obstacles to innovative practices to improve efficiency or deliver more personalised services, and then presented a number of ways in which these obstacles might be overcome. Expert groups were asked to comment on these suggestions:

1. Regulation

Many experts agreed that care regulation and inspection regimes were a key obstacle to innovation and efficiency in the sector. One expert referred to their own experience of running a care home, where they had wanted to respond to residents’ wishes and change the type of care being provided (from traditional care to semi-independent units). However, the expert explained that to do this, they would have had to have de-registered and re-registered with the regulator. As many of the residents came from neighbouring local authorities, there was a risk that this would lead to a loss of many contracts during the interim period. Overall it was felt the cost, complexity and risk to contracts was too great to make this change. Another expert explained how the duplicate

inspections from the care regulator and the local authority when monitoring contracts could create a significant administrative burden, particularly for those homes who had residents from several local authorities. The case was cited of one care home which had been inspected six times in one year due to this.

However, the point was made that in the financial services industry, the regulator (i.e. the Financial Services Authority) actually improved innovation. Under the Treating Customers Fairly regulations, financial service providers had to carry out market analysis to better understand their client base, which in turn helped drive new and innovative services. The opportunity for such a role being carried out by the new care regulator (CQC) was discussed.

2. Commissioning

Some experts countered the points made above by suggesting regulation was no obstacle to innovation and efficiency if providers were “doing it right”. These experts felt that local authority commissioning was the real problem in the current system. This difference of opinion had already been encountered by the Foundation in its research, which found that domiciliary care providers reported little problem with regulation, and instead identified local authority purchasing practices as their principal concern.

Experts explained that local authority purchasing of home care, which specified “time and task” down to the last minute, was fundamentally contrary to personalised, flexible and innovative services. The daily variation in people’s needs was hugely underestimated in this approach, and carers were often unable to meet needs in the time allocated, let alone consider new ways of working. When the concept of outcomes based and average time care contracts were raised, it was explained that these were only being used in very small areas and often as pilots. The vast majority of local authorities had not taken this approach on board, even though it offered a number of benefits: in addition to encouraging innovative thinking and more flexibility, it could also incentivise older people to gain independence (as compared to the current system which encouraged older people to remain dependent in order to keep the length and number of visits they wanted). In addition, some experts cited pilots which had shown outcomes based contracting could achieve a 10-12 per cent efficiency gain, mainly by encouraging independence and a withdrawal of intensive care services from older people. As such, local authority reticence to use this approach could not be blamed on a lack of resources, but rather a lack of imaginative thinking and poor levels of trust in providers’ professional discretion. Relatedly, many experts suggested the “them and us” approach to relations between local authorities and providers fundamentally undermined the quality of commissioning. Some suggested that commissioners ought to come from a social work or care background rather than a procurement background to improve this situation.

3. Market information

Many experts emphasised the importance of market research and information as a means of stimulating new and innovative services. It was referred to as a “classic business skill” which unfortunately many providers lacked the internal capacity to carry out. This was for two reasons – the first was that many small providers did not have the resources to commit to their own market

research, and the second was that providers often only had the local authority as their main client and so had never needed to develop this skill. However, it was pointed out by one expert that most domiciliary providers had entered the care market with a predominantly private client base, and only won local authority contracts as they grew and matured. This reliance on local authority contracts had led to complacency, and some experts felt providers had “forgotten their roots” in now not being able to meet a wider range of needs generated by higher numbers of self funders and personal budget holders.

It was felt, therefore, that the local authority therefore had an important role in providing market intelligence for those providers who were unable to do this for themselves. The local authority also had a responsibility to encourage providers to develop the internal capacity to use the information provided to spot opportunities and think more flexibly regarding how to meet older people’s needs, particularly in the light of the general decline in local authority contracts due to the roll out of personal budgets.

4. *Internal capacity to innovate*

Discussions regarding providers’ ability to use market information to innovate often generated into a wider debate regarding providers’ overall capacity to become more flexible and dynamic in the future.

The point was made that even those providers currently serving self funders were not carrying out market research and finding out about the needs of potential clients, so a history of reliance on local authority contacts was not the only reason why providers did not develop such business skills. Many self funders were unhappy with the range of services they were receiving, but this was not driving change in many cases. A general skills shortage in the sector was cited as one reason behind this, in that undertrained and subsequently demoralised staff were unlikely to be a source of innovative thinking if they were struggling to meet the demands of their job.

However, this argument was countered by those who felt less skilled staff could innovate, if they were given the opportunity to do so. Levels of training and qualifications were potentially less important than the caring nature of the role in this context. This point led to a wider discussion regarding the risks over over-regulating the care workforce and reducing the vocational, caring focus of the role.

5. *Other points*

Although a lack of training was seen as a potential obstacle to innovative thinking on the front line, problems with recruitment and retention more broadly were more often cited as obstacles. This is because high staff turnover generated higher recruitment and training costs – leaving care providers without the time or resources (or staff “buy in”) to think of new and innovative working practices. Staff costs were also seen as squeezing the bottom line for many providers, which reduced the returns for any potential investors in the sector. To achieve better returns, providers also needed a level of critical mass to make economies of scale, and many experts felt that local authority markets

were simply too small to deliver this (which fed into discussions regarding the “scale” of market shaping, above).

Whilst an underlying theme in the discussions regarding innovation and efficiency had been that a general lack of resources hampered efficiency (e.g. by influencing local authority purchasing practices and giving providers little margin of flexibility to try new schemes), one expert suggested the government would be reticent in providing funding to stimulate innovation in the market – as any investment was likely to go towards improving staff wages, or increasing returns, as first priorities.

Concluding thoughts and next steps

The Resolution Foundation seeks to identify and develop practical policy solutions to challenges identified by its research work. It was for this reason that it hosted a series of expert groups, in an attempt to create a tangible vision for reform of long term care.

This is needed because whilst the principles that lay behind a future system of care and support has been well-defined, what a system capable of achieving this vision would “look like” remains vague: in terms of its architecture for delivery, and the roles and responsibilities of and relationships between key actors.

The input from the five expert groups brought together in July helped the Foundation develop a Vision for a new care system – the experts’ subsequent feedback in October will enable us to develop possible options for an architecture to deliver this Vision, which we will present in a report in December 2008.