

**Innovation and efficiency in care supply – a discussion paper**

**December 2008**

## **I – Summary**

This report explains what we mean by “innovation” and “efficiency” in care and why they are so important in the current care market:

- The ability to respond flexibly to more diverse user needs is crucial in the wake of a) an increased government focus on personalisation and choice, and b) growing numbers of self-funding older people and personal budget holders.
- The current care market is “resource constrained” – funding is limited and uncertain, meaning providers are increasingly having to “do more with less” to survive.

Both require a degree of innovation and lateral thinking to create new services or new ways of working to respond to these circumstances.

Innovation can be found in the current care sector – providers are coming up with inventive ways of meeting the growing and more complex needs of older people without corresponding increases in funding.

However, the Foundation differentiates between this improvised “innovation by necessity”, and the more strategic innovation necessary for planned organisational development. Whilst the former is often found in the sector and driven by the need to survive, the latter is much harder to come by in the care sector. As a result, the sector on the whole develops in an ad hoc fashion, with pockets of good practice remaining unrecognised and subsequently unshared with other providers. Care supply remains patchy in quality and efficiency, with different providers progressing at different rates, exacerbating the postcode lottery many older people face when navigating the care system.

This report identifies those factors which hinder care providers from carrying out strategic innovation to deliver personalised and cost effective care services, and from planning responses to forthcoming challenges in the market. Such challenges include demand for more complex care, the use of personal budgets, and the government’s shifting priorities towards prevention and wellbeing. These factors can be summarised as:

1. Regulation and inspection
2. Local authority commissioning behaviour
3. Investors’ behaviour
4. Internal organisational constraints

The final section of this report outlines a number of options to both overcome these obstacles, and to positively create a market environment which fosters innovative practice. A future care market ought to have several of these elements in place in order to create a healthy and responsive supply of care, and therefore function more effectively:

1. Outcomes and quality of life based regulation
2. Continuity in inspection
3. Outcomes based commissioning and average time contracting
4. Cultural change for trust and sharing information between commissioners and providers
5. Job flexibility, loyalty schemes and recognition for care workers

## **II – Introduction**

### **Methodology**

This report draws on existing research carried out by organisations including the Kings Fund, SCIE and the Joseph Rountree Foundation, as well as a variety of departmental and CSCI policy documents. The Foundation also carried out its own research, holding workshops with a range (small and large, voluntary and private) of residential and domiciliary care providers (one with the former, one with the latter, and one a mixture of the two) to explore the issue of innovation and efficiency in care and what obstacles they encountered in the day to day running of their businesses. A note summarising the emerging themes from the discussions held at those meetings can be found on the Resolution Foundation website.<sup>1</sup> This approach has mainly given a provider’s perspective on the obstacles to more innovative working, but the Foundation felt this was a perspective which was often overlooked. However, the Foundation also consulted a range of expert groups and interviewed a number of local authorities during its wider research programme, which provided a different point of view and raised additional issues which have also been included in this report.

### **What is innovation and why is it important to a healthy market?**

The term “innovation” is widely used as a positive expression of “new” and “different”. In reality, however, innovation has little meaning unless it is linked to some form of improvement. The NHS Institute for Innovation and Improvement seeks to provide more clarity by defining innovation as “doing things differently, and doing different things, to create a step-change in performance.”<sup>2</sup> The Institute goes on to define “seven dimensions of performance” which innovation can improve:

1. Effectiveness
2. Efficiency
3. Safety
4. Timeliness
5. Equity
6. Coordination
7. People-centredness

The Resolution Foundation has chosen to focus on innovation in the care sector which helps improve *efficiency* and “*people-centredness*” (i.e. personalisation, or responding flexibly to people’s needs). These two elements were chosen as the most relevant to the current care market and its future development.

### *Personalisation*

The Resolution Foundation’s previous research, *A to Z: mapping long term care markets*, identified as a possible market weakness the inability of care providers to respond flexibly and adapt to changes in demand for care. As such, the care market suffers from low levels of consumer choice and significant unmet need, particularly among self-funders. Yet at the same time, the Government has identified the concept of choice and personalisation as one

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<sup>1</sup> [www.resolutionfoundation.org](http://www.resolutionfoundation.org)

<sup>2</sup> DH (2008) *Commissioning to make a bigger difference: A guide for NHS front-line staff and leaders on assessing and stimulating service innovation*

of the key drivers of social care reform and a central pillar of the forthcoming Green Paper. The DH's *Putting People First* Concordat stated that "In the future, we want people to have maximum choice, control and power over the support services they receive... the right to self-determination will be at the heart of a reformed system only constrained by the realities of finite resources.." The more recent *Case for Change* stated that "Government is committed to extending such self-determination for everyone. This will be at the heart of a new care and support system. Person-centred planning and self-directed support will become mainstream, with a greater emphasis on self-assessment, and everyone who is eligible for social care will receive their support through flexible personal budgets."

The roll out of person centred planning and personal budgets, facilitated by a £520 million transformation grant, will require care providers to have the capacity to respond flexibly to people's needs, as expressed in their individual purchasing decisions. This will require many providers to change the way in which they operate and become more innovative and responsive, and think laterally about how to personalise the services they offer.

### *Efficiency*

In spite of the recent increase in the pace of reform of social care, the issue of social care funding remains a key area of concern. The 2007 CSR announced an annual increase in funding of just 1% for adult social care, which was described as "the worst funding settlement for a decade" by the sector.<sup>3</sup> The tightening of eligibility criteria by local authorities across the country to those with only the most severe needs, and below inflation fee increases paid to care homes and agencies, are just two side-effects of a shortage of funding combined with increasing numbers of older people needing care.

As such, the ability to operate in such a resource-constrained market – and meet an ever more ambitious care agenda and a growth in demand without an increase in funding – requires care providers to be adaptable and innovative. Without some lateral thinking, few providers would be able to maintain good quality care in the face of multiple and often competing pressures from the local authority, central government and care users and their families. For example, a recent report from the Social Care Employers Consortium (SCEC) found that 60% of voluntary sector care providers reported having to top up local authority fees with charitable income despite the Charity Commission having made it clear that charities should not be using donated income to subsidise statutory services.<sup>4</sup> Yet as Mulgan and Albury stated: "Without innovation, the inevitable pressure to contain costs can only be met by forcing already stretched staff to work harder."<sup>5</sup> – the same SCEC report also found care staff in voluntary organisations were the lowest paid of all public servants, had little pensions coverage, and only the minimum holiday and sickness entitlements.<sup>6</sup>

To exacerbate these current shortages, an Independent Review of Public Sector Efficiency carried out by Sir Peter Gershon, *Releasing resources to the front line*, proposed that both central government and local authorities could make efficiency savings of 2.5% per annum, year on year. These targets were incorporated into the 2004 Spending Review and in 2007, the Comprehensive Spending Review raised the efficiency targets to 3% per annum for the next three financial years. Local authorities seeking to make these year on year efficiency

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<sup>3</sup> <http://www.guardian.co.uk/business/2007/oct/10/politics.economicpolicy>

<sup>4</sup> Social Care Employers' Consortium (2008) *SOCIAL CARE: Has Anything Changed? A report into the recruitment and retention of the voluntary sector social care workforce*

<sup>5</sup> Mulgan, G & Albury, D (2003) *Innovation in the public sector*, Strategy Unit London

<sup>6</sup> Ibid

savings have sought to reorganise staff, streamline administration and modernise working practices across the board. In social care, local authorities reported to CSCI that they had made £269 million in efficiency savings. Yet it is inevitable that some of these savings will be sought at the “front line” of care – for example through increased pressure to reduce fees paid to independent providers.

The Department of Health established the Care Services Efficiency Delivery Programme (CSED) in June 2004 to support the implementation of the recommendations of the Gershon report. This programme has subsequently developed a range of online tools to help local authorities streamline their needs assessment processes, for example, and has issued guidance on how local authorities might reduce costs when commissioning care. This guidance has no doubt contributed to the pressures providers feel to provide “more for less” and has encouraged commissioning strategies which have undermined innovation in the sector: as explained below, for example, local authorities are now purchasing care less often from smaller providers, in an attempt to reduce administration costs, according to CSED guidance. However it is these smaller providers who are often a valuable source of innovative practice.

### ***Defining innovation in the current care sector***

Many care providers are currently innovating on a daily basis to remain financially viable in the face of mounting cost pressures. The nature of the innovation demonstrated by the sector confirms the adage “necessity is the mother of invention”: the daily pressures of staff shortages, tight operating margins, and demands from above to make efficiency gains whilst delivering new policy priorities and meeting quality criteria, often requires a degree of lateral thinking on the part of providers. This seems to be rarely, if ever, considered “innovative” by the providers themselves, but rather a case of survival. As such, most examples of innovation are improvised, and result from individual managers and staff doing “what was right” for their client in a particular circumstance. Whilst the conscientious nature of those on the front line is clearly an asset in delivering a “personal touch” to older people and their families, this ad-hoc method is a far cry from what we might call “strategic innovation” – planned ways of investing in and developing new working methods and services to improve the quality of the care being provided.

This report therefore differentiates between “innovation by necessity” and “strategic innovation”. Unfortunately, it seems that often, what drives the former is also what impedes the latter. The day to day pressures of staying in the market seems to leave little time for many providers to consider the strategic development of new services and working methods, but rather leads to individual staff improvising ways of “doing more with less”. As a result, the sector on the whole develops in an ad hoc fashion, with pockets of good practice remaining unrecognised and subsequently unshared with other providers. Care supply remains patchy in quality and efficiency, with different providers progressing at different rates, exacerbating the postcode lottery many older people face when navigating the care system. The Foundation found few providers who explicitly identified innovative practices of a strategic kind, whilst often only the largest providers in the residential and domiciliary care sectors were able to reflect on their organisational development in the face of future challenges, such as the increased use of personal budgets.

### **Section III – What are the barriers to strategic innovation?**

By carrying out a literature review of existing studies into the way in which the care sector operates, as well as a series of workshops with domiciliary and residential care providers and discussions with other stakeholders and local authorities, the Foundation has identified a series of factors which impede care providers from carrying out strategic innovation to deliver personalised and cost effective care services, and think strategically about how they are going to respond to future challenges in the market – such as increased demand for more complex care, the use of personal budgets, and the government’s shifting priorities towards prevention and wellbeing. These factors can be summarised as:

1. Regulation and inspection
2. Local authority commissioning behaviour
3. Investors’ behaviour
4. Internal organisational constraints

#### ***1 – Regulation and inspection***

The care regulation and inspection regime was consistently identified as the largest obstacle to strategic innovation by *residential* care providers consulted by the Foundation. During the Foundation’s expert groups, many providers stated there were too many instances of ill-planned and poorly implemented regulation which caused a range of unintended consequences at the front line. These included inhibiting “common sense” practices which had improved care, as well as creating a bureaucratic burden which made “thinking outside the box” simply too complex.

Dementia care and terminal care in particular were cited as instances where this was especially relevant, though in all areas of care, many providers felt the reporting burden placed on them was disproportionate and several others expressed confusion regarding regulatory rules and how they were supposed to comply – a lack of clarity was a consistent theme in many discussions.

It was also felt there was too much reliance on a “tick-box” approach during inspections and a focus on compliance to minimum standards, rather than a broader evaluation of quality of life and outcomes. Too few residents and their families were consulted during inspections, which were also often too short to gain a full picture of the quality of care being provided.

In short, the perception of a process-based and bureaucratic regulation and inspection regime was viewed as both an obstacle to new and more flexible working practices, as well as a system which did not reward – and sometimes actively discouraged – doing things differently.

Regulation could also inhibit making efficiency gains. For example, one care home owner explained how he had wanted to divide his large home into four separate units to give a “homely” feel, but regulation made this too costly as four separate care managers would need to be required for each unit in the same property.<sup>7</sup> Laing and Buisson calculate that the

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<sup>7</sup> Provider workshops hosted by the Resolution Foundation, August 2008

minimum staffing levels enforced by CSCI in residential care homes means that a only very large homes are financially viable – a 40 bed home would have to spend 82% of its income on staffing, whilst a minimum salary spend for any home with under 25 beds would represent 108% of possible income.<sup>8</sup>

Domiciliary care providers seem to have more positive experiences of regulation and inspection, with the key exception of the staff training requirements imposed on them. CSCI requires all new care staff to start NVQ level 2 or 3 within 6 months of being recruited. The care providers we spoke to were all positive about the qualified status this gave their staff, however, they felt the additional cost burden this placed on them, and the fact their staff were not being rewarded for their training through higher wages, added to the financial constraints in which they operated and could undermine staff morale. As we will see below, financial constraints and staffing problems are key factors undermining the domiciliary sector's ability to innovate and think more strategically about the future.

### **Local authority commissioning**

Whilst the issue of regulation and inspection seems the most problematic for innovation in residential care, domiciliary care providers seem to find the way in which local authorities commission care packages the most significant obstacle to innovation and flexible working.

Several surveys and consultations exploring how domiciliary care is provided, which have been corroborated by the Foundation's own conversations with individual agency managers, have found that many local authorities purchase care from domiciliary providers on a "time and task" basis. These measurable inputs allow local authorities to specify how much time each older person should receive per visit, and the tasks a care worker must carry out in this time. A carer is only insured to carry out those tasks specified in the care plan, and some local authorities purchase 15 minute – or even minute by minute – blocks of time, and will not pay providers for any time they might spend with a client above and beyond this.

This is clearly a very prescriptive purchasing method, which allows very little discretion for care providers to adapt their working methods or respond flexibly to an individual's changing needs. As the time available to the carer per visit rarely takes into account travel time or the time needed to get into a person's home and clock in, every minute is designated to a particular task. As CSCI reports, "there was no slack in the system, so it was very difficult to maintain a consistently good service with all the unexpected variations that occur."<sup>9</sup> It is difficult to see how such an operating model allows for any variation (let alone personalisation) of the care being delivered. As CSCI points out, carers who rush and refuse to do certain tasks are a key issue of complaint by older people, and many older people rely on volunteers to provide more flexible (and personalised) services: "the big difference is that carers come and do what someone else has decided I need, and the volunteers come and ask what I want."<sup>10</sup>

An additional and related problem is that "time and task" based care plans, upon which home carers must base their activities, have proven to be very difficult to change. This means they can both prevent daily flexibility, but also persist in providing inappropriate care if a person's care needs change over time. Any variation to a local authority care plan has to be approved by a social worker, and as CSCI points out, "it can be difficult to get access to a

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<sup>8</sup> Laing & Buisson, *Community Care Market News*, November 2007

<sup>9</sup> CSCI (2006) *Time to care?*

<sup>10</sup> *Ibid*

care manager once they have closed the case, and budget constraints can make them reluctant to change the care plan. Data about councils' performance in reviewing care packages lends credence to the view that care plans are developed at a moment in time rather than being dynamic and variable."<sup>11</sup>

Even if domiciliary care agency managers were able to consider new innovations in such an environment, their ability to implement them would be severely restricted by the amount of time they had available, and the fact they may not be insured to carry out non-specified tasks. Many providers also told us their costs were "pared to the bone" (according to local authorities' need to make efficiency gains – see below), at a time when the intensity of the care being provided in the home was increasing (in part due to contraction of eligibility criteria in many local authorities). As a result, individual care managers and front line carers are mainly innovating *through necessity* and due to a sense of professional responsibility: doing more in less time in an attempt to meet their clients' wider needs, and looking at ways to reduce costs. This environment is certainly not conducive to more strategic innovative thinking.

#### *The impact of funding limitations*

The tightly controlled way in which local authorities purchase care from domiciliary providers is clearly linked to the limited funding available to them, as well as the considerable pressure from national government to make efficiency savings as identified in the Gershon Review. A "time and task" purchasing strategy allows local authorities to exert a tight control on costs, and use easily measurable variables (pence per minute) to calculate value for money. But it also cuts out providers' "room to manoeuvre to be more flexible, innovative and dynamic. One council explained this problem to LGIU: "Services must be able to be provided flexibly, and innovative forms of service delivery are required. This is a challenge for local authorities who are required to demonstrate best value, cost-effectiveness, and deliver within budget; there is a tension between these requirements, equity of service provision, and personalised design and delivery of services"<sup>12</sup>

Resource constraints influence local authority commissioning practices in several ways, the effects of which are also felt in the residential care sector. Firstly, the downward pressure on fees paid by local authorities means many care homes are experiencing tighter margins, with limited ability to reduce their own costs in response (due to minimum regulatory standards and legislation, for example, which more or less fixes their staff costs, which in turn usually accounts for around half of a care home's total costs<sup>13</sup>). Lang and Buisson's survey of local authorities has found many have announced below-inflation increases in the fees they are prepared to pay for a care home bed for 2008-09, whilst a "quality banding fee drift" can even mask fee decreases. This is the case where the full declared fee may only be paid to those homes with the highest quality ratings (as defined by CSCI or by the authority itself), and others are paid less.<sup>14</sup> As such, many providers (in both the residential and domiciliary sectors) stated feeling pressure to produce ever cheaper bids in order to win care contracts. Some care home providers told the Foundation they were planning on withdrawing from the

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<sup>11</sup> Ibid

<sup>12</sup> Aberdeenshire County Council reporting to LGIU, cited in *Never Too Late for Living: final report of the APPG inquiry into services for older people*, LGIU 2008

<sup>13</sup> Laing, W (2008) *Calculating a fair market price for care: a toolkit for residential and nursing home fees*, JRF

<sup>14</sup> Laing & Buisson, *Community Care Market News*, July 2008



local-authority funded market entirely and concentrate on private funders, as they were no longer able to operate within such tight margins.<sup>15</sup>

Whilst a lack of resources does not inhibit innovation *per se* – and as mentioned above does drive much of the existing lateral thinking in the sector – tighter funding does undermine more strategic planning, and mitigates against adopting potentially “risky” new practices, or any investment in developing such schemes.

A second effect of local authority efficiency drives is that many authorities are now contracting with only a few, larger providers rather than several smaller ones, to reduce contractual and bureaucratic overheads, as recommended by the Care Services Efficiency Programme (CSED).<sup>16</sup> Certainly larger providers may have more financial flexibility to invest in strategic innovations, but as the Kings Fund points out, “smaller providers.. may be important innovators, particularly for specific communities.”<sup>17</sup> A study into the opinions of care managers also found that many believed smaller providers were more experienced in negotiating directly with care users to deliver personalised packages of care and were more “in tune” with their local markets.<sup>18</sup> If small providers are excluded from local authority contracting, this source of personalised and dynamic care may be lost. Or, as the UKHCA has suggested, smaller care homes and agencies will increasingly serve the self-funding market, whilst larger organisations will be reserved for local authority-funded older people. Domiciliary agency managers have reported that it is easier to be flexible in delivering services to privately paying clients than those on local authority contracts<sup>19</sup> - as such, it is possible that innovative and personalised care may flourish in the privately funded, smaller provider markets, whilst local authority-funded older people enjoy less flexible and more uniform services.

A third consequence of limited resources which inhibits creative thinking is a tendency by local authorities to commission “tried and tested” services, as these are viewed as lower risk. Providers reported to CSCI that local authorities were less likely to contract new innovations in case they failed and wasted money, so there was little incentive in the sector to come up with new ideas for services<sup>20</sup> - an opinion shared by both residential and domiciliary providers consulted by the Foundation.<sup>21</sup>

Finally, limited and uncertain levels of future funding prompts many local authorities to offer only short term contracts or “spot purchase” (i.e. contracted for one person rather than purchasing several care places or hours)<sup>22</sup>, as they are reluctant to commit themselves to long term or large volume contracts with providers. Unfortunately, this type of contracting passes financial insecurity to providers: the absence of a reliable income stream consequently undermines their ability to plan ahead and consider investing in new schemes or engaging in new untested practices. The Kings Fund also points out that many providers share this insecurity with their staff, employing them on a temporary or casual basis.<sup>23</sup> Whilst this may not undermine innovation *per se*, a lack of continuity in personnel and possibly low

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<sup>15</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>16</sup> <http://www.csed.csip.org.uk/>

<sup>17</sup> King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

<sup>18</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

<sup>19</sup> *Ibid*

<sup>20</sup> CSCI (2007) *Safe as houses - what drives investment in social care?*

<sup>21</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>22</sup> The UKHCA found 61% of contracts with independent home care agencies were spot purchased. Time to care

<sup>23</sup> King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

morale could hamper cultural change that may be required to bring about innovative practices (see below).

### *Trust and information sharing*

A knock-on effect of resource constraints is that it can negatively affect the relationship between local authorities and providers. Residential providers in particular had negative experiences of approaching local authorities about new innovations – they felt they were being treated with suspicion as authorities assumed any approach from a provider was a “pitch” for a contract or more money. The Foundation was told this meant there was little opportunity for providers to “bounce ideas” off of local authorities. Private (i.e. for profit) residential and domiciliary care providers seemed to be most affected by negative perceptions by some authorities – a factor which was even recognised by third sector providers in the Foundation’s Expert Group consultations.<sup>24</sup> However, CSCI has pointed out that the relationships between local authorities and all providers had suffered due to limited funding, and were often characterised by a mutual lack of trust and wrangling over costs.<sup>25</sup> This can make it very difficult for providers to subsequently have an open dialogue with local authorities about possible new services that might serve the local community’s needs more effectively.

A clearly related issue, which several providers raised during the Foundation’s consultation, is that some local authorities do not openly share their longer term investment and commissioning plans with providers. A lack of “market signalling” of purchasing intentions or need for new services means providers have little guidance as to what area they should innovate in, and may be actively discouraged from developing new schemes, as they have no guarantee from often their biggest client (the local authority) that new services will be subsequently purchased.<sup>26</sup> This situation is perhaps driven by the (often conflicting) and certainly numerous policy agendas and priorities emanating from national government, which undermines the ability of local authorities to “signal” their priorities with much certainty. The Kings Fund commented this was also likely to affect investors (see below) and providers themselves: “Different policy drives and uncertainties about their implementation make it difficult for providers to read the market, particularly in a way that encourages innovation.”<sup>27</sup>

### ***Investor behaviour***

Investment in the care sector from private equity firms and banks has grown considerably in the last few years, particularly in the residential sector. Care groups such as Barchester and Southern Cross have become some of the largest providers in the country, owning chains of care homes. In the domiciliary sector franchises have sprung up, so that a group such as Care UK may own several agencies operated by care managers.

CSCI’s study of inward investment in the sector found that private equity and venture capitalists tended to invest in larger care homes, perceiving greater opportunities for economies of scale, whilst smaller providers (which still make up the majority of the care homes and home care agencies in the market) relied more on banks for capital. Nevertheless, both types of investor reported to have a fairly short time frame – 3 to 7, or 7 to 10 years – within which they hoped to make a return on their investment. As such, longer

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<sup>24</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

<sup>25</sup> CSCI (2006) *Time to care?*

<sup>26</sup> CSCI (2007) *Safe as houses - what drives investment in social care?*

<sup>27</sup> King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

strategic planning, and investment in higher risk innovations that might take longer to come to fruition or make a financial return, are unlikely to be investor priorities.

CSCI also pointed out that private equity investment in care homes had a highly geared investment to debt ratio, meaning there was great pressure on investors (and therefore on care home managers) to make a profit in the operation of the home and clear the debt quickly. “there is pressure on profit margins to cover debt.. profit can only come from through a mixture of fees, operating efficiencies and reduced overheads.”<sup>28</sup> However, as mentioned above, the regulatory regime under which care homes operate means only limited efficiencies can be made: staffing is a care home’s largest single cost, whilst minimum wage legislation and CSCI’s minimum staffing level requirements leave little room to reduce this. This might result in care groups innovating “through necessity” to find new ways to make efficiency savings in their homes, but it is less likely to facilitate a wider range of innovations to improve the flexibility of the services offered.

Investors’ focus on shorter term returns also mitigates against truly “new” services: investors are more likely to take over existing (traditional) care homes which are already occupied and funded, than build new homes which take longer to generate a profit.<sup>29</sup> Laing and Buisson’s *Care of Elderly People Market Survey 2008* found that only 10 per cent of care home stock had been built since 2000.<sup>30</sup> The Kings Fund have also expressed concern that a difficult and drawn out planning process to build new homes can delay or prevent new capital investments, which again might undermine providers’ ability to respond quickly or dynamically to demands for new services by older people.<sup>31</sup>

In short, investment is currently a driver for consolidation in the residential care market, which could help encourage economies of scale and in turn give wider operating margins to invest in new innovative practices. On the other hand, lack of investment for newly built homes means it is unlikely new residential care models will be developed,<sup>32</sup> whilst the need for short term returns may limit care home managers’ opportunities to try “riskier” longer term schemes. The Kings Fund also points out that “there are dangers that consolidation in the market will result in less choice for older people and their carers. Having fewer small care homes to choose from may be particularly detrimental for older people from BME communities and those older people with specific cultural needs.”<sup>33</sup>

In addition, the current economic climate and subsequent changes in banks’ lending behaviour may also make this situation worse – potential investors in the market may be harder to come by, and those who are willing to invest may place ever tighter restrictions on their funding and seek to achieve even faster returns in order to pay off debts. They may also be drawn only to the very safest of investments (e.g. tried and tested services with long and stable operating histories).<sup>34</sup>

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<sup>28</sup> CSCI (2007) *Safe as houses - what drives investment in social care?*

<sup>29</sup> Ibid

<sup>30</sup> Laing and Buisson (2008), *Care of Elderly People Market Survey 2008*

<sup>31</sup> King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

<sup>32</sup> The government has recently announced new funding for local authorities to build new “extra care” homes, which combine private home ownership with flexible care services. However, private investment in this area, and independent extra care schemes, are less common.

<sup>33</sup> King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

<sup>34</sup> Although evidence suggests Extra Care facilities have remained somewhat sheltered from the downturn in the housing market and investment remains steady – see Community Care Market News, August 2008

Innovating to provide more dynamic and personalised services, and to become more efficient over the longer term through investment in new working practices (rather than making short-term cuts), requires a degree of risk taking and a longer-term view. Yet the existing market environment discourages providers from taking risks at every turn: the sector's regulator; their main customer (the local authority); and their investors all arguably discourage this. Furthermore, older people and their families themselves may contribute to this risk-averse environment. Older people who have received care in a certain way for a long period may be resistant to change, even if this means regaining some of their independence. Some may also find it difficult to express their preferences in order to receive more personalised care, if they have grown accustomed to others making decisions for them. Families and carers may also be reluctant for their older relatives to try new things if they perceive it to be too "dangerous" and may discourage participation in new schemes developed by providers. An older people's representative attending the Foundation's expert groups stated that traditional residential care homes were seen as "safe" and were therefore more popular with older people's families than more innovative schemes such as extra care housing, Telecare homes and supported living.<sup>35</sup>

### ***Internal constraints***

The obstacles to innovation outlined above are all factors external to care providers, which affect how they operate. However, there are a number of internal factors specific to residential and domiciliary care businesses which can also inhibit innovative practice.

#### *Recruitment and retention*

The care sector is known to suffer from considerable staff shortages, with heavy reliance on foreign workers to make up the shortfall. Retention is also very low, with the UKHCA recently reporting staff turnover in the home care sector at 25%.<sup>36</sup>

The All Party Parliamentary Social Care Group identified a number of reasons for this, stating that "low pay, lack of training and the low morale and status of the sector" were the main problems to be addressed.<sup>37</sup> Most providers consulted by the Foundation confirmed that low pay and job insecurity were the key reasons why recruitment of care staff is so difficult, with many carers on minimum wage contracts which provide no guaranteed hours of work. Poor perceptions of caring as a profession and few opportunities for career progression are also contributing factors. Providers reported to the Foundation that they were unable to pay much more than minimum wage for their staff, due to their tight margins and the fact that staff costs made up such a large percentage of total operating costs. This meant it was very hard to attract quality staff, as better wages could be earned in most other menial jobs.<sup>38</sup> To illustrate the tight margins within which some providers operate, one reported that they were unable to pay the workers for the time they spent undertaking mandatory training. Low retention rates meant paying for three or four days' training for staff who might often leave within a month was proving too much of a drain on scarce resources.<sup>39</sup> As the Kings Fund states: "The pressure on prices does not appear to drive providers out of the market but rather to affect employment conditions for care workers."<sup>40</sup>

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<sup>35</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

<sup>36</sup> [http://www.ukhca.co.uk/mediastatement\\_information.aspx?releaseID=44](http://www.ukhca.co.uk/mediastatement_information.aspx?releaseID=44)

<sup>37</sup> LGIU (2008) *Never Too Late for Living: final report of the APPG inquiry into services for older people*

<sup>38</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>39</sup> Ibid

<sup>40</sup> King's Fund (2007) *Steps to develop the care market*. London: King's Fund

As explained above, recruitment and retention problems do not necessarily prevent innovative practices, but it can make it much harder: discontinuity of staff due to high turnover can undermine the organisational change that may be required to implement innovations; staff shortages might leave little time for front line staff to engage with changes in working practices; and the need to regularly re-recruit and train staff might leave home and agency managers with little time and fewer resources to consider strategic organisational development. The Social Policy Research Unit (SPRU) at York University concluded that staff shortages were likely to affect the successful delivery of personalised care in the domiciliary sector, stating: “Without appropriate staffing levels, agencies could not offer flexible delivery of support... although privately paying clients could pay for additional hours, these could only be supplied if the care workers were available.”<sup>41</sup>

In addition, recruitment and retention problems are often symptomatic of low morale and job satisfaction amongst care workers, driven in part by low pay and job insecurity, but also by the constraints of the job and being over-worked. Home care agency managers reported to the SPRU that the way in which care was commissioned by local authorities (see above) was “limiting the ‘fun things’ that care workers could do with service users, restricting support to the ‘daily grind’ of personal care and reducing the time allowed for each visit.”<sup>42</sup> Whilst some providers reported to the Foundation that their care staff often did “too much” and took on a personal burden above and beyond what they were being paid for (according to their care plans) through a sense of professional conscience.<sup>43</sup> An overworked and demoralised staff are unlikely to engage enthusiastically in what they might see as “another new initiative” from care managers.

### *Organisational infrastructure*

The majority of care providers in both the residential and domiciliary sectors are very small, often family run organisations, sometimes described as “cottage industry” agencies or “mom and pop” homes. These organisations are also often established by former carers. As such, whilst their experience and expertise in caring is often excellent, operating a viable business can be a challenging new skill. This, in turn, may make it harder for some care operators to translate their ideas for innovations in care into new business practices – for example they may be unable to make a clear business case for a new scheme to a local authority or potential investor, or may find it hard to plan and cost organisational changes.

The Kings Fund highlighted this problem: “Some managers of small care services are inexperienced in running businesses and need support to develop their skills in the market place and business development. A recent survey by the United Kingdom Home Care Agency (UKHCA) of home care providers found 89 per cent of respondents would like to receive more business support than they are currently receiving.”<sup>44</sup> Several larger care providers consulted by the Foundation similarly expressed concern at the lack of business support and start-up help given to smaller operators. It was felt these providers ought to be supported in entering and operating sustainably in the market, with a “backbone” of standardisation in areas such as business support, operating models and IT packages.<sup>45</sup>

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<sup>41</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

<sup>42</sup> Ibid

<sup>43</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>44</sup> King’s Fund (2007) *Steps to develop the care market*. London: King’s Fund

<sup>45</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

Business skills *combined with* the ability to innovate is particularly important for smaller providers' survival in the care market. As explained above, they may already be less likely to win contracts in some local authorities seeking to streamline the numbers of providers they commission with. Smaller providers are also less likely to be able to make economies of scale and other operating efficiencies, therefore may not be able to offer as competitive rates as larger rivals and so win fewer contracts from cost-conscious authorities. As such, to survive in the care market, small providers must demonstrate their "added value" to local authorities, and increasingly to older people paying for their own care or using personal budgets. This added value might be their "personal touch", targeting of a particular community group with culturally sensitive care, or offering a wider range of services and flexibility which justifies their possibly higher fees. This requires a degree of innovation and lateral thinking and, importantly, *business acumen* to market their unique selling points and diversify and expand to meet new or unmet demand. The Kings Fund reported a "lack of skills to develop viable business models" as one obstacle to new businesses being set up to meet the needs of niche markets.<sup>46</sup>

However this is not just an issue of honing business skills at management level – care staff also need to be trained to be able to deliver new innovative ways of caring. For example, residential care providers reported to the Foundation that the current mandatory training for carers (i.e. the NVQ) is too narrow, and that "at least half" of the training provided for staff should focus on providing person-centred care and the social aspects of caring roles.<sup>47</sup> All carers – in large and small organisations and in the residential and domiciliary sectors – need to be able to deliver more flexible and personalised services, and a wider range of lower level services, in the light of the roll out of personal budgets to older people. Without this, providers' ability to respond to the opportunities to innovate that personal budgets bring with be severely undermined. As the PRSU points out, "the lack of availability of a suitably flexible, qualified and reliable workforce may limit the opportunities for domiciliary care agencies to respond to client's demands. If service users are to request alternative forms or quantities of care, agencies must have sufficient capacity to respond at relatively short notice if those requests are to be met."<sup>48</sup>

### *Organisational culture*

Clearly, the availability of staff, and the business skills and training to implement innovative ways of delivering personalised services, are crucial factors for successful care providers. However, a less concrete but nonetheless vital issue is that of organisational culture and "buy in" from care staff and managers. It may be difficult for some experienced carers who have become accustomed to working in particular ways to adapt to new schemes and innovations. These carers may well be "innovating by necessity" – using their ingenuity to deliver personalised and responsive care to older people in residential settings and their own homes, despite mounting pressures on time and resources. However large changes in working practices, particularly if this changes the continuity of some older peoples' care, may prove more difficult to adapt to.

As explained above, innovation involves some degree of risk taking. Local authorities, the care regulator, investors, older people and their families may all discourage care providers from taking risks for a variety of reasons. In addition, care home and agency managers may

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<sup>46</sup> King's Fund (2007) *Steps to develop the care market*. London: King's Fund

<sup>47</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>48</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

be faced with staff who also feel resistant to what they perceive as “risky” new schemes. For example, some innovations are likely to involve facilitating the independence of older people or encouraging “re-enablement” with a view to a gradual reduction in the amount of care older people need in their homes or, in the residential sector, the goal of getting people back into their own homes. Greater independence for older people and the prevention of intensive care needs are key government priorities. There is also a growing trend among local authorities to establish in-house re-enablement teams, so that older people discharged from hospital are given a period of intensive home care with the view to a reduction or removal of care needs. Finally, PCTs are increasingly commissioning beds from care homes for older people discharged from hospital, seeking a period of rehabilitative care before that older person returns home. Innovations which help older people do things for themselves may be a cultural shift for carers who find it hard to allow greater risks for the older people they have taken care of for a long period of time.

However, it may very well be the managers themselves who are resistant to innovation. The SPRU, consulting domiciliary care providers about the impact of personal budgets on their businesses, certainly found reluctance to grasp the opportunities to diversify that personal budgets might bring. “A common theme was that if an agency was providing a service already, they might consider expanding it, but where agencies have worked for years to gain a good reputation, why risk losing it by trying to expand into an area they’re not familiar with?.. although there was some willingness to offer new services, this was tempered by concerns about loss of reputation, conflicts of interest and a lack of time or expertise to commit to diversification.”<sup>49</sup>

In addition, the Social Care Institute for Excellence (SCIE) and the SPRU both found reluctance on the part of care managers to provide additional services to self-funders in case this “jeopardised” their main contracts (i.e. with local authorities) by disrupting delivery.<sup>50</sup> SCIE also noted reluctance to provide lower-level services, having invested in training and not wanting to be typecast as low skilled/low cost.<sup>51</sup>

These findings are certainly understandable – in a market constrained by limited resources, short term contracts and uncertain financial futures, care managers will be cautious to try new ways of working or invest in new schemes if they feel this may gamble with their livelihood and that of their staff. Nevertheless, a lack of willingness to grasp new opportunities as the care market diversifies (particularly with the advent of personal budgets and the growing numbers of self funders, potentially demanding a wider range of care services) means there may be an increase in unmet need which will undermine the health of the care market.

### *Sharing best practice*

A final obstacle to innovation in the care sector is the difficulty with which innovative practice is spread. Some providers reported to the Foundation that there was a lack of “hard-nosed” economic evaluation of different care models. Many pilots had been carried out, but with little evaluation of the costs of roll out and their sustainability and business cases. This made the post-code lottery of provision worse, and also led to no one really knowing “what worked”

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<sup>49</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

<sup>50</sup> Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York and Ibid

<sup>51</sup> Ibid

regarding new models of care and efficient working.<sup>52</sup> A lack of opportunities to share experiences and learn from other providers' schemes is certainly an obstacle to the spread of good ideas across the sector. Without this, many providers may be reluctant to try "untested" and "risky" new schemes. Conversely, they are likely to be encouraged by hearing how other providers have been successful in implementing new working methods. This may also affect local authorities, who, in the absence of evidence from other areas, may not want to invest in providers' new ideas. As CSCI reported, "all the councils are grappling with the issue of whether their innovations offer value for money. In doing so, they face the same problems experienced by the Wanless review team – of a lack of data and agreed methodology for making such judgements."<sup>53</sup>

#### **Section IV – the impact of these obstacles**

The previous section has identified a number of factors which can constrain innovative and efficient practices among care providers. As a result, the sector is better known for its improvised (and often ingenious) innovation and efficiency measures, carried out for the sake of survival. Strategic and planned development to systematically improve the services available to older people is much harder to achieve. What impact does this have on the care market and those use it?

The Kings Fund identified the following consequences of a poorly functioning care market resulting from a lack of innovation and flexibility in provision:

- people with their own buying power through individual budgets or direct payments will have access to only a limited and traditional range of services and may turn to family carers in the absence of other appropriate alternatives
- a market that discriminates against BME elders
- an increasing polarisation of services ranging from standard, relatively poor-quality services provided to those people unable to fund their own services to tailored, high-quality, flexible provision for the very few able to afford the top end of the market
- family carers continue to bear the brunt of market deficiencies.<sup>54</sup>

These are direct consequences of care providers not being able to meet demand for an acceptable cost. To meet demand, providers must be innovative and efficient. For lower earners the picture will therefore be very bleak – the majority will find themselves ineligible for state funded care, but their relatively low incomes means buying care privately is prohibitively expensive. This group, therefore, are likely to have the most limited and potentially the poorest quality choices, reflecting their limited budgets: those self-funders with higher incomes will be able to access an increasingly growing market of "top end" providers targeting wealthier older people with good quality, personalised care. At the other end of the spectrum, local authority-funded older people with personal budgets may still encounter a limited range of services if providers fail to respond to their more diverse needs, but it is quite possible they will have *more money with which to buy their care* compared to self-funding low earners.

For low earners who cannot access the type of care they want at a price they can afford, an alternative is to rely on their relatives to provide informal care. Yet cutting down on or giving up work altogether to care for an older relative will have a significant effect on a lower earning families' financial wellbeing, and stores up problems for the future. Today's low earners who care for their older relatives may be reducing their pensions contributions and

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<sup>52</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

<sup>53</sup> CSCI (2006) *Time to care?*

<sup>54</sup> King's Fund (2007) *Steps to develop the care market*. London: King's Fund



the level of savings they have available in later life – potentially undermining their ability to pay for their own care in the future, and creating a vicious circle for future generations.

## **Section V – What would a future care system which encouraged innovation and efficiency look like?**

Having identified the obstacles to innovation and efficiency in care provision, the following section outlines a number of options to both overcome these and to positively create a market environment which fosters innovative practice. Some of these suggestions will prove more effective in helping domiciliary providers (e.g. average time contracts), others may be more valuable for smaller or larger and for-profit providers, or residential providers (e.g. continuity of inspection). As such, a future care market ought to have several of these elements in place in order to create a healthy and responsive care sector where all types of provider are encouraged to innovate.

### ***Regulation and inspection***

In 2009, the current care inspection agency (CSCI) will form part of a larger health and social care inspectorate, the “Care Quality Commission” (CQC). This restructuring could represent a valuable opportunity to re-think how inspections, and the regulations on which they are based, respond to innovation (and the accompanying risk) in care provision.

In order for the inspection regime to stop acting as a barrier to innovation, inspection guidelines need to shift their focus from process and input-based measurements to the monitoring of improvements in outcomes. This would give providers greater freedom over the “how” they achieved outcomes and encourage them to think more laterally to achieve better outcomes more efficiently. Whilst outcomes may seem harder to measure than inputs and processes, several providers and local authorities have already established successful systems for this purpose. The key is to speak to care users themselves, establishing what their desired outcomes are, and then monitoring whether the care home or home care agency has managed to deliver these. The Social Care Institute for Excellence (SCIE) gives useful examples of this method, citing one local authority’s guide used to help its social workers review older people’s care packages based on “outcomes domains”, which the older person and their carer are asked about:

Outcome domains – review assessment	
• Increased physical abilities	• Quality of life maintained
• Higher morale	• Changes in behaviour
• Essential physical needs met	• Improved mental health
• Safer environment	• Have finances in order
• Increased confidence or skills	• Cleaner environment
• More social contact	• Risk(s) reduced/remove

And also suggests the following methods could be used to monitor outcomes care homes:<sup>55</sup>

<sup>55</sup> Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York

## Monitoring and evaluation in residential care settings

- Feedback from residents' monthly meetings
- Quality Circles of resident, relative and staff representatives that met monthly to discuss performance and areas for improvement
- Routine questionnaires, for example about meals, privacy
- Annual surveys of residents, relatives, staff and GPs
- Suggestion boxes
- Managers being easily accessible to residents
- Feedback from routine audits (for example, kitchens, accidents)
- Information from performance indicators

In addition to speaking to more care users during the inspection visit, care providers consulted by the Foundation also suggested that more continuity of inspectors would greatly improve the quality of inspection. Having the same inspector visit a care provider would enable the inspector to better identify and monitor changes in provision over time, getting to know the provider in question and recognising “softer” improvements to delivery rather than relying on a “tick box” system. Providers also suggested this would enable inspectors to monitor changes in care users’ attitudes and behaviour, which were important outcomes in themselves.<sup>56</sup>

In addition to not *discouraging* innovation, the care inspectorate should also have a role of actively encouraging it. Inspectors need to recognise more explicitly, and more importantly *reward* provider’s attempts to respond more flexibly to a broader range of users’ needs, or improve the quality of the care they were delivering, by thinking in new ways and implementing new practices. This should be a natural corollary of “outcomes based” inspection, as providers are likely to respond to greater freedom regarding “how” to achieve outcomes by thinking outside the box in order to improve their success rate. Nevertheless, many providers may still be held back by not wanting to engage in “risky” new schemes. Care regulation could ease this problem by adopting a more pragmatic approach to the concept of risk – perhaps by allowing inspectors to interpret regulations more flexibly to recognise where acceptable risks are being taken in order to achieve greater independence and better outcomes for older people.

This issue will need to be considered particularly carefully where a provider may have *failed* to improve outcomes through innovation. A provider ought not to be punished disproportionately at the point of inspection for attempting something which subsequently failed – provided that the new scheme had been well thought through and the provider had reasonably expected a success based on acceptable risk. Failure is often an opportunity to learn and improve, and a care inspector ought to be able to have the flexibility to recognise well intentioned attempts and subsequent “lessons learnt” by providers. If care regulation renders the consequences of failure too harsh, and leaves no margin for mitigating circumstances or the opportunity to put mistakes right, providers will always be deterred from trying new schemes and remain loyal to tried and tested processes, even though these may be inefficient or no longer meet the changing needs of today’s older people.

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<sup>56</sup> Provider workshops hosted by the Resolution Foundation, August 2008

### ***Local authority commissioning***

As with care inspection and the regulation on which it is based, *outcomes-based* commissioning can also do much to encourage innovation in care provision. In domiciliary care, where commissioning in particular proves to be a significant barrier to innovation and flexibility, outcomes-based care plans would represent an enormous shift in the way in which agencies operate day to day. Local authorities would essentially specify the outcomes to be achieved by the agency, rather than the time to be spent or tasks to be undertaken in a person's home.

This approach would have two benefits. It would give care providers (both agencies and care homes) much more discretion regarding how care outcomes were achieved and potentially the time taken to achieve them, encouraging new and more effective ways of working. Also, assuming the outcomes set out in a care plan were agreed with the older person themselves, it would lead to more personalised care by prioritising those outcomes most important to the older person themselves. Outcome based commissioning could, in fact, replicate the desired effect of personal budgets (i.e. more autonomy and choice for older people regarding the type of care they receive), even if personal budgets were not used – a point raised by Thurrock council – see below.

Some local authorities are already practicing outcomes-based commissioning of domiciliary care services and have increased the flexibility of services that agencies are able to deliver:

#### ***Oldham***

Oldham has shifted from purchasing 30 minute or 1 hour blocks of home care to more flexible contracts which define outcomes to be achieved, and a weekly average number of hours in which to achieve them. Domiciliary care providers can deliver care within a 10% margin above or below this weekly average, without needing to seek a change to their client's care plan. This gives carers greater discretion to decide how to meet the outcomes specified within the contract, and more flexibility regarding how to use the allotted time to achieve this. This approach also gives carers more flexibility to respond to an older person's changing needs, which may vary on a daily basis and require more or less time in a particular visit as a result.

Outcomes are monitored by a talking to older people themselves, as well as their carers, combined with an on-going "flagging" system: those in regular contact with the care users (including community matrons, Neighbourhood Access and Prevention Officers, and those delivering community services such as shopping and transport) are able to flag-up any changes in an older person's condition or behaviour to their social worker, who can then investigate further if it looks like care outcomes are not being met, or indeed, if an older person's care plan needs changing to take into account a change in that person's condition.

#### ***Thurrock***

Thurrock uses a 3-way dialogue between care user, provider and the local authority to create outcome based "commissioning plans":

- The care user decides the outcomes they value and how they want them achieved;
- The provider decides with the care user what tasks need to be carried out to achieve the outcomes;
- The local authority agrees resources to carry out these tasks.<sup>57</sup>

<sup>57</sup> Documentation kindly provided by Les Billingham, Contracting and Commissioning Services Manager, Thurrock Council. September 2008

The resulting plan identifies outcomes to be achieved by the provider, and an aggregated monthly budget to use as required to meet the outcomes. Although Thurrock has as yet no defined “margin of error”, like Oldham, on how much time providers should spend achieving outcomes, the council is pragmatic regarding the amount of time required, and will pay for the amount specified even if the agency’s electronic monitoring shows them spending less time with the client (as long as outcomes have been met).

This approach has resulted in far more personalised services being delivered, as care users have more say over “what” care they receive and “how” they receive it. Care providers also have greater discretion over how they order their time and resources to meet these needs, and can work with care users to think of new ways of working and innovative practice.

As such, this has created a “virtual” personal budget environment, of user-centred planning, flexibility and choice. Thurrock believes personal budgets may have limited take up amongst older people, and their approach certainly gives a positive alternative means of delivering personalisation and choice. In addition, it helps providers grow accustomed to a more flexible and dynamic way of working, in preparation for an increase in the numbers of personal budget-holding clients in the wake of their national roll out.

The care provided in residential homes are not bound by “time and task” like domiciliary agencies – as such, residential providers have reported that commissioned care packages are less of an obstacle to innovation than, say, regulation and inspection. Nevertheless, outcome related commissioning can give more freedom to innovate for residential care providers too: a local authority focussing on achieving a wider series of outcomes for older people might encourage a broader spectrum of residential care options than the traditional care home model, for example. This could include extra care housing, which the government has already provided dedicated funds for local authorities to build, but could also include “traditional” residential homes expanding and diversifying into other services. Cumbria has considered expanding six of its own homes to provide extra care units, GP practices and respite support as a way of making efficiency savings,<sup>58</sup> whilst a care home owner the Foundation consulted explained how he had converted some of the rooms in his home into self-contained flats for residents with less intensive needs, which could be bought on a long term lease. This gave a sense of independence, privacy and property ownership to residents, whilst also generating more income for the care home.<sup>59</sup> Birmingham council has also recently established three care centres, offering short and long term residential care, rehabilitation and day care services.<sup>60</sup> Unsurprisingly, more remote locations have also taken on-board a multi-service approach to residential care, with care centres in Shetland providing residential, respite, day and home care all from the same location.<sup>61</sup> One of the leading proponents of a more flexible approach to residential care services, facilitating the creation of innovative new care mixes by residential providers, is Hertfordshire.

#### *Hertfordshire*

Hertfordshire has mapped accommodation (including residential homes, sheltered and extra care housing) available for older people across the local authority to identify where supply was not meeting demand. This information is passed to providers who, through flexible

<sup>58</sup> Laing & Buisson, *Community Care Market News*, November 2007

<sup>59</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>60</sup> Laing & Buisson, *Community Care Market News*, August 2008

<sup>61</sup> Social Work Inspection Agency (2007) *Improving Care for Older People: good practice examples*, SWIA Scotland

contracts with the local authority, can change the type and volume of care services they are offering to meet shortages in particular areas within their existing contracts. Clear signalling from the local authority about its requirements and shortages means residential providers can adapt and expand to meet demand, in the knowledge their services will be taken up.

This has led to traditional care homes building extensions to their building to create re-enablement units, and converting some of their care places to nursing places. This allows the provider to adapt and diversify their services to offer a variety of care for people with both higher and lower needs, without having to renegotiate their contracts. The council is also looking into mixed tenure extra care and residential homes being built alongside extra care developments (potentially so that the staff of the former can provide the care services for the latter).

Giving providers discretion over the “how” of care delivery demonstrates clear potential for stimulating innovative new ways of working in the home care sector and new models of residential care to meet a wider set of needs and support independence. This approach can also help deliver more personalised and meaningful care packages for older people, in line with the government’s reform priorities. It is important to bear in mind, however, that outcome-based commissioning, whether in residential or domiciliary care contexts, must clearly be supported by a complimentary regulation and inspection regime – one which also monitors and evaluates outcomes (as explained above).

### *Trust*

Outcomes-based commissioning clearly requires significant cultural change on the part of local authorities and providers. Primarily, local authorities must be able to trust care providers to give them the degree of professional discretion required to deliver outcomes without proscribing how these are to be achieved. However, as the case of Oldham demonstrates, trusting care providers does not necessarily imply giving them carte blanche or a lack of oversight or accountability. Outcomes based commissioning can be, and indeed should be, combined with joint working between the local authority, provider and care user to create, monitor and evaluate outcomes enshrined in care plans.

SCIE recommends the regular review and re-evaluation of outcomes, so that these can be adjusted to the changing requirements of older people (potentially as outcomes are achieved and new, more ambitious ones are set). More than this, SCIE suggests evaluation of outcomes should be “a continuous process rather than a discrete event... ways of ensuring services remain compatible with desired outcomes include audits of service users; focus groups with purchasers and providers; quality assurance schemes informed by users; user-led interviews; and diaries kept by service users.”<sup>62</sup> This continual monitoring would not only enable local authorities to better identify the outcomes which were important to older people and commission care services appropriately, but would also ensure outcomes were being met, within average time parameters, without the need to prescribe inputs and processes.

There seems to have been mixed progress in building such cultural change thus far. CSCI, SCIE, the UKHCA and several providers consulted by the Foundation report relations remain poor between providers and many local authorities, driven by a resource constrained environment and pressure on local authorities to make efficiency savings at all levels. Providers report that years of difficult fee negotiations have undermined communications channels and levels of trust on both sides. This perception is demonstrated by SCIE’s findings, which show that outcomes-based services were progressing much faster in in-house re-enablement services than in long term home care delivered by the independent

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<sup>62</sup> Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York

sector. SCIE found that better funded in-house services attracted staff more easily due to better pay and more rewarding work, and clear “change” outcomes were set and monitored. Conversely, “maintenance” outcomes – to be delivered once older people had moved from intensive re-enablement services to lower level home care services – were not set or monitored, and a lack of resources meant many independent providers were unable to deliver these outcomes in any case: “The most striking disjunction, acknowledged by many managers and practitioners, was between short-term reablement services and longer-term home care services. Here resource constraints and poor relationships with independent providers meant that home care services were often inflexible, of poor quality and insufficiently responsive to the outcomes desired by older users.”<sup>63</sup> As a result, the gains made by in-house teams were often lost once older people were moved to the independent sector. Given that an increasing number of local authorities are out-sourcing the majority of their home care services, but may be keeping in-house re-enablement teams to deliver higher cost, short term intensive interventions, the issue of professional trust and sufficient funding to maintain outcomes needs to be addressed.

### *Sharing information*

The previous section describes how poor “market signalling” by local authorities undermines providers’ ability to plan ahead and think strategically about innovation, or to identify opportunities to expand and diversify. Firstly, local authorities are often the single largest customer of many care providers. If the authority does not share its future purchasing intentions or highlight its longer term commissioning priorities, providers are unlikely to try and offer something new, but rather stick to tried and tested services which have won previous contracts. Second, if local authorities provide no information about the needs and preferences of the local population, or demographic information, providers will not be able to spot unmet need or opportunities to diversify or expand into niche markets. It could be argued that good providers would carry out such market research as good business practice anyway – but as mentioned above, many providers are very small and may not have the resources or capability to carry out this type of analysis. Local authorities already have to carry out local population analysis for a variety of reasons – joint needs assessments, population mapping for economic development plans, monitoring of the use of personal budgets and how they are being spent, and so on. These and other data could all be passed to care providers to help them spot new opportunities to innovate to meet emerging or unmet demand. CSCI also points out that providers who are armed with solid business cases based on market analysis and future demand are more likely to attract investment from banks or private equity companies.<sup>64</sup> Examples of effective information sharing include:

#### *Oldham*

Oldham uses data from a variety of sources, including its Strategic Needs Assessments, and feedback from its “Forum for Age” 50+ consultations, to establish the council’s “commissioning intent”. This is shared with providers to give them certainty regarding what the council needs and will want to purchase in the future. The 50+ forums act as sounding boards for new ideas and can challenge the set up or quality of existing services, giving providers a direct source of market information from its potential clients.

#### *Hertfordshire*

Hertfordshire uses provider forums, bringing together care providers from across the area, to discuss the council’s purchasing intentions based on local needs and the shortages in

<sup>63</sup> Ibid

<sup>64</sup> CSCI (2007) *Safe as houses - what drives investment in social care?*

current supply identified by their mapping of the market (see above.) The local authority gives clear requests for the volume and type of services needed in different locations. Flexible contracts allow providers to then respond to this information and expand, adapt or diversify their existing services to better meet needs.

### *Warrington*

Warrington council also has a provider forum, which meets regularly (at least quarterly) to discuss and monitor the council's contracting and commissioning strategy. Social workers visiting care users' homes also feed back information to the forum so that providers and the council can work out how to better meet users' needs. This gives providers "buy in" to the council's commissioning strategy, with an opportunity to suggest how better to meet the council's objectives. It also allows for greater certainty of what is needed and will be purchased, which can encourage providers to diversify and move away from "tried and tested" methods and services.<sup>65</sup>

### *Contracting and funding*

As explained above, an environment where resources are limited can lead to financial instability for local authorities, who, in an attempt to make efficiency savings, may place downward pressure on fees, and contract only "tried and tested" services with a small number of large providers. Outcomes-based commissioning can help overcome the tendency to contract "tried and tested" services by giving providers more discretion regarding how outcomes are met. Some local authorities consulted by the Foundation also explained how they had given providers greater financial security by setting up longer term contracts (up to 25 years in some cases) which had flexibility (i.e. an annual review with the option to change the services specified in the contract, or a condition which allowed providers to develop unspecified new services at a later date) written in.<sup>66</sup> This gave stability of income to providers, whilst allowing for renegotiation of services to respond flexibly to changes in need.

Nevertheless, there still remains the issue of limited resources and pressure on local authorities to make efficiency savings where possible, which can both indirectly and directly undermine providers' ability to consider strategic innovation. This is not something that can be easily resolved without a change in how care for older people is funded in the future. However, it would certainly help if there was clearer and more coordinated direction from central government on how local authorities should balance competing priorities of the choice and prevention care agendas on one hand, with efficiency savings on the other.

### ***Internal constraints***

It is clear that the care market suffers in a number of ways due to recruitment and retention difficulties in the care workforce. A lack of continuity in care provision, low staff morale and shortages across the board make care home and agency managers' lives very difficult – including limiting the resources and internal capacity they have to implement new working practices and bring about innovation through organisational and cultural change.

Improving the pay and conditions of care staff is the most obvious, and perhaps the hardest, measure that could be taken to improve recruitment and retention, as many providers feel low pay is the single largest obstacle they have to finding and keeping staff. Without a significant increase in the level of funding available to care providers (through both local

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<sup>65</sup> Community Care Magazine, 10/07/08

<sup>66</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008



authority and privately paid fees), it is unlikely wages in the care sector will improve, and those staff who gain their NVQs are unlikely to enjoy much career progression or increased pay to reflect their newly qualified status. Some providers raised concerns with the Foundation that much of the non-ring fenced funding passed to local authorities from central government to provide training for carers was being diverted to plug other funding shortages.<sup>67</sup>

Nevertheless, many providers reported to the Foundation that job satisfaction was also very important to carers, whose principle motivation to take up a caring profession was rarely financial. Several providers and local authorities have already come up with innovative ways of improving the morale and job satisfaction of staff in the independent sector:

- The PRSU spoke to care providers who variously offered work-related mobile phones, bus passes, subsidised driving lessons and dental care schemes, as well as “introduce a friend” bonuses to attract and keep care staff.<sup>68</sup>
- Another home care provider offered opportunities to socialise and network for its otherwise quite isolated staff by synchronising rotas to allow for staff to meet each other and managers between care visits.<sup>69</sup>
- Southampton and Oldham increasingly use home care contracts which provide guaranteed hours of employment and continuity of pay if a carer’s client goes into hospital for a short time.<sup>70</sup>
- Sunderland Home Care Associates operates as a social enterprise, so its employees own shares in the company and have a say in general meetings to make decisions on issues such as budgets, pay and conditions, and training. Profits are passed to staff or go back into the running of the business. As a result, the agency pays a very competitive wage compared to local competitors and retention is high.<sup>71</sup> This approach could also encourage innovation, by making use of the experience of front line staff to come up with new ideas and consider the strategic direction of the organisation in general meetings, whilst the sense of “buy in” likely to come from the staff “owning” their company will improve the chances of successful implementation of any new scheme or working practices. Such schemes might also benefit from the £100 million Social Enterprise Investment Fund announced by the government in 2007, to encourage the creation of new social enterprises to deliver health and social care.

Other providers have adjusted the way they deploy their staff to deliver more flexible and personalised services:

- Some providers reported to CSCI that they used staff “down time” (i.e. the off-peak periods during the day when fewer hours were contracted by local authorities for home care services) to offer lower level services (such as social opportunities and trips out) to older people.
- Sunderland Home Care Associates assign small rotating teams of three staff to each client, to ensure continuity of care if one carer is off sick, for example.<sup>72</sup>

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<sup>67</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>68</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

<sup>69</sup> Ibid

<sup>70</sup> CSCI (2006) *Time to care?* and Information from Tom Wolstencroft, Adult & Community Services, Oldham Council

<sup>71</sup> CSCI (2006) *Time to care?*

<sup>72</sup> Ibid

- Dundee’s home care service uses small self-managing care teams who provide services for a cluster of other people, again ensuring continuity of care, greater autonomy for staff to organise their own schedules, and reducing the number of carers each client might deal with.<sup>73</sup>
- Care UK in Fleetwood has piloted a similar approach, with a staff team of eight caring for 15 older people and organising rotas between them. They have found carer attendance has improved from 73 to 94% as a result.<sup>74</sup>
- Home care providers consulted by the PRSU were considering sub-dividing their agencies into two staffing teams, with one providing more expensive and one less expensive care services, delivered by less experienced carers, to capture the growing market of personal budget holders who may have different purchasing preferences. Another was considering having a tier of less skilled care workers, or “companions”, to deliver lower level services and social trips alongside its traditional care services. However, providers noted that these innovations might be prevented by the regulation and training requirements of CSCI.<sup>75</sup> Similarly, when the Foundation asked residential care providers about using “two tier” staffing to carry out more and less skilled care tasks, many reported regulation would prevent this, as both types of carers would be side by side on site and risked carrying out the “wrong type of task” if an older person they were with needed more than one “type” of help simultaneously.<sup>76</sup>
- An alternative to using two tiers of care staff is to use volunteers, with the latter carrying out lower level and social aspects of care. This enables agencies to offer a wider and more flexible range of services to their clients than may be specified in their care plans, but without using the scarce resource of qualified carers. This is the approach taken by the Mushkil Aasaan agency in Wandsworth, who offers a very wide range of additional “back up” services, alongside domiciliary care. CSCI commented that the additional staff “enable the agency to meet people’s needs in a holistic way that might not be possible if it only followed the council’s care plan. So, if a person needs help with shopping and cooking, but this is not covered in the care plan, this can be provided using the back-up volunteer support.”<sup>77</sup>
- There are also several existing voluntary organisations offering “sitting” services and companionship for older people in their homes.<sup>78</sup> An alternative to integrating a volunteer workforce within an agency, is for an agency to partner with such organisations and refer clients with needs falling outside the agency’s remit, (or more likely, outside the person’s care plan) to them. These are likely to be lower level services which older people are not often eligible for from the local authority. Again, this allows home care agencies to respond flexibly to older people’s needs, even if they do not have internal capacity to do so.

Of course, the responsibility to improve recruitment and retention in the care sector also falls to local and national government. Care providers themselves can only do so much to attract new staff and keep them in the face of competition from better paid industries. Providers expressed to the Foundation the need for a concerted effort from national government to improve the training available, career prospects and public perceptions of the caring profession. The LGIU recommended the same: “...the government needs to communicate a

<sup>73</sup> Social Work Inspection Agency (2007) *Improving Care for Older People: good practice examples*, SWIA Scotland

<sup>74</sup> Information kindly provided by Les Billingham, Contracting and Commissioning Services Manager, Thurrock Council. September 2008

<sup>75</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

<sup>76</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>77</sup> CSCI (2006) *Time to care?*

<sup>78</sup> Such as WRVS and Age concern Thurrock

better vision of the careers that are available in the sector”.<sup>79</sup> Another issue raised, particularly by residential providers, was that if the government’s proposals for a points based immigration system were to go ahead, employing non-EU carers would be almost impossible. The introduction of a point-based system could mean that workers from non-EU countries, where many skilled carers come from, would be unable to enter the country as they were not a designated “shortage” occupation.<sup>80</sup> The care sector relies heavily on migrant workers to fill shortages in the domestic labour market, and providers felt the government would cut off one of their key sources of employment (particularly as many reported a trend in eastern European staff, who had hitherto been numerous in the care sector, returning to their home countries in the light of improving economies).<sup>81</sup>

When it came to local government, providers also felt the non-ring fenced funding passed to local authorities by central government for carer training ought to be more effectively monitored, and some suggested this be ring fenced, to ensure the funds were not diverted for other purposes.<sup>82</sup> CSCI commended Southampton for using all of the funding it received from central government for training, as well as adding additional funds to boost the amount available. As a result, CSCI noted the authority’s recruitment and retention rates were good, and staff morale was high among the care workers it spoke to.<sup>83</sup>

Local authorities could also help providers with their recruitment by carrying out local campaigns to promote caring as a profession, and linking carer training to their related adult basic skills and local employment and economic development targets – for example Mushkil Aasaan in Wandsworth offers English literacy training as a means of attracting local Asian women to become carers.<sup>84</sup> Local authority funding used to improve basic skills and local employment could certainly be applied to such cases and promote the caring profession.

### ***Personal budgets and innovation***

The increased use of personal budgets by older people could be hugely important in encouraging new innovative practices and efficiencies in the care sector. This is because personal budgets have the potential to overcome one of the key obstacles to provider innovation – i.e., the way in which some local authorities commission care services, use prescriptive care plans and purchase a narrow range of “tried and tested” services.

If personal budgets become the mainstream, providers will need to be more responsive and flexible, as older people using personal budgets are likely to ask for a wider, more diverse range of services than had previously been prescribed to them by their local authority care plan. This represents both a challenge and an opportunity for providers, some of whom may find it hard to expand and diversify in response to this shifting market. There are several ways to maximise the potential of personal budgets to encourage innovation:

- There needs to be adequate support in place for care users to make informed choices and ensure their purchasing decisions actually reflect their needs. This support needs to range from information and advice regarding the services on offer, through to more active advocacy and brokerage services which would “hold” a

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<sup>79</sup> LGIU (2008) *Never Too Late for Living: final report of the APPG inquiry into services for older people*

<sup>80</sup> <http://www.ukba.homeoffice.gov.uk/managingborders/managingmigration/apointsbasedsystem/howitworks>

<sup>81</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

<sup>82</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>83</sup> CSCI (2006) *Time to care?*

<sup>84</sup> *Ibid*

person's personal budget for them and help purchase the care they need. The Foundation's research has found such support can be patchy and inconsistent.<sup>85</sup>

- Conversely, providers need to market their services to personal budget holders. Several stakeholders reported to the Foundation that care homes and agencies currently targeted local authorities and GPs for their marketing activity, rather than consumers (except for those who were focussing on the private care market).<sup>86</sup> The SPRU also found home care agencies were not advertising their non personal care services (such as shopping) in case "LA-funded service users began to ask why they couldn't get their shopping done."<sup>87</sup> In this instance, private-paying clients may be missing out on services they do not know are on offer to buy, and the same might be true for personal budget-holders if they remain a minority group of customers for care providers.
- Local authorities also have a role to play to ensure providers can seize the opportunity to innovate and diversify in response to personal budgets. There is a risk that smaller providers in particular may not have the capacity to adapt their business model to a more diverse client base, multiple contracting and the risk of bad debt that personal budgets can bring. Transitional business support from local authorities could help providers adapt to this new system.
- Local authorities should also consider information sharing to a) help providers identify and locate personal budget holders in the community and b) have access to some "market signalling" regarding the types of services being bought with personal budgets. Sharing this information would allow providers to innovate in the knowledge that they were in line with consumer trends, as well as identify niche markets and unmet needs. In addition, local authorities could use these data themselves to find out what services and outcomes people value if given more control. This valuable source of guidance could be used to help commission more appropriate services for those older people who may not use personal budgets.

There is, of course, a real and significant downside to the wider use of personal budgets, which could exacerbate some of the obstacles to innovation outlined above which providers already face. For example, many providers (in both sectors, though mainly in domiciliary care) are concerned that the direct employment of personal assistants by personal budget holders will worsen staff shortages. As care homes and agencies have larger overheads than a single older person with a personal budget, the former may not be able to pay as high a rate of pay as the latter – meaning some staff may leave their employers to become better paid personal assistants. Fewer available staff means fewer resources and willingness on the part of care providers to try new working practices or make strategic innovative change. In addition, personal budgets may be paid at a lower rate than the actual cost of care<sup>88</sup> – meaning even greater cost pressure on providers and a potential loss of business as older people find they cannot afford agency care and employ personal assistants instead.<sup>89</sup>

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<sup>85</sup> See Resolution Foundation (2008) *Navigation Care Service*

<sup>86</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

<sup>87</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

<sup>88</sup> A national survey on Direct Payments in 2004-05 showed most local authorities allocate users less money to buy their services than would have been allocated if the council had arranged the care themselves. [www.pssru.ac.uk/pdf/dprla.pdf](http://www.pssru.ac.uk/pdf/dprla.pdf)

<sup>89</sup> Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

Unfortunately, personal budgets are still in the early stages of roll out amongst older people, and so their impact on the care workforce remains unknown. Nevertheless government, local authorities and providers have to start preparing for the potential destabilising effects personal budgets may have on the care market, at least in the short term, in order to ensure the care market can grasp the opportunity to provide new and more personalised services that personal budgets will bring.

#### **IV – Concluding thoughts**

The care market is currently operating in a challenging environment – with very limited resources combined with growing and more complex needs, and a more ambitious government reform agenda. This means both local authorities and providers often have to juggle competing pressures, and it is within this environment that care providers are struggling to respond flexibly to older people’s needs and meet new challenges with broader and more diverse services.

At the same time, the need to remain economically viable and deliver good quality care in the face of these challenges has stimulated considerable ingenuity and improvisation among care providers. However, this is a far cry from what we might call “strategic innovation” – planned ways of investing in and developing new working methods and services to improve the quality of the care being provided.

The inevitable impact of this is that there are significant pockets of unmet need in the current care market – among those currently using services who find they do not meet their needs or respond to their demands, as well as the large numbers of older people who cannot access the care they want at a price they can afford – or indeed, at any price – due to gaps in supply.

This situation may potentially become worse due to a range of factors:

- The numbers of older people with care needs will rise considerably, suggesting the traditional and narrow range of service options on offer will suit a smaller proportion of those having to use them.
- The range of care needs is set to become more complex, and the next generation of older people are likely to have higher expectations and demand more choice and flexibility from the services they receive than those currently using care services.
- The roll out of personal budgets means a growing proportion of older people will be demanding a wider and more diverse range of services than providers who have otherwise delivered according to local authority-set care plans.
- If eligibility for care continues to tighten due to a lack of public funding, the numbers of self-funding older people will increase, who again will demand a more varied range of services, delivered more flexibly, from providers.

Care providers constrained by the internal and external factors described above are unlikely to be able to respond to the challenges and opportunities these future trends present. As such, the suggestions presented here are critical to improving the overall health of the care market, by helping care supply to more effectively meet demand.