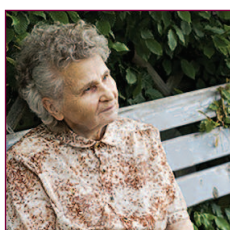
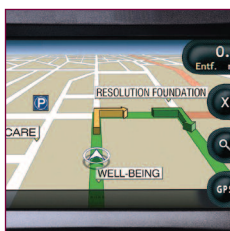


# Navigating the way:

the future care and well-being of older people



## Acknowledgments

The evidence on which this report is based was generated by a substantial programme of research carried out by the Resolution Foundation, which included the use of questionnaires, focus groups, workshops and interviews. We would like to thank the large number of care providers, local authorities, advice organisations, financial experts and low earners who have contributed to this process and provided us with invaluable insight into how the care system currently functions and how it could be improved. The Foundation would also like to thank the experts drawn from a variety of fields who participated in our consultation exercises in July and October 2008 to create a new “care architecture” and provide vital feedback on our four research projects.

Particular thanks go to: Brian Fisher, AXA Lifetime Care; Philip Brown, Partnership; Ged Hosty, In Retirement Services; Andrea Rozario, SHIP; Karen Evans, ABI; James Lloyd, ILC; Chris Curry, PPI; Julien Forder, LSE; Nick Barr, LSE; Mark Joannes, SHIP; Les Billingham, Thurrock Council; Sarah Pickup, Hertfordshire County Council; Tom Wolstencroft, Metropolitan Borough Council; Christine Beyga, Liverpool City Council; Lynn Bassett, Coventry City Council; Lesley Rimmer, UKHCA; John Edwards, ACE; John Trigg, A4E; Julie Jones, SCIE, Ruth Hancock, UEA; members of our Steering Group – in particular Nick Hurman, Stephen Burke, Counsel and Care and Patrick South, Age Concern; and Opinion Leader for carrying out focus groups with 40 low earners on our behalf.

## Executive summary

### The Resolution Foundation and care for older people

The Resolution Foundation is an independent research and policy organisation. Our goal is to improve the well-being of low earners in today's mixed economy. We aim to deliver change in areas where this income group is currently disadvantaged by producing new research and engaging actively in the policy-making process.

Since the beginning of 2008, we have focused our efforts on the issue of long-term care for older people. This report is based on a programme of research and consultation with experts in the field, and workshops with groups of low earners. From our research we have drawn the following important conclusions:

**a. The market for social care needs reform before levels of state funding can be determined.**

Whilst much of the debate on social care is about funding, our research clearly demonstrates that there is much scope to improve how social care is delivered. Enabling the market for social care to work effectively is vital to improving outcomes for older people, and for delivering a vision of greater choice and personalisation. A new funding settlement remains critical in light of demographic change, but this must relate to a reformed delivery model.

**b. The key reforms needed are:**

1. **A clear national framework:** this would enshrine a national minimum entitlement and bring clarity to the entire system by defining roles and responsibilities.
2. **A new strategic role for local authorities to shape supply:** local authorities are best placed to provide strategic oversight of local markets, but this also requires joint working with neighbouring authorities and co-ordination at a regional and national level.
3. **A care navigation service available to everyone:** a first stop shop at a national level, linked to local networks, would provide universal and integrated support.

**c. These measures would improve outcomes for everyone, but particularly low earners.**

Low earners are on the cliff-edge of means-tested eligibility – the majority are not eligible for free or subsidised care, and yet their relatively low incomes make care costs a significant financial burden. A national minimum entitlement, which includes access to advice and a care and well-being assessment, will go a long way to addressing the confusion and unfairness currently experienced by low earners.

### The route to reform

This report describes seven elements of a new care architecture which would create a fairer and more efficient market.

A key consideration in developing our reform proposals has been that care is a “social good”. As such, the state has a responsibility to provide care (either directly or increasingly via financial contributions) to the most vulnerable in society, and those who cannot afford to buy it themselves. This has led us to conclude that in the future, care should be provided by a mixed “social market”. This can neither be managed like a public service, nor given the freedom to function as a purely private market (i.e. with levels of regulation and consumer protection afforded to other markets, but more or less free to develop according to market forces). We suggest that the route to reform is to develop the role of local authorities as primary ‘market shapers’ with strategic oversight of local care markets. Combined with a clear national framework which enshrines a new minimum care entitlement, and an infrastructure which facilitates better access to information, advice and advocacy, the market for care and support should then develop in a way that more effectively meets the needs of all older people and allows suppliers to predict and invest.

Our work has explored, but not in all cases resolved, which agents should be responsible for each element of the new architecture. For example, our model suggests a revised role for local authorities in providing effective strategic oversight of local care markets. However, what does this mean for other responsibilities of local authorities – should they still be gatekeepers to state funds and should they provide information and advice if they are also providers of care?

Resolution of many of these decisions hinges on whether, as a society, we prioritise local control and flexibility over national consistency, and we present in this report some of the principal trade-offs that must be considered when making such decisions.

### Our previous work

In February 2008, the Foundation published *Lost: low earners and the elderly care market*. This report sought to explore low earners' perceptions and experiences of long-term care. From this, we discovered that:

- Low earners experience the long-term care system as unfair and confusing.
- Nearly three quarters of low earners are unlikely to be eligible for state funding to pay for care, yet their low incomes will make the costs of care a significant financial burden.
- Low earners are often asset rich and income poor – but their assets are usually tied up in their home, so the resources they might use to pay for care are difficult to access in a flexible way.
- Low earners are more likely to be informal carers and to be part of the care workforce.

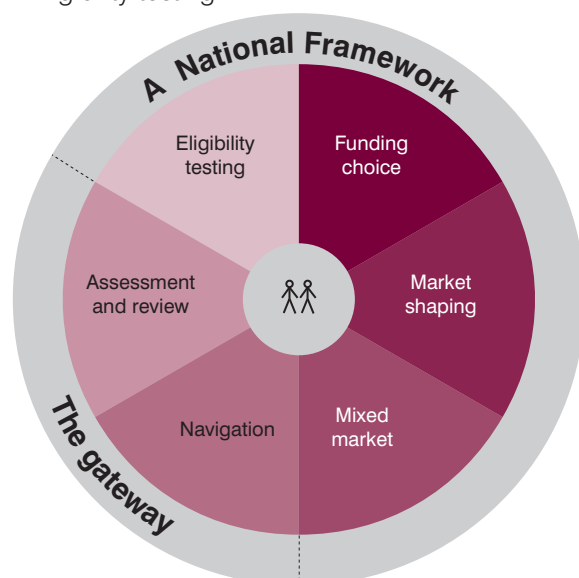
In April, we published A to Z: mapping long-term care markets. This report mapped the current care market and assessed how well it functioned. It concluded that the care market was actually a collection of local mixed markets, operating as a collection of parts rather than a unified whole. This report also uncovered a number of weaknesses:

- The system is very complex and serious information asymmetries occur – meaning the consumer of care is in a very weak position.
- There is poor communication between supply and demand. Consumers find it difficult to express their needs to providers and intermediary processes (such as local authority purchasing decisions) can obscure the “market signals” for providers to respond to.
- Even if providers did have clear market signals, they have limited ability to respond to demands due to factors such as cost, regulatory and contractual constraints.
- There are a number of market distortions in local care markets, often created by the dominant purchasing position of local authorities.

## Findings from our latest research

Since then, the Foundation has undertaken a programme of research to develop an architecture for a fairer and more efficient care market, capable of delivering better outcomes for older people, their carers and families. Key elements are:

- A national framework
- Funding choices
- A navigation service
- A mixed market
- Market ‘shapers’
- Assessment and review
- Eligibility testing



## i. A National Framework

A National Framework, to provide clarity for the entire system, is vital. The framework would include:

- A new universal minimum entitlement for older people and their carers;
- A national regulatory framework;
- Clear delegation of the key functions of the care system to appropriate agents;
- Clarity over the roles and responsibilities of the state, the individual and their family; and
- A national set of eligibility criteria for state contributions to an older person's care costs.

A national minimum entitlement for all those over 65 and their carers will include: regular care and wellbeing assessments; access to a navigation service; and a minimum package of ‘care and support’ for those who need it.

## ii. Funding Choices

A long-term funding settlement is needed to define what will be funded collectively and what should be paid directly by individuals themselves:

- Growing demand requires increases in funding from both collective and individual sources.
- A mixed market of state-sponsored and private funding mechanisms that co-exist and complement each other could best meet individuals' needs, resources and attitudes.

It is also clear that different vehicles will be needed for different generations – a mix of products for the current, largely asset-rich, older population and products for younger cohorts, who have more time to plan but may not have the housing wealth of previous generations.

A number of immediate reforms could be taken forward which help people access sources of private finance, in particular helping the current older population access housing wealth.

## iii. Assessment and review

A care and well-being assessment will be part of a national minimum entitlement for everyone over 65 and their carers. Divorced from questions of eligibility to state funding, it will be a comprehensive assessment of a person's health, care, social, learning and other needs related to their wellbeing:

- People will be approached at key life-stages and encouraged to have regular assessments.
- They will emphasise prevention but also be used at the point of needing care.

#### iv. A navigation service

Central to meeting people's needs is a service which integrates a range of support (information, advice and advocacy) on a range of issues (care, health, housing, finance and entitlements) to help people navigate the care system:

- This will take the form of a "first stop shop" at local and national level.
- It will build upon existing capacity.
- Support will be provided via the internet, telephone, face to face and home visits and outreach.

Combined with the care and wellbeing assessment, this will form the gateway to the care market.

#### v. A mixed market of care and support services

The diverse needs and preferences of older people, their carers and families can most effectively be met through a mixed market of care:

- A range of large and small, private, third sector and public providers offering a broad range of services.

A well functioning care market will deliver choice and personalisation, key drivers of the Government's current reform programme and of a future vision.

#### vi. Market 'shapers'

As care is a "social good", there is a vital role for market "shapers" – agents who can ensure the mixed market delivers a choice of good quality and affordable care to all who need it.

- Local authorities should have a very different role in the future, acting as market shapers and providing strategic oversight of their local care markets.
- This will also require joint working with other local authorities and other market shapers will also have an important role to play – key among these are the care regulator, regional and sub-regional bodies.
- To fulfil this role, local authorities will also provide a strategic oversight of the interaction between care services and other related markets and services (such as housing and health, etc.) at local level.

#### vii. Eligibility testing

In a separate process to the "care and wellbeing assessment", older people will have their needs and means tested for eligibility to state funding. The care and wellbeing assessment will form the basis of the needs test in this process. Local variation of entitlement based on need ought to be replaced by a national benchmark to complement the national means testing benchmarks, so that older people with similar needs will have them met, regardless of where they live:

- An entitlement based on national needs and means eligibility criteria, set out in the National Framework.
- This can be compatible with maintaining local budgets if councils set their own monetary values for different levels of eligibility (increasingly in a transparent way in the form of personal budgets).

#### How will these reforms create a fairer and more efficient care market?

There will be clear demand signals as people have more resources to spend, and better information and advice to become confident "care consumers":

- The range of individual funding products available will ensure people can access adequate resources to buy the services they want.
- The care and wellbeing assessment and navigation service will give people a better understanding of their needs, as well as information and advice on the services available to meet those needs and how to access them.
- The National Framework will raise awareness of the need to prepare for care costs, and provide greater clarity regarding what they are entitled to from the state.

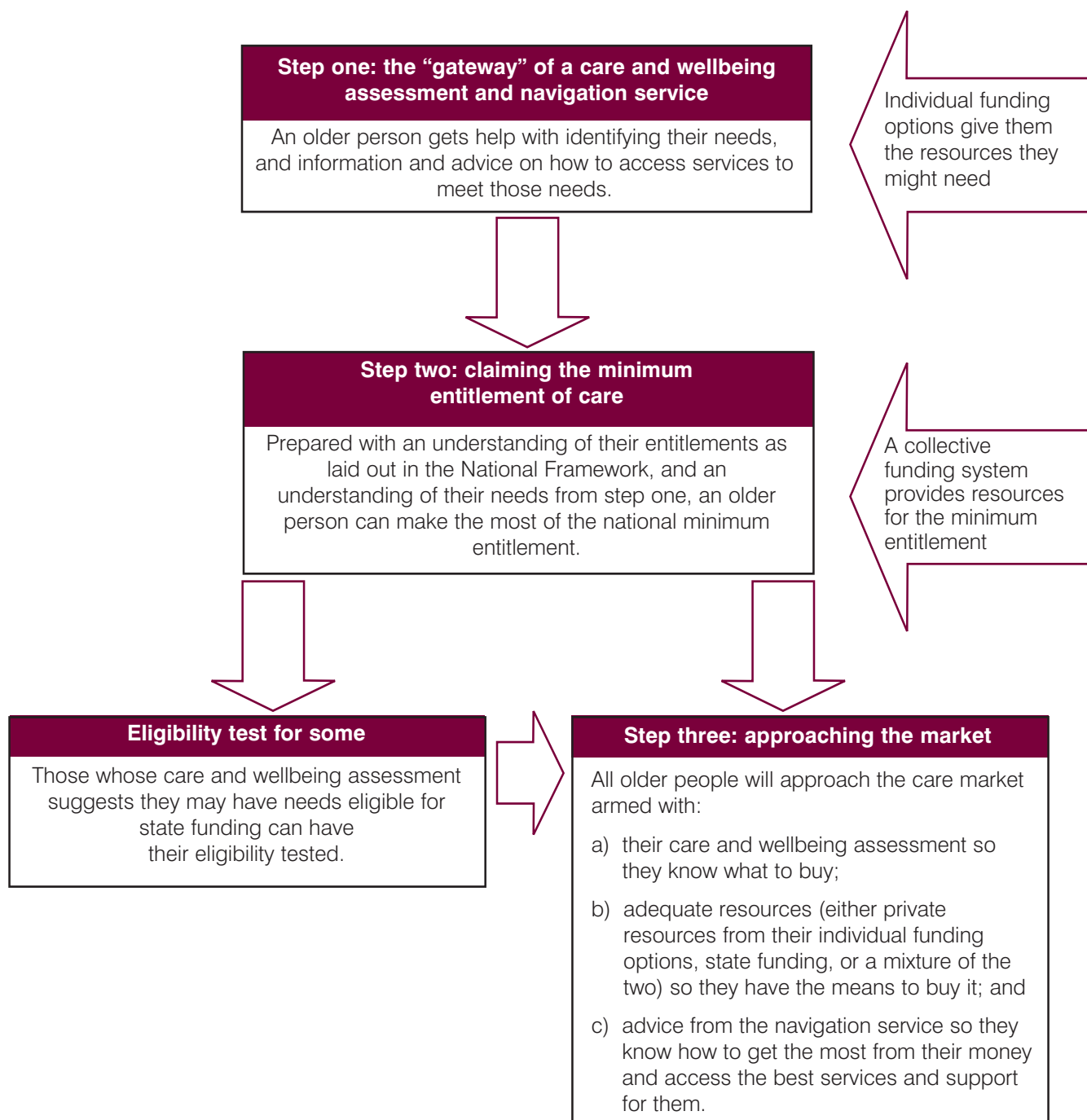
There will be healthy supply, able to plan and invest in response to more predictable demand:

- "Care consumers" are better able to express their needs and preferences, and give better quality feedback to care providers.
- A mixed market of care and support services will be best able to respond to this feedback, and ensure a diverse range of needs and preferences can be met.
- Market shapers will work behind the scenes to facilitate and encourage this market, help providers to respond to consumer feedback, and to offer flexible, affordable and good quality services.

#### How will this help low earners?

- The central importance of a **navigation service** addresses low earners' strong concerns about the complexity of the system, and their low awareness of where to go for help and advice.
- The range of private and state sponsored **individual funding options** can help low earners access their housing wealth – as many are asset rich and income poor.
- A **mixed market for care services** (supported by **market shaping**) if the most effective way of delivering choice and good quality at affordable prices, vital for low earners as their purchasing power is likely to be low.
- A **National Framework**, including a minimum entitlement, can address low earners' specific concerns regarding the "unfairness" of the system with its lack of clarity regarding entitlements and responsibilities of the individual and the family.
- A **minimum entitlement and national eligibility criteria** will help low earners predict whether they will have to contribute to their care costs and prepare accordingly.

## How will an individual experience this new market?



## Four elements of the architecture in more depth

The Resolution Foundation chose to explore four elements of a new care system in more depth. We selected those areas where we felt an issue had been under-explored or could benefit from greater coordination of existing research.

### *Project one – navigating the care system*

Older people, their families and carers find navigating the care system very difficult. Many do not know where to turn for help, and risk making poor care choices. The aim of this

project was to consider how people need help navigating the care system now and in the future, whether the existing support available is sufficient to meet these needs, and consider the options for developing a more integrated navigation framework.

We found many people’s navigation needs were not being met, but that there are a variety of forms a more effective “navigation system” could take to address this:



1. A new independent information, advice and advocacy service, which could variously take the form of:
  - a) a national “first stop shop”
  - b) a local “first stop shop”
  - c) some combination of the two
2. A service managed by local authorities:
  - a) taking the role of a local “first stop shop”
  - b) commissioning a “first stop shop” from local providers
  - c) providing brokerage in-house
3. A specialist brokerage market to develop alongside either option

Our research illustrates how the most effective approach would be a national first stop shop combined with a network of local first stop shops commissioned by the local authority.

#### ***Project two – innovation and efficiency in care***

One of the weaknesses in the care market is that care providers are unable to be sufficiently flexible and innovative to respond to people’s needs, meet future challenges, and deliver efficiency gains.

This project sought to identify the obstacles to strategic innovation and efficiency in the sector, and suggest how they might be overcome. A number of factors were identified, falling into four broad categories:

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

Solutions to overcome these obstacles included:

- Outcomes based and average time purchasing of care
- Outcome based and quality of life regulation
- Sharing market intelligence with providers
- Joint working with voluntary organisations to provide wrap-around support

#### ***Project three – local market shaping***

This project explored the concept of “market shaping” within the context of care for older people. Care is a social good, and therefore the mixed market of care has to be treated as a “social market”. Within this context, the Foundation has identified an important role for a market “shaper” – an agent or agents who can ensure the care market delivers a choice of good quality and affordable care to all who need it.

This project identified the tools available for a “market shaper” to ensure sufficient volume, diversity, quality and affordability of supply. These include:

1. Comprehensive market analysis
2. Commissioning
3. Purchasing
4. Sharing information with providers
5. Providing services in-house
6. Shaping on a larger scale
7. Overcoming barriers to market entry and growth
8. Improving the health of demand

The local authority seems well-placed to be the primary market ‘shaper’, in providing strategic oversight of local care markets. However, national government sets the regulatory framework, national policy direction and funds specific priorities, all of which strongly influence the shape of care markets. Regional or sub-regional strategies will also play an important role in shaping a more effective “scale” of care market.

#### ***Project four – funding care for older people***

A future funding settlement for care will require increased contributions from both the government and the individual. Yet the current funding system is both unfair and inefficient: it incentivises more costly remedial care; leads to premature use of residential care as people are unable to access their assets; implies older people bear the entire risk of needing care; and creates a two-tier pricing system which penalises self funders.

The aim of this project was to identify and assess a range of individual and collective funding options that can enable people to meet potential long-term care costs and the government to raise resources to invest into the system.

Key conclusions include:

- There is no one size fits all funding vehicle: there needs to be a range of private and state funding mechanisms that co-exist and complement each other to enable individuals with different care needs, resources, attitudes to risk and inclinations to plan for long-term care in a way that suits them.
- There need to be a range of state-sponsored “decumulation” products to help people access their housing assets in later life, complementing the range of schemes currently available to help people accumulate assets in their working lives (e.g. shared ownership).
- It is also clear that different vehicles will be needed for different generations – a mix of products for the current, largely asset-rich, older population and products for younger cohorts, who have more time to plan but may not have the housing wealth of previous generations.
- Overall, a central problem in take-up of products is a lack of awareness of the need to plan or even pay for care. Demand needs to be stimulated through awareness-raising and availability of guidance and advice.

## Conclusions and next steps

The Foundation's research has shown that the only care architecture that will deliver over time is market based. This is the most effective way of addressing the particular concerns of low earners, brought about due to their vulnerable position in the market. It is also the best way to deliver the government's vision for a care and support system which improves the outcomes for everyone, whilst remaining financially sustainable.

The Foundation's research demonstrates that much can be done to improve how the current system works and achieve better outcomes for older people within existing resource constraints, and steps can be taken immediately:

- 1) Local authorities can grasp the challenge of market shaping, utilising the range of tools identified by the Foundation to improve volume, diversity, quality and affordability in local markets, without the need for significant investment.
- 2) A number of steps can be taken by local authorities, national government and the new regulator (CQC) to help support the care sector to be more innovative and provide more flexible services, ahead of any allocation of additional resources.
- 3) A new, consistent model for a "first stop shop" navigation service at local level can be developed, given that resources from the £520 million Transformation Fund have already been passed to local authorities for, among other things, improving their advice and information delivery.
- 4) Individual funding options can be discussed between the government and the financial services industry, developing new private and state sponsored products in advance of a new funding settlement.

However, a long-term and sustainable vision for social care will only be achieved if some key challenges are addressed:

- 1) **Agree a funding settlement:** define what will be publicly funded or subsidised, and what remains the responsibility of the individual.
- 2) **Clarify what will be included in the national minimum entitlement:** progress towards universal care and wellbeing assessments and access to a navigation service can be made in the shorter term, but the package of care and support within this entitlement can only be determined in the light of the resources available (depending on a new funding settlement, above).
- 3) **Delegate roles and responsibilities:** of all strategic and delivery agents. This will require decisions to be made regarding the balance of responsibility between national and local government.

The creation of a fairer and more efficient care market can help ensure that the system as a whole is "investment ready" – i.e., capable of using any increase in (government and private) investment to maximum effect. It is vital, therefore, that immediate steps are taken to improve the operation of the care market within existing resource constraints, to pave the way for a future funding settlement which can achieve the longer term transformation of the care and support system.

During the course of 2009, the Foundation will consider these challenging issues and shape our thinking regarding the development of a new care market.



## I – Introduction

### The Resolution Foundation

The Resolution Foundation, established as an independent research and policy organisation in 2005, seeks reform of the mixed economy to achieve better outcomes for low earners – people independent of state support but on below average incomes.<sup>1</sup> The Foundation works on a project basis, focusing our resources on one issue at a time in order to bring about real policy change. We achieve this by producing research and economic analysis to generate evidence-based policy suggestions and by engaging actively in the policy-making process.

In 2008 we began a programme of work looking at long-term care for older people. We chose this area for a number of reasons. First, the long-term care system functions as a mixed market of both funding and supply, and the Foundation is particularly interested in how low earners fare in such circumstances. Second, our research confirmed that this area is of significant concern to low earners, as they face particular challenges in the system as it is currently configured (see our research findings below). Finally, the care reform agenda is growing in political significance, and 2009 is likely to be a critical period in the development of a new care system which is fit to meet the demands of an ageing society. The Foundation's approach to questions of policy reform has the potential to add value and bring about real change at such a time.

This report presents new research which the Foundation has carried out since our analysis of the care market in April 2008. The research has sought to create a new “architecture” for a care system capable of creating a fairer and more efficient care market. The first part of the report describes this architecture and explains each of its seven elements in detail. In particular it explains how it can improve the care market, address the particular problems faced by low earners, and deliver the Government's vision for a future care and support system. We also present some of the options regarding which agents might carry out the key functions of the architecture and identify the potential trade offs that need to be made. The second part of this report summarises research projects carried out by the Foundation over the summer, in which we examined in greater depth four of the elements of our care architecture: navigating the care system; innovation and efficiency in care; local market shaping; and care funding options. We conclude by presenting a number of steps that can be taken immediately to improve the functioning of the care market, and identify the outstanding longer term decisions that must be made in order to create a new architecture for care and support.

### What have we done so far?

The first stage of our work was to examine the problems related to the current care system for older people. We achieved this with two pieces of research. The first, entitled *Lost: low earners and the elderly care market*, looked at the care system from a low earner's perspective – exploring how this group perceived and experienced care for older people. The Foundation built on these findings in a second piece of work, entitled *A to Z: mapping long-term care markets*. This report, based on analysis by Deloitte, mapped the existing market of care and assessed how well it was functioning.

### Low earners and care for older people

The Foundation has undertaken a range of research, (including literature and statistical reviews of existing qualitative and quantitative data, polling, focus groups and interviews with low earners) to understand better how this group fare in the current care system – as care users and carers, but also as those navigating the system on behalf of an older relative and those planning their own care. Our findings can be summarised thus:

- Low earners are more likely to be over 55. This is both the peak age for becoming a carer of an older relative, as well as a time when individuals may be considering their own care needs.
- Low earners are on the “cliff edge” of eligibility for state funding: nearly three quarters of low earners are likely to have too much capital to be eligible for state funded care, but their relatively low incomes mean they are likely to have little money available to spend on care as self-funders.
- The principle source of wealth is their home – low earners have homes worth three times their liquid assets (this is only double for higher earners) – so their capital is hard to access.
- Informal carers and members of the care workforce are over-represented in the low earning group – low earners are 25 percent more likely to be informal carers, for example.
- Overall, the main concern low earners have is that the system is unfair – in the geographical variability of entitlements, in the way people are penalised for saving and having their own homes, and because there is a sense of having to “fight” for information and entitlements.
- Low earners believe the system to be highly complex, and most have had negative experiences of trying to navigate the system for themselves, relatives or friends.

<sup>1</sup> We define this group as those individuals who earn less than median incomes but who are receive less than 20 per cent of their incomes from state benefits. Households earning between around £11,180k and £25,790k are likely to be in this group

## The mixed market of care for older people

The Foundation asked Deloitte to carry out a comprehensive analysis of the current care market, in order to gain a clear picture of its features (e.g. how many people use the system, how many providers are in the market and of what type, etc.), and more importantly, to assess how well it functioned as a market. Deloitte assessed the care market according to key criteria of fairness and efficiency, and found:

- The care market operates as a mixed market of supply and funding, with private and state resources being used to purchase services from statutory, private and third sector providers. State funding and provision is part of this market because care is a market for a social good – it provides a service which the state has a duty to provide to those in need and who cannot afford it themselves.
- There is a complex interface between supply and demand: eligibility and assessment processes and state purchasing of care on behalf of consumers can prove obstructive to clear communications between supply and demand, meaning the former cannot easily respond to the latter. This is exacerbated by the fact that older people and their families have little awareness of how the system works, and do not know where to go for help. This means there are very few informed “care consumers” to whom providers can cater their services. Furthermore, the financial services market is under-developed in this field, meaning there are few viable choices for older people to have prepared financially for care or decumulate their assets at the point of need. This also serves to dampen demand for care services.
- Insufficient resources in the market can generate inefficiency (as there are few incentives to provide preventative services which reduce cost in the longer term) and unfairness (as self-funders often cross subsidise state-funded care users).
- The care market operates in fact as a collection of local markets, each with their own supply and demand characteristics. Each local care market also interconnects with other markets and public services that contribute to an older person’s well-being, such as housing, and functions as a series of interdependent parts.
- Care markets are fragile in the face of demographic change and can be destabilised by piecemeal reform. The care system must, therefore, be considered in the round, with system-wide reform rather than isolated “tweaking” at the edges.

## The policy context

One of the reasons we chose to look further at social care for older people at the beginning of 2008 was that the issue seemed to be gaining greater political significance and there were signs that there was a growing appetite for reform among all political parties after a long period of relative inactivity. In the light of clear demographic data illustrating how the ageing population would require a significant increase in funding for care, the Government gave a clear signal that it planned to tackle the problem in the 2007 Pre-Budget Report and Spending Review, which announced a forthcoming Green Paper on Adult Social Care. Outlines for a broad reform programme for 2008-09 have developed since this announcement: In December 2007, the ministerial concordat *Putting People First* stated that “*there is now an urgent need to begin the development of a new adult care system.*” It went on to outline a multi-departmental commitment to a raft of ambitious reforms, many of which are expected to be developed in the Green Paper.

Ideas for reform and policy development have subsequently grown apace: In January 2008, the Government responded to the Commission for Social Care Inspection (CSCI)’s *State of Social Care* annual report by announcing an investigation into the way in which eligibility criteria for subsidised care was operating at a local level and the unintended consequences this might be having. At the same time, the Liberal Democrats proposed a new “Care Guarantee”, entitling older people to a personal care payment based on need rather than the ability to pay, and using Wanless’ partnership model to fund it. To indicate the cross-party importance of the care issue, the Shadow Minister for Pensions also signalled the Conservative’s support for care costs to be shared between the state and the individual in August 2008, and the party held a high profile debate, *Caring for an Elderly Population* in the main conference hall at their Party Conference in September.

On 1st April 2008, a three year Transformation Programme began, using £520 million of ring fenced funding to roll out a number of reforms, including facilitating the use of personal budgets by the majority of older people using care services. In May 2008, the Government launched *A Case For Change – why England needs a new care and support system*, which presented the difficult choices that had to be made to reform of the care system, and launched a country-wide public consultation and engagement process which would feed into the Green Paper.

At the same time, important developments in related areas have taken place: in February 2008, *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society* was published, which outlined the Government's commitment to "age-proofing" new housing and public spaces, as well as investment in housing advice services for older people, and joined up provision and commissioning of housing, health and care services. The Darzi Review of the future of the NHS in June also emphasised the need for better integration between care and health. It stated that PCTs will carry out comprehensive wellbeing assessments, people with long term conditions will have personal care plans, and announced a pilot of "personal health budgets" – possibly paving the way for joint personal health and care budgets in the future.

Now, at the end of 2008, the Government's ambitious programme is bearing fruit. CSCI's investigation into eligibility criteria has produced a series of recommendations for a new needs eligibility test and national allocation system in *Cutting the Cake Fairly*, the deadline for submissions to the Green Paper consultation was on the 28th November, and a cross-government ageing strategy and dementia strategy are due in the next few months. To demonstrate the growing importance of the issue, the Prime Minister raised the status of adult social care by appointing the first Minister of State for the sector when Phil Hope replaced Ivan Lewis, who had been a parliamentary under-secretary of state with responsibility for care.

Furthermore, 2009 looks set to be an even more critical period for care reform. The Green Paper will be launched early in the year, the first National Skills Academy for Social Care will be established in March 2009 and the care regulator and inspectorate, CSCI, will merge with the Healthcare Commission and Mental Health Act Commission to create the Care Quality Commission (CQC) in April 2009. However, in a time of growing economic instability, there is a risk that the momentum of reform may be lost: long-term care may lose its political profile as other more pressing financial reforms come to the fore; and the public spending possibilities for care reform may be constrained amongst other budgetary priorities.

In the light of these latest developments, it is all the more vital to scrutinise how the care system currently functions and ensure it is both "investment ready" and financially sustainable in the longer term. The Foundation hopes the research and conclusions presented in the following sections, which include a range of short term steps that can improve the fairness and efficiency of the care system without significant investment, will prove a valuable contribution to the debate at this critical time. We hope also to inform the important and difficult decisions that must now be made to create an effective and sustainable care and support system for the future.

## II – Our new research

This report summarises a programme of research undertaken by the Foundation, the aim of which was to develop a *vision and architecture of a future care system* capable of delivering better outcomes for older people, their carers and families, through a *fairer and more efficient market for care*.

### Why do we focus on the market?

As we explain above, care is a mixed market of funding and supply: provided by statutory, third and private sector organisations, and purchased by state and private resources.

#### A mixed market of supply:

This type of market is effective in ensuring a good range of high quality and affordable services are on offer:

- A range of different types of provider increases the diversity of services on offer at different prices, to cater to all older people.
- Independent providers tend to be more cost effective than statutory services, so the market is more efficient.
- "Care and support" is actually a catch-all term to describe a diverse range of products, entitlements and services, encompassing state provision and many different private markets. As such, it does not lend itself well to either state or private provision – an older person's needs could simply not be met by just one or the other.

Using a mixed market to deliver care and support is also very much in line with Government thinking, which, since 1997, has been driven by a focus on personalisation and choice as the central pillar of most public service reform. Steps to introduce elements of a market, such as contestability, to more traditional public services which are free at the point of use clearly demonstrates the Government's faith that this is the most cost effective way of improving choice and driving up quality. The Darzi review of the future of NHS reform illustrates how these market functions will be embedded in health. For example the review's final report, *High Quality Care For All*, recommends:<sup>3</sup>

***Introduce a new right to choice in the first NHS Constitution.*** *The draft NHS Constitution includes rights to choose both treatment and providers and to information on quality, so that, wherever it is relevant to them, patients are able to make informed choices.*

***Pilot personal health budgets.*** *Learning from experience in social care and other health systems, personal health budgets will be piloted, giving individuals and families greater control over their own care, with clear safeguards.*

<sup>2</sup> DH (2008) *The NHS Next Stage Review final report, High Quality Care For All*

<sup>3</sup> Ibid

One could argue, in fact, that social care was “ahead of the curve” in many ways, taking on aspects of a mixed market by the early 1990s, whilst reforms to introduce these aspects to other areas, such as childcare, social housing and health, came about five to ten years later. This is due to the fact that:

1. Social care is a means tested service – a proportion of care users receive no financial support from the state and so purchase the care services they need privately. Rather than buying from the state, these self funders need and want private markets to secure the services they need; and
2. As explained above, the “care” which has been traditionally funded by the state is a narrow set of services, and so many older people (including those with state funding for “care”) find themselves purchasing goods and services from wholly private markets to meet their wider support needs.

### A mixed market of funding

In the light of these points, it is clear that social care could not be wholly paid for or provided by the state, without a significant increase in funding to a) extend care to all those who needed it (but could also afford to buy it themselves) and b) to extend what the state paid for or provided to encompass a vast array of support services. Using a mixture of private and state funding means those who can afford their own care can pay for it, reducing the cost pressure on the state, which in turn ensures those who cannot afford to pay for care get it for free or at a subsidy.

### A social market

A mixed market of funding and supply is clearly the most effective way of delivering such a diverse range of services to those using state and private resources to purchase them. However, the Foundation also believes that the mixed market for care must also operate as a social market:

- Care is a “social good”, which the state has a responsibility to provide (either directly or increasingly via financial contributions) to the most vulnerable in society, and those who cannot afford to buy it themselves. The care market, therefore, cannot be given the freedom to function as a private market (i.e. with levels of regulation and consumer protection afforded to other markets, but more or less free to develop according to market forces), as this may risk the government failing in its duty to ensure everyone who needs care can access it. For example, a private market for care might not cater to the poorest older people in the system, if the returns are not large enough and better profit margins can be made elsewhere (i.e. by targeting wealthier older people).

- More broadly, a significant proportion of potential consumers of care – state funded and privately funded alike – may be vulnerable: in poor mental or physical health, socially isolated, and lacking confidence to express their needs. The care market must, therefore, offer greater levels of support and protection than a typical private market.

The key is to ensure the care market is operating as effectively as possible as a ***mixed social market***. This can provide the best of both worlds – efficiency and personalisation as well as a safety net of affordability and support to access services. This is also what consumers of care today (and perhaps even more so in the future) prefer: they want some of the benefits that markets bring (such as choice, flexibility and value for money), but expect the state to maintain care as a “social good”: i.e. ensuring it is universally accessible and of reasonable quality and price.

### Creating a fairer and more efficient care market

The Foundation's objective, then, was to develop an architecture which created a fairer and more efficient care market, i.e. one which would still operate as a mixed market for a social good, only more effectively. To achieve this, we drew on our previous work, in particular the findings of *A to Z: mapping long-term care markets*. This report, based on analysis by Deloitte, mapped the existing market of care and identified a number of key weaknesses. We have since looked at these weaknesses in depth, and developed an architecture for a future care system with a number of elements designed to resolve them.

This is a potentially valuable contribution to the Government's reform programme: whilst the principles for its reform have been well articulated in the past year, what a care system capable of delivering such a vision looks like has yet to be determined. This report presents just such a system, and also discusses possible options regarding who might be responsible for its key functions.

The Foundation's approach, (i.e. to consider the system as a whole rather than focus on a specific area for reform), is based on the conclusions of Deloitte's analysis of the care system, explained above, which suggests that reform has to be undertaken on a system-wide rather than piecemeal basis.



Nevertheless, we also wanted to explore in more depth some of the key elements of the architecture we created, and selected those where we could add most value with new analysis and the drawing together of existing strands of research. The second section of this report, therefore, summarises the findings of four research projects which looked in depth at:

- Navigating the care system
- Innovation and efficiency in care
- Local market shaping
- Care funding options

We chose to look at the options for funding a future care system because whilst research suggests there is considerable scope for improvement within existing resource constraints, the reality of demographic trends means further resources from the government and the individual will undoubtedly be required. The inevitability of the need for increased funding for care must, therefore, be considered alongside the reform programme – the new system can be reformed and helped to be made “investment ready” for additional resources in the short term, but longer term and sustainable change will require a new funding settlement.

### **Our findings**

The findings from our previous work has informed our approach to this new research. As a result, we have considered a series of reforms for the whole care system, but with:

- A focus on low earners, within a framework that can work for everyone;
- A focus on care and support of older people, though many of our conclusions can be applied to all adult social care; and
- An investigation of reform alongside questions of funding, but particularly regarding how the care market can be improved.

In defining a new architecture for care, we have also prioritised a practical yet visionary interpretation of care reform, which we hope will bring greater clarity to the potential way forward in implementing change, and highlighting the key questions that still remain to be addressed.

### **Methodology**

The Foundation carried out a wide and varied programme of research to develop the conclusions in this report. In addition to extensive reviews of existing research, a range of primary studies were carried out, including interviews, questionnaires and workshops with care providers, local authorities and third sector organisations. We also carried out a series of focus groups with low earners to ensure our recommendations addressed their particular concerns and the difficulties they face in the care system. This has given us a valuable insight into how the care market functions now, and a rich source of ideas as to how it could be made to function more effectively in the future.

The Foundation also undertook an extensive consultation exercise with groups of experts from local government, the care sector, central government, policy and research organisations, and representative groups of older people and carers. These groups were brought together in a series of workshops and tasked with envisioning a new architecture for care. We took this evidence-based, consultative and iterative approach so that our conclusions (and the suggestions we make based on them now and through the course of 2009), resonate with both policy makers and those on the front line of the care system – care workers, users, and their families.

### III – An architecture creating a fairer and more efficient care market

In *A to Z: mapping long-term care markets*, the Foundation concluded (based on analysis by Deloitte) that the care market was suffering from a number of significant weaknesses which undermined both its fairness and efficiency. Key among these were:

1. **System complexity and information asymmetry:** the care system, and the interface between older people and care services and funding, is highly complex and geographically variable. This makes the system very difficult to navigate, but in addition consumers are also poorly informed regarding what they are entitled to, what services are available, and how to access them. This lack of general public awareness also means few people prepare financially for their care costs.
2. **Poor communication between supply and demand:** partly due to point (1) above, consumers find it difficult to express their needs to providers. Intermediary processes (such as the local authority deciding eligibility and purchasing care on behalf of some older people) exacerbate the problem as suppliers do not have clear “market signals” from consumer to respond to.
3. **Lack of flexibility of supply:** even if providers did have clear market signals, they have limited ability to respond to demands due to factors such as cost, regulatory and contractual constraints.

These factors combined result in:

- Weak demand – consumers with neither the ability nor means to purchase care effectively
- Weak supply – suppliers unable to identify or respond to demands

Overall this creates an unhealthy market, characterised by unmet and/or unexpressed need; an over-reliance on informal care; and care providers artificially limited and unable to fulfil their potential for growth.

The aim of this work is to address these problems – identifying which factors need to be in place to strengthen supply and demand in the care market to deliver both fairer and more efficient outcomes.

#### What does a healthy care market look like?

A healthy care market is characterised by:

##### 1) Healthy demand:

- There is clarity regarding what people are entitled to from the state in old age, what they will be expected to pay for themselves, and how this is decided – e.g. according to their level of need and means.

- Care users, their carers and families are helped to identify their care needs and are supported by a well developed system of information, advice, advocacy and brokerage to make choices which meet their needs, or have their care planned and purchased for them.
- Local infrastructure which facilitates people's access to care services (such as transport and housing).
- Care users, their carers and families are encouraged to plan ahead and consider the costs of care in advance so they have sufficient resources to access the care they want when they need it (complemented by a clear entitlement framework, above).
- There are a range of products available, suited to different levels of income and assets, to help people pay for their care.

##### 2) Healthy supply:

- There are effective mechanisms in place to enable providers to identify unmet and emerging demand, so that they know the volume and type of services required, in which locations, and at what price.
- There are clear communication channels between consumers and providers to allow providers to monitor changes in demand and attain feedback from consumers about quality and price.
- Providers are not prevented from responding to new or changing demand by growing and diversifying, and barriers to entry are minimised for new providers wishing to enter the market.
- A wide range of different providers (large, small, voluntary and for profit, specialist and mainstream etc.) are encouraged to enter and supported to remain sustainable within the market to ensure there is a diverse range of services available for consumers to choose from.
- Care providers are encouraged and rewarded (with more business) for being flexible and responsive to older people's needs, rewarded for improvements in quality, and helped to provide value for money services whilst remaining financially viable.



To achieve these outcomes, elements which support consumers to make better care choices, and which support providers to respond to these choices, need to be in place. A healthier care market is key to delivering the Government's vision of a future care system, which simultaneously seeks to achieve personalisation, choice, quality and affordability:

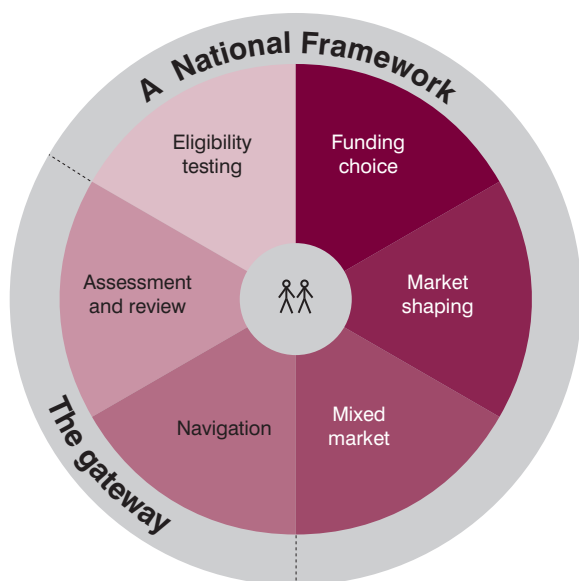
- Promoting independence, choice and control for everyone who uses care and support services.
- Ensure that everyone can receive the high-quality care and support they need, and that everyone gets some support from the Government, but that funding is targeted at those most in need.
- The system must be affordable for the Government, individuals and families in the long term.<sup>4</sup>

This vision also implies important changes to the roles and responsibilities of the individual and the family, as well as key agents like the local authority, national government and care providers. Therefore, our work has also explored, but not in all cases resolved, which agents should be responsible for each element of the new architecture.

### A new architecture for a care and support system

The diagram below helps to illustrate the nature of the architecture the Foundation has created:

- It has the individual care user, carer and family at its heart, who actively engage with and are supported by the elements surrounding them;
- Each element is interdependent, working in tandem to create a fairer and more efficient system; and
- The National Framework encompasses the entire system to provide clarity to the structure.



### Elements of the architecture:

1. **National Framework:** the foundation stone of the new architecture, enshrining a new national minimum entitlement and clarifying roles and responsibilities of all agents within the system
2. **Funding choices:** a range of individual and collective funding options, including private and state sponsored products
3. **Mixed market:** care and support services provided by statutory, private and third sector organisations can offer the widest range of choice for consumers
4. **Market shaping:** to ensure volume, diversity, quality and affordability of care in a mixed market
5. **Navigation:** a navigation service, taking the form of local and national first stop shops, can provide integrated forms of support on care and a number of related issues
6. **Assessment and review:** a comprehensive assessment of wellbeing, divorced from questions of eligibility, for all older people and their carers. Combined with free use of a navigation service, this acts as a gateway to the care system
7. **Eligibility testing:** national needs and means test to determine eligibility for state funding, with the needs test based on the care and wellbeing assessment

### Elements of the architecture:

- i) The national framework

- Enshrines a national minimum entitlement for older people and their carers
- Encompassing the entire architecture and setting out the roles and responsibilities of all agents

<sup>4</sup> HMG (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care*

Based on our research, it is apparent that many of the care market's weaknesses stem from a lack of clarity (for the public, care providers and local authorities). A new national framework, setting out the roles and responsibilities of everyone in the system, is therefore vital for a well functioning market.

The National Framework provides clarity and certainty for all:

- It presents a national minimum entitlement for all older people and their carers. This consists of regular "care and wellbeing assessments", free use of a new navigation service and a minimum package of care and support for those who need it.
- It sets out the responsibilities of each agent in the care system, clarifying their roles and their relationships with other agents within the context of a set of clear outcomes for older people and their families.
- It provides "vertical integration": setting out the roles and responsibilities of the state, the individual and their family, so that people know a) what to expect from the state, enshrined in a new universal minimum entitlement, and b) what they are expected to contribute (financially and otherwise).
- It provides "horizontal integration": clarifying how the care market interacts with other related markets and public services, such as health and housing, by presenting a set of joint cross-departmental outcomes and objectives for older people.
- It also includes a national regulatory framework for care services, and a national set of eligibility criteria for state contributions to an older person's care costs (see below for further discussion of this issue).
- It creates the basis of a national communications strategy, which provides clarity and raises awareness of the need to prepare for care costs in later life.

#### ii) Individual and collective funding options

- Growing demand requires increases in funding from both collective and individual sources
- A range of financing products will allow individuals to access those which best suit their differing needs, resources and attitudes

To better meet society's long-term care needs, particularly against a backdrop of demography-driven growth in demand, a future funding settlement will require increases in both collective and individual sources of financing.

### Collective contributions

The introduction of a national minimum entitlement and the provision of further support for the most vulnerable members of society will require an increase in collective state-administered funding. This increase could be secured by redirecting funds from other public services, increasing taxes, or a hypothecated fund such as an income or wealth tax, or an age-specific care contribution.

### Individual contributions

While collective funding sources will provide a national minimum entitlement, it is important that a range of different products are available to enable individuals to top-up their care. Three broad markets would provide a comprehensive range of options allowing individuals to select the mechanisms which best suit their needs, resources and preferences: equity release, long-term care insurance and long-term savings. Existing financial products can be built upon and the state can also provide or sponsor new products.

#### iii) A mixed market of care and support services of care.

- A range of large and small, private, third sector and public providers offering a broad range of services
- Capable of meeting older people's and carers' diverse needs

The diverse needs and preferences of older people, their carers and families can most effectively be met through a mixed market of care. Large and small, private, third sector and public providers are best placed to offer a range of care and support services at different prices, which is particularly important for low earners as they have restricted purchasing power. A well functioning care market will deliver choice and personalisation, key drivers of the Government's current reform programme and of a future vision.

#### iv) Market shapers

- The social market for care cannot be managed like a traditional public service nor given the freedom of some private markets
- The local authority should develop a role of "strategic oversight" of local markets to ensure sufficient volume, diversity, quality and affordability of care services, but other market shapers (particularly at regional and national level) have an important role to play

Care is a “social good”, which the state has a responsibility to provide (either directly or increasingly via financial contributions) to the most vulnerable in society, and those who cannot afford to buy it themselves. In the future, therefore, care should be provided by a fair and efficient “social market”. This can neither be managed like a public service, nor given the freedom to function as a private market (i.e. with levels of regulation and consumer protection afforded to other markets, but more or less free to develop according to market forces). Regulation of care is an important tool to drive quality in the market and can influence its development, but there is also a vital role for a market “shaper” – an agent or agents who can ensure the care market delivers a diverse choice of good quality and affordable care to all who need it.

A market shaper will be a source of strategic market oversight to forecast new demands and reduce obstacles to market entry and growth. Its role will involve a range of functions, including carrying out comprehensive market analysis to identify unmet need, and encouraging and facilitating providers to meet that need. Some methods identified include sharing market analysis to allow providers to respond accordingly, providing business support, and commissioning or purchasing services directly. The following section presents the full range of tools open to market shapers, and discusses the concept of market shaping more broadly.

#### v) Assessment and review

- Regular care and wellbeing assessments covering care, health, and wider wellbeing issues will be a universal entitlement for all older people and their carers
- Emphasising prevention but also used at the point of needing care

Whilst an assessment of an older person's care needs is an entitlement that all local authorities must currently provide, in practice, it is often conflated with the more specific assessment of eligibility for state funding. Consequently, the current assessment is often a narrow consideration of need for those services the state might have to fund, and many self funders and those receiving informal care will never have their needs assessed.

The Foundation believes the assessment of need should be divorced from a test of eligibility, by creating a new “care and wellbeing assessment”, which everyone over the age of 65 *and their carers* are entitled to. The wellbeing of informal carers is still overlooked in the current system, and their needs ought to be assessed alongside the older person they care for in order to consider the full range of options (i.e. including respite care and support services) that are appropriate for the older person.

By divorcing this assessment from questions of eligibility, it can be more comprehensive and consider a wider spectrum of needs – including health and care, but also discussing factors which might contribute to a person's wellbeing, such as social and learning opportunities in the community and home adaptations. This is also likely to be a far more interactive and needs-led process, where an older person or carer can discuss the entire spectrum of issues that might improve their quality of life rather than diverted (either consciously or unconsciously) towards fitting in to levels of eligibility. This is both in tune with the Government's focus on self-assessment, and more compatible with the use of personal budgets: as personal budgets need not be spent on traditional personal care services, a broader assessment will provide a far more useful set of information that an older person can use essentially as a “shopping list” of services to buy from the care market. This would also be valuable for self-funders, who in the current system might not consider their wider needs (particularly regarding prevention), or know what to buy.

Everyone will be informed of their entitlement to an assessment when they reach 65 (perhaps via an equivalent to a “Baby Bounty” pack for new mothers<sup>5</sup>, or as part of a pension statement), and offered the assessment at regular intervals to encourage take up and repeated use – as older people's needs change over time, it is important that older people claim their assessment at regular intervals.

These assessments would also have a strong focus on preventative services, so that, for example, a 65 year old having their first assessment, and who has no actual “care” needs falling within the category of social care, would still have a thorough assessment of their wellbeing. This would consider preventative health services (nutrition, physical activity), but also opportunities to socialise and contribute to the community – factors which the POPPs evaluations have demonstrated to be vital to wellbeing and prolonged good health in later life.<sup>6</sup> This preventative focus would remain throughout a person's subsequent assessments – covering home adaptations and falls prevention for older people, for example.

Whilst separate from considerations of eligibility, this assessment could still act as a filter to the eligibility test. Those older people whose “care and wellbeing assessment” indicated their care needs were significant enough to potentially make them eligible for state funding could be signposted to the eligibility test, rather than everyone being put through the process automatically. This would remove the burden on the eligibility testing process, avoid the need for older people to go through two processes unnecessarily, while still preserving the universal entitlement (which is currently in place though not always provided) to a “needs assessment” – and replacing it with a more comprehensive assessment and removed from calculations of eligibility to state funds.

<sup>5</sup> See Counsel and Care (2008) *Lifelong: a new vision for the wellbeing of all older people, their families and carers*, which recommends a “Bounty Bag” of offers and information given to everyone at 65 and then at regular intervals

<sup>6</sup> DH (2008), *National Evaluation of Partnerships for Older People Projects: Interim report of progress*

#### vi) Navigation services

- Taking the form of a first stop shop to integrate a range of support (information, advice and advocacy) on care and a range of related areas (health, housing, entitlements, etc.)
- A first stop shop at national level linked to a network of local first stop shops
- Providing support via the internet, telephone, face to face and home visits and outreach

A critical weakness in the current care market is that older people, their families and carers find it very challenging to navigate. This is in part due to the sheer complexity of the system, but also because there is insufficient support available to help people make care choices.

A new navigation service must be a central component of a new care architecture, supporting people at every stage, building upon but most importantly coordinating and extending the reach of the existing advice sector.

A new navigation service should take the form of a “first stop shop” at national and local level to benefit from economies of scale for generic advice over the internet and telephone, leaving resources free to build outreach capacity at local level. The two would be linked with a two-way referral system and information sharing (potential options for different navigation services are discussed in greater depth in the following section). Alongside this navigation service, a market of brokers and intermediaries could be developed to provide specialist support and professional services for those who needed additional help employing their own personal assistants, for example.

#### A care gateway

In the future these two elements – a care and wellbeing assessment and use of the navigation service, would be part of a universal entitlement for everyone over 65 and their carers as enshrined in the National Framework. Combined, they would act as a “gateway” to the new care architecture: at the point of a care and wellbeing assessment, an older person could be introduced to the navigation service and have their options explained regarding the advice and support they could receive. Conversely, people approaching the new navigation service will be made aware of their entitlements enshrined in the National Framework, and should be advised to have a care and wellbeing assessment as a first step to accessing the care and support they might need.

These two services, working in tandem, would equip older people, their carers and families with a better understanding of their needs, what services are available to meet them, and how best to access them. Armed with a care and wellbeing assessment, and advice from the navigation

service, an older person would enter the care system with the knowledge and confidence required to make them a more effective “consumer” of care and support services.

Many older people may not need or want such help, and are quite capable of purchasing the care and support services they need from the market directly. However, a significant number of older people and their families experience a far less positive “first contact” with the care system – often after a fall at home and a hospital stay, or the death of a spouse. This group of potential care consumers are likely to be far less prepared to deal with the local authority or care providers to access the services they need. In such circumstances, older people must (wherever practicable) be diverted – by GPs, hospitals, care providers, the local authority and others – to the “gateway” to equip them with the support they need to enter the care system.

#### vii) An eligibility test based on needs and means

- An entitlement based on national needs and means eligibility criteria, set out in the National Framework
- A national benchmark of need would replace local variation of current FACS criteria
- This could be compatible with local budgetary control

In a separate process to the “care and wellbeing assessment”, older people will have their needs and means tested for eligibility to state funding. The care and wellbeing assessment will form the basis of the needs test, and, as explained above, could act as a filter of sorts: those older people whose “care and wellbeing assessment” indicated their needs were significant enough to potentially make them eligible for state funding could be signposted to the eligibility test.

In the current care system, local authorities set the level of need older people must have to be entitled to care. In a resource constrained environment, most local authorities have raised their needs thresholds so that only those with the most serious needs are eligible for state funding. The Foundation’s research into people’s perceptions of the care system found, however, one source of perceived “unfairness” was the local variation in eligibility for care, rather than the level set, per se. This issue must therefore be treated as two separate questions: 1) how locally variable are eligibility benchmarks? and 2) where is the eligibility benchmark set?

The first question can be addressed within the framework of a new care architecture. When consulting a number of experts on the issue of eligibility and funding, the Foundation found that many felt the “gatekeeper” to resources (i.e. the agent carrying out eligibility testing) should not have an inherent interest in rationing those resources. This is discussed in more detail in the next section.



The Foundation has concluded, therefore, that local needs benchmarks ought to be replaced by a single national benchmark, so that older people with similar needs will have them met, regardless of where they live. This improves both the fairness and transparency of the system.

This need not, however, remove the control local authorities have over their budgets. Indeed, as CSCI recommends<sup>7</sup>, local authorities could set their own monetary values for different levels of eligibility (increasingly in a transparent way in the form of personal budgets), to reflect the cost of labour and other local variations that might need to be taken into consideration.

Where needs eligibility is set at national level (i.e. the equivalent of critical, substantial, moderate or low FACS level in the current system), however, is mainly a political decision. This decision will reflect the Government's ambitions for how older people and society are treated in the future, the priority given to preventative care, and dependent on both the content of the new minimum entitlement to care and support<sup>8</sup> and the available resources for care funding as weighed up against other priorities.

As such, the architecture of a care system cannot resolve this issue, but rather it requires decisions regarding the funding settlement of a future care system.

This decision would, however, be supported by a collective funding system (selected as the fairest and most effective from a range of possible options), used to raise the resources required to provide this level of subsidy. The benchmark would also need to be enshrined in the National Framework to ensure all citizens knew what to expect from the state, and what they would be expected to contribute themselves.

### **How would this architecture create a functioning market?**

The elements outlined above can generate a fairer and more efficient market by improving the health of demand and supply:

There will be **healthy demand** as people have more resources to spend, and better information and advice to become confident “care consumers”:

- The range of individual funding products available will ensure people can access adequate resources to buy the services they want.
- The “gateway” of a care and wellbeing assessment and navigation service will give people a better understanding of their needs, as well as information and advice on the services available to meet those needs and how to access them.
- The National Framework will raise awareness of the need to prepare for care costs, and provide greater clarity regarding what they are entitled to from the state.

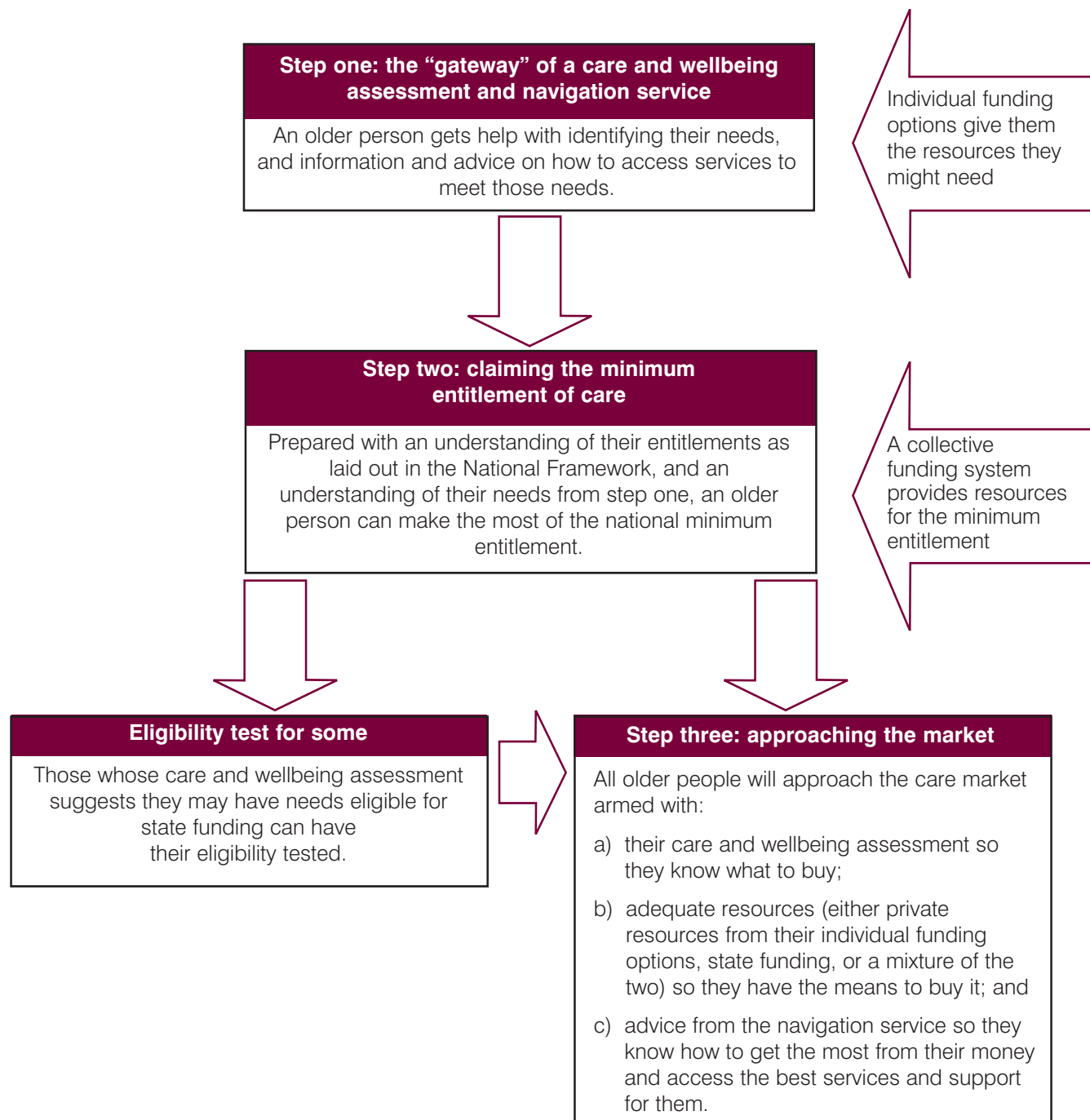
There will be **healthy supply** thanks to more confident care consumers and support framework:

- “Care consumers” are better able to express their needs and preferences, and give better quality feedback to care providers.
- A mixed market of care and support services will be best able to respond to this feedback, and ensure a diverse range of needs and preferences can be met.
- Market shapers will work behind the scenes to facilitate and encourage this market, help providers to respond to consumer feedback, and to offer flexible, affordable and good quality services.
- Market shaping will be enhanced by the “care and wellbeing assessment”, which will collate valuable information regarding the local population’s needs. This information can be used by providers to ensure supply meets local demand.

<sup>7</sup> CSCI (2008), *Cutting the cake fairly: review of eligibility criteria for social care*

<sup>8</sup> Counsel and Care, for example, recommends that low and moderate care needs are met by a universal entitlement, while older people would be means tested for contributions to substantial and critical needs. See Counsel and Care (2008) *Lifelong: a new vision for the wellbeing of all older people, their families and carers*

## How will an individual experience this new market?



## What would the experience of low earners be?

The Foundation decided to explore the issue of care for older people as our research demonstrated it was an important issue to low earners. More importantly, their financial circumstances, interacting with the current care market, leave them particularly exposed to poor outcomes:

- Nearly three quarters of low earners are unlikely to be eligible for state funding to pay for care.

- Yet as they still have relatively low incomes, which just put them over the cusp of eligibility, care costs are likely to be a large financial burden which many will be unable to afford.
- They have more of their assets in housing equity than liquid savings compared to other income groups – so the resources they have to fund their own care are harder to access and use in small amounts.



We designed the architecture outlined above, therefore, with a focus on improving the outcomes of this group in particular, but within a framework which would work for everyone:

- The central importance of a navigation service reflect the fact that our research findings indicated that whilst everyone found the care system complex and had difficulty in accessing the services they needed because of this, this was low earners' greatest concern. Low earners also had little awareness of where to go for help and advice, and consistently spoke of "fighting" to get the services and benefits they were entitled to.
- The range of private and state sponsored individual funding options was a response to the fact that whilst the use of financial products to prepare for care costs is low across the board, low earners are in particular need of flexible ways to access their housing wealth – as many are asset rich and income poor.
- A mixed market for care services if the most effective way of delivering better care outcomes for everyone, but is vital for low earners as their purchasing power is likely to be low. A mixed market of care and support (facilitated by market shapers) can deliver choice and good quality at affordable prices.
- A National Framework, including a minimum entitlement, can improve the clarity of the system and increase awareness for everyone, but also addresses low earners' specific concerns regarding the "unfairness" of the system stemming from its opaque nature regarding entitlements and responsibilities of the individual and the family.
- A minimum entitlement and national eligibility criteria will help empower all consumers to have a better understanding of what they are entitled to. For low earners, whose experiences of the care system are marred by having to "fight" for benefits and services, this will inject much needed transparency and fairness into the system. As an income group sitting just on either side of means-tested eligibility, this will also help them predict whether they will have to contribute to their care costs in the future.

How would this architecture deliver the Government's vision for a future care and support system?

The Government's vision of a future care and support system has been well articulated in the cross departmental concordat Putting People First. In this document, the Government described a care and support system that would support people to:

- live independently;
- stay healthy and recover quickly from illness;

- exercise maximum control over their own life and where appropriate the lives of their family members;
- sustain a family unit which avoids children being required to take on inappropriate caring roles;
- participate as active and equal citizens, both economically and socially;
- have the best possible quality of life, irrespective of illness or disability;
- retain maximum dignity and respect.<sup>9</sup>

This vision was further developed in the strategy document A Case for Change. This outlined the key principles which lay behind the Government's vision:

- Promoting independence, choice and control for everyone who uses care and support services.
- Ensure that everyone can receive the high-quality care and support they need, and that everyone gets some support from the government, but that funding is targeted at those most in need.
- The system must be affordable for government, individuals and families in the long term.<sup>10</sup>

In spite of the Government's progress in outlining a vision for care, important questions remain regarding what a system capable of achieving such a vision would look like – namely, the infrastructure required, and the roles of key agents within that infrastructure. The Foundation's suggested architecture for a future care system represents an effective means of delivering this vision:

- As explained above, the elements of the architecture create a **fairer and more efficient care market**. This is the most effective way of delivering choice, personalisation and control for care users, *high-quality care services*, and *affordability for government, individuals and families*.
- **The National Framework** will be of critical importance if the government hopes to raise public awareness of the care system, and encourage people to prepare for costs in later life.
- **The minimum entitlement** enshrined in the framework will help ensure that *everyone gets some support from the Government* and everyone will know what they are entitled to.
- A range of **individual funding options** to meet different people's situations and preferences and an effective **collective funding mechanism** for the Government to raise funds nationally will help ensure the system is *affordable for government, individuals and families*.
- The **eligibility test** will ensure *funding is targeted at those most in need*, but in a more transparent and predictable way.

<sup>9</sup> HMG (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care*

<sup>10</sup> HMG (2008) *The case for change - why England needs a new care and support system*

## The delegation of roles and responsibilities within a future care architecture

The Foundation's architecture identifies the key characteristics of a system capable of creating a more effective care market and delivering the Government's vision for care. However, whether this architecture is successful will critically depend on the agents carrying out many of its key functions. Indeed, the question of "who does what" will fundamentally affect many of its outcomes. A key factor that will influence this decision is the balance of responsibility between national and local government.

The Foundation brought together a number of experts for a series of discussion seminars in July and October 2008. At these seminars, the groups were tasked with envisioning a new architecture for care by answering key questions of "who", "what" and "how". Some functions within the architecture were subject to broad agreement regarding the agent responsible:

The following agents should have the following responsibilities:

- National government must set out a National Framework for care: clarifying roles and responsibilities of key agents; deciding on a minimum national entitlement for older people and how this was to be funded; and using this as a vehicle to increase public awareness and preparation for care and the costs of care in later life
- The options available for individuals to fund their own care should be a mixture of state sponsored and privately provided products
- Care and support services ought to be delivered through a mixed market of providers

However many questions generated much debate regarding the potential trade offs that would have to be made:

### Who will be the most effective "market shaper" in a future care system?

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

The Foundation concluded:

- Local authorities should have a very different role in the future, acting as market shapers and providing strategic oversight of their local care markets to ensure these interact effectively with related markets (housing, health, etc.) at a local level. This will also require joint working with other local authorities and at a regional and national level
- Other market shapers will also have an important role to play – key among these are the care regulator, regional and sub-regional bodies, and care users themselves

### Who ought to assess people's eligibility for state funding?

It was suggested that assessment of **eligibility** and the **funding** of care ought to be separated to resolve the inherent conflict of interest that currently exists at local authority level. One suggestion was that assessment should still be carried out by local authorities, but funding ought to then be distributed centrally. This idea was the subject of much discussion, with some pointing out that such a system would remove budgetary control and the ability for government to cap costs, and risked creating perverse incentives for local authorities to claim as much funding from a "central pot" as possible.

An alternative idea was for social workers to carry out assessments independently, whilst funding came from local authorities. It was pointed out that social workers are experienced in providing high quality needs assessments already, but would often feel demoralised at having to "fight" for the resources required once they returned to their (local authority) offices. However, social workers do not actually have to be part of the local authority, and independent practices already exist. Divorcing social workers from the local authority would remove the conflict of interest between assessor and funding gatekeeper, whilst making the most of existing expertise in the social work profession. However, the same problem arises in that this might potentially lead to spiralling costs and local authorities losing control of their care budgets.

The Foundation concluded:

- The local authority could assess eligibility, but this would be according to national eligibility criteria based on needs and means to replace current local needs setting
- Budgetary control could be maintained by authorities setting their own values for different levels of need and means, to reflect local labour and other costs
- A funding settlement which increased both state and individual contributions would be required to ensure eligibility was set nationally at a level which met older people's needs and funded a minimum entitlement for care and support

## Who ought to help people navigate the care system?

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

The Foundation concluded:

- In light of the conclusion above regarding national eligibility criteria, local authorities would have less of a conflict of interest in helping people navigate care
- Providing consumer support would be a key function in their role as strategic overseer of local markets.
- Local first stop shops could therefore be commissioned by the local authority, who would also act as a key partner in providing relevant information and advice
- Local first stop shops would be linked to an independent national first stop shop, via information sharing and two-way referral. The national "hub" would provide a free hotline and website for independent advice and support

In spite of the above recommendations, critical decisions regarding the delegation of roles and responsibilities within the new architecture can only be made in conjunction with:

1. A funding settlement for care, reached by evaluating wider budgetary priorities;
2. Wider strategic considerations regarding the role of the national and local government; and
3. An assessment of the impact such decisions will have on the delivery of other services and welfare spending priorities.

The following trade offs need to be borne in mind when considering the options available, covering both potential conflicts as well as the potential opportunities for greater coordination:

- **Assessing eligibility for state funding**

If the agent assessing eligibility for funding also provides that funding, they may have an incentive to restrict eligibility to reduce costs. Conversely, if these functions are separated, there may be a risk of exhausting available funds – meaning some older people may lose out. An optimum balance of fairness and affordability must be struck within a fixed budget.

- **Navigation**

Better information and advice can improve the take up of services and benefits that people are entitled to. If the agent providing state funding also provides a navigation service, it may have an interest in not stimulating demand for services that it will subsequently have to pay for. Similarly, if the agent providing care services also provides a navigation service, it may have an incentive to steer people towards its own services.

- **Care and wellbeing assessment**

The agent carrying out care and wellbeing assessments could usefully carry out a market shaping role. This is because these assessments are a valuable source of information on older people's needs, which is a key market shaping tool and could be put to use in encouraging supply.

The agent carrying out a care and wellbeing assessment could also act as a first point of contact for a navigation service, so that everyone having an assessment could be offered information and advice at the same time.

The agent carrying out a care and wellbeing assessment could also be the agent carrying out eligibility testing, as this would create a more seamless process. On the other hand, combining the two may undermine the perceived impartiality of the care and wellbeing assessment as a separate entity to claiming state funding. A care and wellbeing assessment could certainly act as a filter to eligibility testing so older people did not have to go through this process unnecessarily.

- **Market shaping**

An agent assessing eligibility for state funding may not be able to act as an effective market shaper, as the former responsibility encourages a focus on state-funded needs and services only. A market shaper must have a broader overview of all older people's requirements.

## IV – Four elements of the architecture in more depth

The Resolution Foundation chose to explore four elements of the architecture of a new care system in more depth. We selected those areas where we could add most value, due to our own experience and specialist knowledge, and where we felt an issue had been under-explored or could benefit from greater coordination of existing research. Each of the four research projects, summarised below, are explored in more detail in four discussion papers, which are available to download on the Resolution Foundation website.

### Project one: navigating the care system

#### Aim of the research

Older people, their families and carers find navigating the care system very difficult. Many do not know where to turn for help, and risk making poor care choices. This is due to four key factors: 1) the care system is very complex; 2) there is little awareness of the sources of information, advice and advocacy (IAA) available to help people make care choices; 3) existing sources of advice can be fragmented and are often over-stretched, and 4) people tend not to prepare for their or their relative's care needs, and only find out about the system at a point of crisis.

Yet in any market, it is vital that consumers can make informed choices – if they do not, they might lose out by not being able to access the services they want, or not recognising poor quality. Providers can also lose out – poorly informed consumers may not be aware of their existence, and not buy as much or as often as well-informed ones.

The aim of this project was to consider how people need help navigating the care system now and in the future, whether the existing support available is sufficient to meet these needs, and to consider the options for developing a more integrated navigation framework.

#### Methodology

This project used desk research to synthesise a large body of existing work exploring older people's advice and information needs and preferred communications channels. Primary research was used to gain a clearer picture of the current sector's capacity to meet those needs, as well as to gauge potential users' reactions to different advice models. This included:

- Questionnaire data from 60 voluntary sector advice organisations asking about their client group, the nature of their work and the capacity to meet demand.

- Qualitative feedback from expert groups and other stakeholders regarding the issue of navigating care.
- Focus groups with 40 low earners to discuss possible advice models.

#### Key findings

What do older people, their families and carers need to navigate the care system?

A large body of research demonstrates that to navigate the care system, older people actually require information and advice on a range of issues, including: social security benefits/entitlements, health, housing, finances and community services – as well as questions regarding care funding and assessment, and choices of services.

The Resolution Foundation's recent survey of 60 advice giving organisations<sup>13</sup> found that the most commonly reported enquiries from clients included:

- Money, benefits, assets, care funding and debt (reported by 40% of respondents)
- Housing and/or residential care choices (18% of respondents)
- General care and care/support service enquiries (10% of respondents)
- Health and mental health (9% of respondents)

These issues reflect the reality of older people's (and indeed, everyone's) lives – home, finances and care/health. In the case of older people, they are also mutually reinforcing: for example, home adaptations and housing support can improve an older person's health and reduce their need for care, whilst financial advice can lead to better use of resources, leading to better care.

#### How do they need to be helped?

##### i) Integration of information

Older people and their families need to be fully informed about a diverse range of issues to make an effective decision about care, but research shows that this is most effective when delivered in a joined up, integrated fashion. People do not want to have to seek separate pieces of information from multiple sources before they can access the support they need. When consulting low earners on possible new advice services, the key factor that all groups identified first was that a new service had to allow people to access help with one phone call. Having to "ring round" and repeat the same query to several people was seen as a major disadvantage of most other telephone-based services.<sup>14</sup>

<sup>11</sup> <http://www.resolutionfoundation.org>

<sup>12</sup> Key studies include: Tinker, A., McCreadie, C., & Salvage, A. (1993). *The information needs of elderly people – an exploratory study*. Age Concern Institute of Gerontology, London; Barrett, J *The information needs of elderly, disabled elderly people, and their carer*. Disability Information Trust, 2000; Age Concern (2008) *Transforming Lives - Tackling Poverty and Promoting Independence and Dignity through Information and Advice*; Age Concern (2004) *Bridging the Gaps: The outcomes of information and advice services for older people and assessment of unmet need*

<sup>13</sup> 200 questionnaires were sent to organisations across England providing information, advice and advocacy to older people. 60 were returned

<sup>14</sup> Ibid



Given the complexity of the current system, it is likely an older person may have to deal with a large number of separate statutory agencies, third sector and commercial organisations, each with their own processes and procedures, to secure the care they need. Even in a new care architecture, which should substantially simplify and clarify the care system, there will always be a number of interrelated markets and services older people will need to deal with to meet the full range of their care and support needs (such as welfare benefits, local transport, etc.)

Therefore, creating a single point of contact between an older person and the care and support system is vital. More than a support tool, a navigation service should become an interface between the individual and the range of statutory agencies, third sector and commercial organisations, and their separate application procedures and processes, which will make up the mixed market of care and support in the future. It is for this reason that a navigation service is a central component of the “gateway” to a new care architecture.

#### ii) integration of support

Whilst organisations often define and categorise their services according to information, advice, advocacy (IAA) and increasingly brokerage, and much research will use these terms as a way of classifying areas of activity, evidence suggests these categories mean less to older people:

*“They wanted assistance or help in order to receive a service, and did not distinguish between information, advice or advocacy as services in their own right. Information was seen as a means to an end.”<sup>15</sup>*

When older people are asked to explain the types of help they need, they identify activities which fall into all three categories of IAA, even though they do not define them as such. This suggests that all three forms of help may be required to ensure people can navigate the care system, depending on the particular case. What is important, therefore, is that organisations have the capacity to draw upon a range of methods of support across the IAA spectrum and to use them seamlessly under a more accessible and intuitive concept of “help”. Of course, some specialist services (such as brokerage services in the future) may require a more defined status (particularly if these are paid for – see below) separate to mainstream “help”, but the referral to these and other specialist services could be made as seamless as possible through close partnership working and information sharing.

#### iii) A range of communication channels

Using a diverse “multi-channel” approach to deliver advice and information is the best way of reaching as many people in the heterogeneous group of older people and their families as possible. This involves using outreach, face to face, telephone, written and internet-based information as appropriate, and incorporating good practice in each. For many, telephone access to an advice service would be adequate, and certainly could be used in conjunction with a website as a first port of call for the majority of users (before face to face or other services were then used where needed).

#### Is the current sector meeting this need?

Studies have found that many different organisations providing support to older people have a specific interest or specialism. Fragmentation of advice services means that people navigating care may have to seek information from a range of different sources to find out separately about care, house adaptations, benefits, transport, and so on. Providing a spectrum of types of support (information, advice and advocacy) also proves problematic for some voluntary organisations: there are often disagreements regarding the definitions of IAA, with some organisations reluctant to offer advice due to perceptions of “legal responsibility if something went wrong.”<sup>16</sup> and stick to what they describe as a “signposting service”, providing information and nothing more. Yet some organisations who feel providing advice is legally problematic are actually fulfilling advocacy roles in order to secure information for their clients. The Foundation also found some advocacy services reported that they could only provide advice and information once their advocates were at capacity due to lack of resources.<sup>17</sup>

Another need which may not yet have been fully expressed is the need for brokerage. Given the forthcoming expansion of the use of personal budgets, it is likely demand will grow for brokers to carry out payroll and accountancy tasks for people employing personal assistants. Local authorities may find their current brokerage services become overstretched in the light of universal personal budgets, and it is unlikely many of the small third sector organisations currently delivering IAA will be able to branch out into professional services such as accountancy without significant additional resources and expertise.

<sup>15</sup> Quinn, Snowling and Denicolo, (2003) *Older people's perspectives: Devising information, advice and advocacy services*. JRF

<sup>16</sup> Ibid

<sup>17</sup> Resolution Foundation survey of 60 advice giving organisations in England, July 2008

The organisations surveyed by the Foundation reported a mixed range of methods for delivering IAA - 27% reported to deliver this via the telephone, 28% face to face, and 30% with “case work” (which we defined as home visits, follow-up and advocacy). 14% stated they used “web enquiries” to deliver advice. This represents a good mixture of communication channels. However, much of the current information provided by statutory sources still relies heavily on written forms of communication – in leaflets or websites – which evidence suggests is less effective at reaching older people. Furthermore, some delivery channels, such as face to face and casework, are resource intensive. Every organisation the Foundation surveyed mentioned resourcing as a major challenge, with Age Concern already reporting cuts in advice services in the wake of tighter local authority budgets.<sup>18</sup> A lack of resources is a significant constraint on the current advice sector, with most organisations we surveyed reporting they had turned clients away as they were at capacity.

What options are available to provide a more integrated and sustainable navigation framework?

The current advice sector may not be sustainable in the face of demographic change and Government reforms, which are likely to generate greater demand pressures in terms of an overall increase in the number of older people, particularly with complex care needs and no family support, as well as an increase in the number of personal budget holders requiring specialist help.

From the analysis of older people and their families’ needs, it is clear that to address the weaknesses outlined above, the following would be required:

- A method of providing independent and integrated information, advice and advocacy on a range of issues relevant to older people navigating care – including housing and benefits advice.
- A way to access this range of IAA via multiple communication channels, including face to face, telephone and written forms.
- A service which could be integrated with the growing market of organisations offering brokerage services as a natural extension of IAA for some older people (particularly those using personal budgets).
- A service which can be integrated with developing services in other advice areas, such as MoneyGuidance.
- A means of ensuring the capacity to deliver continuity in IAA to all older people who need help navigating the care system, and which can pro-actively engage with those who are unaware that such help exists ahead of a care crisis.

There are a variety of forms a more effective “navigation system” could take to meet these objectives:

1. A new independent information, advice and advocacy service, which could variously take the form of:
  - a. a national “first stop shop”
  - b. a local “first stop shop”
  - c. some combination of the two
2. A service managed by local authorities
  - a. taking the role of a local “first stop shop”
  - b. commissioning a “first stop shop” from local providers
  - c. providing brokerage in-house
3. A specialist brokerage market to develop alongside either option

- 1) A new independent IAA service
  - a) National first stop shops

It is clear that for any new navigation service, integration is key – in content, form and delivery. First stop shops may prove the most effective method to achieve this. Unlike one stop shops, which attempt to gather all relevant information and advice sources under one roof, “first” stop shops act as a single contact point for a range of separate IAA services an individual might require.

First stop shops may be more appropriate for care because

- a) “care and support” covers a very large range of services,
- b) it is related to a number of other public services and private markets (such as housing and health) and
- c) there are already a large number of voluntary and statutory organisations involved in the delivery of advice regarding care and other related issues.

A first stop shop approach is currently being trialled by Counsel and Care, the Elderly Accommodation Counsel, Help the Aged and NHFA Care Fees Advice services. They have combined their specialist advice areas into “FirstStop”, providing a single service for advice on care and support, accommodation, money and benefits and complaints and redress.<sup>19</sup> Older people and their families can call a single telephone number and be directed to the most appropriate service for their enquiry. If, as it likely, they need more than one issue dealt with, their case can be passed to another of the organisations without them having to repeat the details of their situation to another person. This makes signposting between these services a smoother process than would have been the case if they were operating as separate advice organisations. FirstStop is also looking to expand its local outreach, potentially to provide face to face advice within the community.

<sup>18</sup> See Age Concern (2008) *The Price of No Advice*

<sup>19</sup> [www.firststopcareadvice.org.uk](http://www.firststopcareadvice.org.uk)



A wider ranging first stop shop could take advantage of new developments in care related areas: for example, bringing together the new carers' helpline and housing advice and information service (outlined in the Government's carers' and lifetime homes strategies respectively) under its single umbrella. Indeed, the first stop shop could expand and include a much wider range of advice services, such as the new MoneyGuidance service being trialled by the Financial Services Authority. The breadth of the issues covered, and the number of organisations integrated under a first stop shop umbrella as a gateway to a new care system, can only be addressed in conjunction with decisions regarding the concepts of care, support and wellbeing – an important step in longer term care reform.

Whilst a degree of referral and signposting is inevitable within first stop shops, it is important to ensure that clients do not have to repeat their query to different specialists unnecessarily, by using effective care referral and information sharing systems. Also, signposting to other services external to the first stop shop umbrella also need to be as seamless as possible – perhaps through joint service agreements.

#### b) Local first stop shops

It is important to bear in mind that care for older people is a highly localised service. Consequently, people may have to navigate very different systems according to where they live. Accessing localised information via local first stop shops is important therefore, to integrate the variety of sources of local advice that exist (including local voluntary and community groups, offices of national networks such as Age Concern, as well as the local authority, the PCT, etc.)

This approach would have all the benefits of a national first stop shop, but would be able to provide locally specific information and face to face support in local communities. This is quite different from a national first stop shop, which would more likely rely on a telephone and website as its main delivery channels and might be geographically removed from those who ask for help.

The disadvantage of local first stop shops is that they may be limited in the scope of advice they are able to provide, and there are some issues related to care which are national in scope, such as pensions and benefits, and so may not require specialist local knowledge. Using local organisations to deliver this advice may be less cost effective than using a national platform.

#### c) Combining national and local first stop shops

Given the issues raised above, there is a strong case for combining the benefits of a national and local first stop service. A national first stop shop, using the web and telephone as a single point of contact for a range of specialist advice organisations at national level, would work alongside a network of local first stop shops. These could be based in each local authority, and would replicate the national model on a smaller scale by acting as a single access point for a range of local advice organisations.

This approach may prove more cost effective – the burden of demand for IAA currently placed on small local organisations could be effectively shared with the national hub and the economies of scale it might bring. For example, general information, advice and advocacy dealt with over the phone by local organisations could be passed to the national body to carry out, leaving local organisations more capacity to deliver services where they add value – namely, locally specific advice, face to face, home visits, and advocacy/case work which requires face to face activity (such as form filling).

National and local services would need to work closely together, however, to ensure clients were referred between national and local levels as seamlessly as possible. The national service could offer a single telephone number and website and provide national-level advice and information on a wide range of areas helping people navigate care. It could then put callers through to their local first stop shop, if they required specific local information or needed face to face advice or advocacy. Conversely, local services could pass their clients to the national hub for wider general or national advice, or in cases where local expertise was not available to meet the query. This process would need to be supported by significant information sharing between national and local levels and an integrated telephone and database system.

#### 2) A local authority-led system

The options outlined above assume the creation of independent first stop shops. However, the Government's Putting People First and the Transformation Agenda clearly envisage a role for local authorities in establishing a joined up information and advice service, and require some form of linkage of local advice services by 2011.

In the future, therefore, the local authority could have a role to play in shaping and stimulating local advice services. This could be compatible with a local "first stop shop" approach, in that a local authority could be one of the key partners under the first stop shop umbrella, as well as the commissioner of third sector organisations to provide a wider range of advocacy and outreach in their area. The local authority could perhaps commission a "lead partner" (such as the local Age Concern) to act as the coordinator and "front end" of the first stop shop.

Alternatively, the local authority could take on the role of the first stop shop itself, as well as being a source of information in its own right. The advantage of this is that it would give the local navigation service a clear and high profile status, and as its coordinator, the local authority would also be in the best position to identify gaps in local IAA coverage and commission services accordingly. In a new architecture for care, the local authority may take on a key role as a shaper of the local care market. Providing consumer support to stimulate demand is an important function of this role, and providing a first stop shop for advice would certainly contribute to this.

A possible disadvantage of this approach is that the sense of public trust in an impartial and independent service might be undermined, if it were perceived as being provided by the local authority. There is certainly a potential conflict of interest between the authority's current role as "gatekeeper" of state funding and "facilitator" of access to these services. However, it is quite possible that in the future, the local authority's role may change considerably and this conflict may not exist.

### 3) A market for brokerage

Brokerage will be a vital part of a future care system as more people take control of their own care, purchase their own services and employ their own staff. The brokerage market is still in its early stages of development, with a small number of independent specialists offering care planning, payroll, record keeping, CRB checking, and other professional services to support people using personal budgets. A number of local authorities with in-house brokerage services also cover care planning and budgeting, but stop short of the professional services (such as payroll) that some older people may want. Local authorities may expand into these services as more people become personal budget holders, but there are clear arguments why it may be preferable to stimulate a private market of brokers:

- Firstly, future demand for brokerage may not only come from personal budget holders – self-funders too may take advantage of the growth in personal assistants, and will need to purchase brokerage services from independent sources.
- Second, self-funders (and potentially many personal budget holders) may prefer to use independent rather than local authority brokers if they are better value for money or perceived as more impartial.
- Finally, and most importantly, local authorities may not have the internal capacity to offer services such as payroll and record keeping to all personal budgets holders, and certainly not to self-funders who may also demand these services in future.

### Marketing and take up

Whichever model is adopted for a new navigation service, it is critical that older people are encouraged to use the service, and preferably before they reach a care crisis. Strategic marketing (i.e. advertising the service in places older people go and may be disposed to act) is important, but outreach, pro-active case finding and using intermediaries to promote the service is vital. Building on trust relationships with GPs, health visitors and community helpers will be an effective way of ensuring vulnerable and harder to reach older people get support and advice. A dedicated referral channel for individuals in the community in regular contact with older people could facilitate this strategy. Peer support and "viral marketing" are also important – older people themselves are likely to be one of

the most effective vehicles for spreading awareness of the service to their friends and families, and could be recruited to deliver information and advice themselves.

### Conclusions

It is clear that making choices regarding care and related services in old age will always be a challenging time. Nevertheless, this otherwise stressful situation is only exacerbated by the lack of help available for people to make their choices. At the root of this problem is the sheer complexity of the task facing them. The current care system is beset by complicated eligibility criteria, funding rules and fees which differ from local authority to local authority. So whilst many organisations attempt to help people navigate their care choices, existing provision falls short in some key areas.

#### How do the findings from this project relate to a new care architecture?

A new care architecture, as we outline in the first part of this report, will help improve the transparency of the system and reduce its complexity (e.g. through a national framework, minimum entitlement and national eligibility criteria). However, a navigation service remains a vital element of a future care system: acting as a "gateway", with a care and wellbeing assessment, to ensure people are well informed and confident in making care choices in a mixed market.

A number of key questions regarding the form of the navigation services remain, including how broad first stop shops should be, and whether they can be delivered by the local authority. These and other questions can only be answered in conjunction with wider decisions regarding the architecture of a future care system and the roles and responsibilities of different actors within it. However, the Foundation suggests the following approach might be the most effective within a broader architecture of care:

- Local first stop shops could be commissioned by the local authority, who would also act as a key partner in providing relevant information and advice
- The first stop shop would be coordinated and operated by an independent organisation within the community
- Local first stop shops would be linked to an independent national first stop shop, via information sharing and two-way referral. The national "hub" would provide a free hotline and website for independent advice and support
- A part of its role of strategic oversight, the local authority would be responsible for ensuring sufficient support services existed in the local market – including a market for independent brokerage

## Project two: innovation and efficiency in care

### Aim of the research

One of the weaknesses in the care market identified by Deloitte's analysis was the fact that care providers are unable to be sufficiently flexible and innovative to respond to people's needs, meet future challenges, and deliver efficiency gains. We differentiate in this project between innovation "by necessity", and planned strategic innovation. The former defines much of the existing innovations in the sector, which tend to be ingenious, but very much ad hoc and improvised by care providers struggling to "do more with less" in a resource constrained environment. The latter is harder to come by – and this lack of strategic planning and innovation to meet future challenges means many providers remain unprepared for changes to the care system, such as the increase in personal budgets and greater focus on prevention.

This project sought to identify the obstacles to strategic innovation and efficiency in the sector, and suggest how they might be overcome.

### Methodology

Desk research was used to identify examples of innovative schemes and those driving efficiency in care, but focused mainly on the information provided in workshops, hosted by the Foundation, with a range of residential and domiciliary care providers. One of the expert groups the Foundation hosted in July was also composed of representatives from larger care groups, which gave another perspective on this issue.

### Key Findings

A number of factors can hinder care providers from carrying out strategic innovation to deliver personalised and cost effective care services. These obstacles fall into four broad categories:

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. Although there was wide recognition that the care regulator had contributed much to driving up quality in the sector and certainly improved and standardised inspection practice, many providers stated there were still 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 lateral thinking simply too costly and time consuming.

Regulation could also inhibit making efficiency gains. For example, one care home owner explained to the Foundation 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. Laing and Buisson calculate that the minimum staffing levels enforced by CSCI in residential care homes means that 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. Smaller, more personalised services, therefore, are unlikely to be able to remain financially sustainable in this environment.

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 explained below, financial constraints and staffing problems are also key factors undermining the domiciliary sector's ability to innovate and think more strategically about the future.

#### 2) 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 contracts 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 or even single minute blocks of time, and will not pay providers for any time they might spend with a client above and beyond this.

<sup>20</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>21</sup> Laing & Buisson, *Community Care Market News*, November 2007

This is clearly a very prescriptive purchasing method, which allows little discretion for care providers to adapt their working methods or respond flexibly to an individual's changing needs. 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>22</sup> It is difficult to see how such an operating model allows for any variation (let alone personalisation) of the care being delivered. 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.

### The impact of funding limitations

Many domiciliary providers also told us their costs were "pared to the bone", 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: 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 need to demonstrate value for money also reduces 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>23</sup>

Resource constraints influencing local authority commissioning practices are also felt in the residential care sector. 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 which more or less fixes their staff costs, which in turn usually accounts for around half of a care home's total costs<sup>24</sup>). Whilst a lack of resources does not inhibit innovation per se – and 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.

Another 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 bureaucratic overheads, as recommended by the Care

Services Efficiency Programme (CSED).<sup>25</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>26</sup> If small providers are excluded from local authority contracting, this source of personalised and dynamic care may be lost.

Yet another consequence of limited resources 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 purchase new innovations in case they failed and wasted money, so there was little incentive for the sector to come up with new ideas for services<sup>27</sup> – an opinion shared by both residential and domiciliary providers consulted by the Foundation.<sup>28</sup>

Finally, limited and uncertain levels of future funding prompt many local authorities to offer only short term contracts or "spot purchase" (i.e. contract for one person rather than purchase several care places or hours)<sup>29</sup>, as they are reluctant to commit themselves to long term or large volume agreements. Unfortunately, this type of contract passes financial insecurity to providers: the absence of a reliable income stream 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>30</sup> A lack of continuity in personnel and possibly low 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 local authorities.

A 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 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>31</sup>

<sup>22</sup> CSCI (2006) *Time to care?*

<sup>23</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>24</sup> Laing, W (2008) *Calculating a fair market price for care: a toolkit for residential and nursing home fees*, JRF

<sup>25</sup> <http://www.csed.csip.org.uk>

<sup>26</sup> King's Fund (2006) *Steps to develop the care market*. London: King's Fund

<sup>27</sup> CSCI (2007) *Safe as houses - what drives investment in social care?*

<sup>28</sup> Provider workshops hosted by the Resolution Foundation, August 2008

<sup>29</sup> The UKHCA found 61% of contracts with independent home care agencies were spot purchased. *Time to care*

<sup>30</sup> King's Fund (2006) *Steps to develop the care market*. London: King's Fund

<sup>31</sup> CSCI (2007) *Safe as houses - what drives investment in social care?*



### 3) Investor behaviour

Investment in the care sector from private equity firms has grown considerably in the last few years, particularly in the residential sector. Private equity-based care groups have become some of the largest providers in the country, owning chains of care homes. In the domiciliary sector franchises have also sprung up.

However, private equity firms and banks often have a fairly short time frame – 3 to 7, or 7 to 10 years – within which they seek to make a return on their investment. As such, longer 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. 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>32</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>33</sup> So whilst 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, a lack of investment for newly built homes means it is unlikely new residential care models will be developed.<sup>34</sup> 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>35</sup>

The current economic climate and subsequent changes in banks' lending behaviour may also make this situation worse, if potential investors in the market are harder to come by, and those who are willing to invest place 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>36</sup> On the other hand, demographic trends ensure care remains a predictable growth market, perhaps encouraging more investors at a time of economic instability in other areas. We should also bear in mind that a new architecture of care, creating a more effective care market, may attract investors who see the potential for further growth and greater efficiencies in an "investment ready" market.

### 4) 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>37</sup> The All Party Parliamentary Social Care Group identified "low pay, lack of training and the low morale and status of the sector" were the main problems to be addressed.<sup>38</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.

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.

### Organisational infrastructure

The majority of care providers in both the residential and domiciliary sectors are very small, often family run organisations. These organisations are also often established by former carers, and so whilst their 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. Providers may also lack the business skills needed to grasp opportunities for innovation – for example they may not have access to market data to alert them to new demands or niches in the market, or may not know how to respond to this information.

<sup>32</sup> Ibid

<sup>33</sup> Laing and Buisson (2008), *Care of Elderly People Market Survey 2008*

<sup>34</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>35</sup> King's Fund (2006) *Steps to develop the care market*. London: King's Fund

<sup>36</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

<sup>37</sup> [http://www.ukhca.co.uk/mediastatement\\_information.aspx?releaseID=44](http://www.ukhca.co.uk/mediastatement_information.aspx?releaseID=44)

<sup>38</sup> LGIU (2008) *Never Too Late for Living: final report of the APPG inquiry into services for older people*

## Organisational culture

The availability of staff and business skills 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. 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. 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.

## 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” regarding new and more efficient models of care. A lack of opportunities to share experiences and learn from other providers’ schemes means many providers may be reluctant to try “untested” and “risky” new schemes. This may also affect local authorities, who, in the absence of evidence from other areas, may not want to invest in 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>40</sup>

How can these obstacles be overcome?

There are a range of practical and immediate steps that can be taken to encourage innovation in the sector. Some of these suggestions will prove more effective in helping domiciliary providers, others may be more valuable for smaller or larger and for-profit providers, or residential providers. 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.

### 1) 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 regulation on which they are based,

respond to innovation (and the accompanying risk) in care provision.

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 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, and also suggests the following methods could be used to monitor outcomes in care homes:<sup>41</sup>

#### Monitoring and evaluation in residential care settings

- Feed back 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 and 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 in 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>42</sup>

<sup>39</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

<sup>40</sup> CSCI (2006) *Time to care?*

<sup>41</sup> Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York

<sup>42</sup> Provider workshops hosted by the Resolution Foundation, August 2008



## 2) Local authority commissioning

Outcomes-based commissioning can also do much to encourage innovation in care provision. Local authorities should specify the outcomes to be achieved by the provider, rather than the time to be spent or tasks to be undertaken. This approach would have two benefits. It would give care 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 choice for older people regarding the care they receive and more flexibility for providers to deliver this), even if personal budgets were not used – a point raised by Thurrock council:

### Thurrock

Thurrock uses a three-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>43</sup>

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” 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.

*continued*

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.

Outcome related commissioning might also encourage a broader spectrum of residential care options than the traditional care home model. This could include extra care housing, which the Government has already provided dedicated funds for local authorities to build, but could also include existing residential homes expanding and diversifying into other services. For example, Birmingham council has recently established three care centres, offering short and long-term residential care, rehabilitation and day care services.<sup>44</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>45</sup>

### 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 prescribing how these are to be achieved. However, 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.

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 pressure on local authorities to make efficiency savings at all levels. Providers report that years of difficult fee negotiations have undermined communication channels and levels of trust on both sides. This is demonstrated by SCIE’s findings, which show that outcomes-based services are progressing much faster in in-house re-enablement services than in long-term home care delivered by the independent sector.<sup>46</sup>

<sup>43</sup> Documentation kindly provided by Les Billingham, Contracting and Commissioning Services Manager, Thurrock Council. September 2008

<sup>44</sup> Laing & Buisson, *Community Care Market News*, August 2008

<sup>45</sup> Social Work Inspection Agency (2007) *Improving Care for Older People: good practice examples*, SWIA Scotland

<sup>46</sup> Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York

## Sharing information

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. A critical element of outcomes-based commissioning is the sharing of these outcomes with providers, so that their expertise can be harnessed to suggest new and potentially more effective methods of achieving them.

In a new care architecture, local authorities may take on an important role in shaping local care markets. One of the key methods of shaping markets is to first collate market intelligence on the needs of the local population, and then to share it with providers to encourage them to spot new opportunities to meet emerging or unmet demand (see below for a fuller discussion of this strategy).

### 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.

## Contracting and funding

As explained above, pressure on local authorities to make efficiency savings may mean they contract only “tried and tested” services in the short term or spot purchased contracts. Yet some local authorities consulted by the Foundation 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>47</sup> This gave stability of income to providers, whilst allowing for renegotiation of services to respond flexibly to changes in need.

### 3) 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. Improving the pay and conditions of care staff is the most obvious, but perhaps the hardest, measure that could be taken to improve recruitment and retention. Nevertheless many providers also reported 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, including free bus passes, subsidised driving lessons, dental care schemes and guaranteed hours of working.

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 and retention is high.<sup>48</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. For example, some domiciliary providers use staff “down time” (i.e. the off-peak periods during the day when fewer hours are contracted by local authorities) to offer lower level services (such as social opportunities and trips out) to self-funders – essentially increasing their incomes by making efficient use of staff time. Others use small rotating teams of staff, to ensure continuity of care if one carer is off sick, for example. These teams can be self-managing to provide autonomy for staff to organise their own schedules. Some home care providers are 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.

<sup>47</sup> Expert Groups on redesigning social care, hosted by the Resolution Foundation, July 2008

<sup>48</sup> CSCI (2006) *Time to care?*

Of course, the responsibility to improve recruitment and retention in the care sector also falls to local and national government. A concerted effort from the Government to improve the training available, career prospects and public perceptions of the caring profession could help relieve the shortages in the sector. The Government should also consider the impact of its points based migration system, which, whilst the status of skilled carers is still under review, could increase the costs placed on care providers.<sup>49</sup> Local government could also boost 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. This would certainly be a key feature of local authorities' responsibility for "local market oversight" in a new care architecture – ensuring the care market was healthy and well integrated into related markets and services (in this case, the local labour market).

To tackle staff shortages in Liverpool, a large recruitment event takes place every year, with employers and trainers from various care professions, combined with several smaller events held in different neighbourhoods around the local authority. A social work placement scheme is also in operation, and workforce development staff go in to schools to promote this opportunity.

## Conclusions

The care market is currently operating in a challenging environment, often having to juggle competing pressures of making efficiency savings whilst meeting greater demands, 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.

The need to remain economically viable and deliver good quality care in the face of these challenges has undoubtedly 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.

This situation may potentially become worse as the numbers of older people with complex care needs rises, and the numbers of personal budget holders and self-funders increase. The traditional and narrow range of service options currently on offer is unlikely to satisfy these groups.

## How do the findings from this project relate to a new care architecture?

A fair and efficient mixed market is a vital component to a future architecture for care, and in turn, providers who can innovate to meet demand and achieve greater efficiencies are central to such a market. Providers constrained by the internal and external factors described above are unlikely to be able to respond to the challenges and opportunities of a future care architecture – such as "care consumers" armed with a better understanding of their needs, and possibly greater levels of individual resources to access them.

The suggestions presented here are critical to improving the overall health of the care market and, although funding restrictions and efficiency drives at local level are a significant barrier to innovation, many can be implemented without a significant increase in resources. With commitment from local authorities, national government and the new care regulator, there is scope for the care sector to become more innovative and efficient in the shorter term. This will help the care system become "investment ready" before new resources are committed, though with a mind to the fact that these resources are nonetheless critical for its effective functioning.

<sup>49</sup> <http://www.guardian.co.uk/politics/2008/nov/12/immigration-policy-jobs-home-office>

## Project three – Local market shaping

### Aim of the project

This project explored the important concept of “market shaping” within the context of care for older people, and identified a range of tools that can be applied to effectively shape local care markets.

The agent with the most influence over market development in the current system is the local authority – their role as dominant purchaser and gatekeeper of state funding means the care market is actually a collection of many local markets, each with their own supply and demand characteristics. This project therefore examined the tools local authorities currently use to “shape” their local care markets, and considered whether other potential methods had been overlooked.

### Methodology

Desk research was combined with a series of interviews with local authorities, investigating their own market shaping strategies and their perceptions of the role more broadly. Expert groups convened in July and October were also asked to reflect on the concept of market shaping and comment on our research findings as a means of providing an alternative perspective on the local authority’s role as a “market shaper of the future”.

### Key Findings

As we explain in our discussion of the elements of a future architecture for care, care is a “social good”, and cannot be left to be delivered by the private market, but equally, cannot be provided by the state as a public service (due to the use of private resources to purchase care). Today’s consumers of care want some of the benefits that markets bring (such as choice, flexibility and value for money), but expect the state to ensure care is available to the most vulnerable, and of reasonable quality and price.

This requires some degree of market shaping. This function has an important role to play in a future architecture of care. At the most basic level, market shapers must deliver:

- 1) **Sufficient volume:** Enough services in an area for people to access care when they need it;
- 2) **Variety:** A mixed range of services to choose from so people can access the type of service that best meets their needs;
- 3) **Adequate quality:** Good quality services so that people can choose services freely, without worrying if they are sub-standard; and
- 4) **Affordability:** Affordable services, so people have real choice and are not priced out of the market.

### Challenges to market shaping

Market shaping implies a balance between efficiency and choice. In order for people to have a meaningful choice of care services, there needs to be sufficient volume and diversity to choose from: choice is not “real” if all of the care homes in a particular area are full, for example. However, maintaining spare capacity runs contrary to the principle of efficiency: maintaining several care homes at 70 per cent capacity (to ensure people can choose freely between them) is more wasteful than operating fewer care homes at 95 or 100 per cent capacity. A market with several small care providers may also be less efficient than one with a smaller number of large providers, but the former generates a more diverse range for people to choose from. In the current resource-constrained environment<sup>50</sup>, local authorities may well prioritise cost savings ahead of choice. Indeed, they are being actively encouraged, through the Gershon efficiency agenda, to take such decisions.

Another challenge is that markets cannot be shaped in a vacuum. External factors can have a strong influence on how the care market functions. The Gershon efficiency agenda is just one example of such a factor, which local authorities have little control over. Similarly, the national roll out of personal budgets – perhaps the largest single change to the care market in over a decade – is driven by the Government’s Putting People First reform agenda.

### Tools to shape care markets

We should bear in mind that regulation is a vital component which shapes the care market. The care regulator – currently CSCI but soon to be CQC, has a very important role to play in driving up quality in the sector. However, this paper examines local care markets and the tools available at a local level to actively influence the way the market operates. Within this context, market shapers have the following tools at their disposal:

1. Comprehensive market analysis – an analysis of the needs of all older people and whether supply is meeting those needs (in volume, type, quality or price) is a vital first step before any other market shaping tools can be applied.
2. Commissioning – outcome based commissioning, and commissioning beyond care and for the whole population, will help ensure the wider needs and wellbeing of all older people are met.
3. Purchasing – local authorities must consider how their purchasing strategies for state funded older people affect providers and self funders. This includes balancing spot and block contracting, zoning strategies, and issues of affordability and choice.

<sup>50</sup> 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. 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.



4. Sharing information with providers – It is vital that providers are included in the commissioning process, and that the comprehensive market analysis is shared with them to encourage them to spot emerging demands and niches in the market.
5. Providing services in-house – this is a direct but not particularly cost effective means of increasing supply. Local authorities may be faced with strong community opposition to outsourcing some services, but in residential care, leaseholds specifying the type of care to be provided by independent operator are an effective way of making efficiency gains in the operation of services whilst maintaining overall ownership.
6. Shaping on a larger scale – regional or cross-local authority market shaping may prove more in tune to the movements and choices of local populations, and can help providers achieve larger economies of scale.
7. Overcoming barriers to market entry and growth – this covers a variety of tools, including encouraging recruitment and retention, providing business support, overcoming planning barriers and tapping in to national pilots and funding schemes for care and wider regeneration. These are all vital in helping providers enter the market and remain financially sustainable but few local authorities have made effective use of them.
8. Improving the health of demand – supply can be stimulated by stimulating demand: improving information and advice services and “care intermediaries” can create better informed and more confident “care consumers”, who will provide better market signals for providers to respond to.

#### 1) Market analysis

Before any other market shaping tool is applied, market shapers need to have a clear picture of the existing market by carrying out a thorough analysis of local need and supply. It is only by mapping existing levels of volume, diversity, quality and affordability across the local market and establishing whether this meets local need (of all older people – including self-funders and informal care users), will a market shaper know which of the tools outlined below to apply, and where.

By speaking to care providers, voluntary organisations, older people and carers’ forums, and asking older people directly through, for example, questionnaires in libraries and GP surgeries, local authorities can gain a better idea of the needs of the wider older population, and how well these are currently being met. This level of “market mapping” is certainly a challenging undertaking, and will only be achieved by drawing on a range of different sources to supplement the data that local authorities may already have (as part of their Joint Strategic Needs Assessments, for example). Several organisations provide tools and services

to help with this, including the Older People Population Information (POPPI) tool, available from the DH’s CSED, as well as services provided by Dr Foster and Lang and Buisson.

A national minimum entitlement for a care and wellbeing assessment, part of the future care architecture, could also be a valuable means of collecting data regarding the needs and care choices of a large number of older people (as those claiming their entitlement might include self funders, and indeed, those who have no intention of using formal care at all).<sup>51</sup>

#### 2) Commissioning

Commissioning includes the purchasing of care, but is a quite distinct and broader concept. Local authorities have been accused of conflating the two terms, or being in “purchasing mode” when they should be thinking about the wider strategy of commissioning.<sup>52</sup> For the purposes of this paper, the DCLG definition of commissioning can be used<sup>53</sup>:

Commissioning refers to a series of interlinked processes, based on a robust analysis of needs in a defined area, that enable the purchasing of services that vulnerable people need in a timely, efficient and acceptable manner, at a quality and affordable price that meets stated minimum requirements. It involves developing policy, service models and delivery capability to meet the identified needs in the most appropriate and cost effective way; and then managing performance and seeking service improvement through parallel management of various relationships with providers and commissioning partners.

As such, commissioning involves employing a range of tools to a) ensure supply meets demand and b) maintain and encourage quality and affordability. Effective commissioning is therefore clearly a vital component of market shaping, though the latter remains a broader and more varied activity: one which includes the concept of “place shaping” and creating a local economic environment in which markets flourish, and which looks beyond care to other markets and related issues such as the local workforce and regeneration. To ensure commissioning is used effectively to shape the market, the following methods need to be considered:

*Intelligence based commissioning* – Commissioning decisions based on concrete evidence of levels of supply and demand (as a result of comprehensive market mapping, outlined above) improves the quality of commissioning by pinpointing shortages in the volume and type of care required in a given area. This ensures the right services are commissioned in the right locations to meet pockets of need.

<sup>51</sup> Expert Groups hosted by the Resolution Foundation, October 2008. A note summarising these discussions can be found at [www.resolutionfoundation.org](http://www.resolutionfoundation.org)

<sup>52</sup> Workshop discussions with domiciliary and residential care providers hosted by the Resolution Foundation, July 2008

<sup>53</sup> DCLG (2008) Needs Analysis, Commissioning and Procurement for Housing-Related Support: A resource for housing-related support, social care, and health commissioners



*Outcomes based commissioning* – Commissioning strategies working towards a clear set of outcomes improve the clarity of local decisions, gives providers a better steer on what needs to be achieved, and are more intuitive and valuable to care users and their families.

*Involving care users and providers in commissioning* – a fundamental prerequisite of outcome based commissioning is the involvement of older people and their families to help identify outcomes. Without this input, local authorities can only assume what older people find important to their quality of life.

*Commissioning for the whole population* – As explained above, local authorities must map their local markets to create a clear picture of the nature of local supply and demand for all older people, including self funders and informal care users. Commissioning for self funders will clearly not involve the direct purchasing of care, and as such, some local authorities may not recognise how else they might commission for those outside of the local authority system. There are in fact a number of ways local authorities can commission for all older people – for example:

- The capacity of domiciliary agencies operating in a given area can be assessed based on the entire population. Even if local authority contracts are being met in the area, the authority should ensure providers are not turning private clients away due to a lack of capacity.
- A high concentration of informal care users in a particular area could be investigated – it might be that there are no affordable day care services in the area for these people to use. If this were the case, the local authority might provide grants to third sector providers to help boost affordable provision in that area and meet some of the unmet need that would otherwise be masked by reliance on informal care.

*Commissioning beyond care* – Many older people are deemed ineligible for state funded care because their needs do not fall into the defined categories covered by traditional personal care services. Another way of commissioning for the wellbeing of all older people, therefore, is to commission services which fall outside traditional care provision. This includes community services (such as social and learning opportunities), as well as services which support and facilitate access to care (housing and transport).

### 3) Purchasing and contracting

Commissioning care is a wider and more complex activity than purchasing, in that it requires an understanding of supply and demand to ensure the former will meet the latter over the longer term. Nevertheless, purchasing care is still a critical part of this activity – it is an important tool to ensure

commissioning objectives are met. As the number of personal budget holders grows, it is likely that local authorities will purchase care directly from providers less often, though this is likely to be a gradual shift. In the meantime, the following approaches to purchasing ought to be adopted:

*Outcome based purchasing* – Outcome based purchasing, like outcome based commissioning, establishes the desired outcomes to be achieved rather than the inputs or processes required. This means basing a contract on a set of outcomes and leaving how these are achieved to the professional discretion of the provider. In relation to domiciliary care, this can also imply having a more flexible approach to the time set out to achieve them

As explained in the previous section regarding innovation and efficiency, this approach can help improve the flexibility of care provision. As regards the wider market, it can also help address tensions between choice and efficiency: giving providers more freedom to deliver flexible services can generate greater choice within care providers, thereby reducing the need for such a large choice between several providers (which can be inefficient).

*Balancing spot and block contracting* – Local authorities mainly use two types of contract when purchasing care: “block” contracting, where the local authority pays a provider for a block of services e.g. beds in a care home or hours from a home care provider, and “spot” contracting, where a contract is negotiated with a provider for an individual care user.

The advantage of block contracts is that they are more efficient – local authorities can achieve a better price for care as a bulk purchaser with aggregated block contracts. They also generate fewer contracts than spot purchases, thereby reducing administration costs for local authorities and care providers. Block contracts also provide more stability for providers, who can plan ahead, hire staff and develop services in the knowledge of guaranteed business and income.<sup>54</sup> On the other hand, block contracts are less flexible than spot contracts, and more likely to lead to a present “menu” of care options for local authority-funded individuals.

When purchasing care, therefore, local authorities need to balance the benefits and disadvantages of block and spot contracts, and consider the unintended consequences purchasing decisions can have on their wider commissioning strategies: for example, a block contract can achieve a low purchasing price for the local authority, but this might undermine the affordability of services for self-funders (due to cross subsidisation). At the same time, a sudden shift to large volumes of spot contracts may increase a provider’s administrative overheads and increase the costs to all of its clients.

<sup>54</sup> CSCI (2006) *Time to care?*

*Balancing the advantages and disadvantages of zoning* – To reduce contracting costs (and travelling costs within care fees), many local authorities sub-divide their area into a number of smaller geographical zones and purchase most of their domiciliary care from one preferred “zone provider”. However, using zones to shape the market may significantly reduce the diversity, volume and affordability of care. In the current market, around 80% of home care is purchased by the local authority. As the dominant purchaser in most areas, therefore, local authority contracts will provide the bulk (if not all) of some domiciliary care providers’ business. Having a preferred zone provider, taking all local authority business in a given area, may discourage other providers from operating in the same area (as they may only be able to compete for self-funders which, particularly in disadvantaged areas, could be a very small proportion of the potential market). This reduces choice for state funded and self-funded older people alike. Having only one provider in an area could also limit the range of services on offer as well as the quality – particularly if the monopolistic position of the zone provider makes them complacent to responding to different users’ needs.

Local authorities must carefully consider the implications of zoning, therefore, and balance this with the potential benefits zoning can bring: it can improve the affordability and quality of care, by reducing providers’ overheads (something state and self-funding older people should benefit from). It can also improve the diversity of the care market by making smaller providers more viable, by artificially creating a “micro market” for them to operate in (and not have to compete with larger providers who can potentially achieve lower prices in a larger market).

However, local authorities must also consider the argument that potential economies of scale can be achieved on a multiple local authority, or even regional scale. Zoning may achieve savings in travel costs and be suitable for small providers, but large providers may benefit more from a scaling up, not down, of their contracted areas. Purchasing from a small preferred zone provider and a larger area provider may be an effective compromise: this would create a diverse and “mixed” market of small and large providers, by creating market environments that favoured them both.

*Purchasing to drive up quality* – As the largest single purchaser of care in most parts of the country, local authorities have within their power the ability to drive a provider out of the market by cutting off all contracts with them. Seen more constructively, local authorities can use this purchasing power as a lever to drive improvements in the quality of services. The advent of CSCI’s star rating system for care providers has given local authorities the transparent and measurable quality ratings needed to award contracts, or higher fees, to better quality providers, and conversely, withdraw contracts from poorly rated ones. This can certainly incentivise providers to improve the quality of

their services, but there is a risk that by cutting off funding to poor performers, vicious circles of low quality/less funding will be created.

Whilst some may believe that adopting this “sink or swim” approach will ensure only the best quality providers survive, the care market is not a purely private market – it deals with often quite vulnerable people. It is important, therefore, that market shapers consider the impact on residents of care homes with poor quality ratings, which subsequently lose contracts or receive lower fees from local authorities in return. Financial decline is often a slow process – in the period preceding a home being driven from the market, there is likely to be a long period of poor quality care for residents (self funders and state funded alike), who might be unable or unwilling to move until its closure.

Local authorities must therefore consider how to encourage high quality provision, whilst taking into account the human cost of driving poor quality providers from the market. It may be possible to support poor quality providers, whilst also providing financial incentives and rewards for high quality providers, though this could prove a resource intensive strategy. As such, the decision whether to let care providers “sink” or support them in the market requires the consideration of a number of factors, such as a provider’s sustainability and capacity to improve (discussed in the “business support” section, below).

*Purchasing for diversity* – Local authorities can use their purchasing power to improve diversity (and therefore the range of care providers in the local area from which people can choose), by purchasing care from a range of different types of provider. This can help create a mixed market – a key element of a new care architecture. However, as there is a finite amount of care to be purchased by a local authority, a larger number of smaller contracts would be required to create a mixed market. The local authority might then decide to award contracts to: large and small providers; voluntary and private (for profit) providers; those with different specialities (e.g. catering to an ethnic or linguistic group or providing certain types of care); across a geographical spread, and so on, to meet as diverse a range of care needs as possible.

However, there arises a tension between efficiency and diversity. Purchasing only with efficiency in mind would prompt purchasing from a small number of large providers – to reduce overheads, and ensure the providers were able to make economies of scale and charge lower fees than their smaller competitors. This reduces the number of providers to choose from, and may threaten the viability of smaller and voluntary providers – a valuable source of innovation in the market.<sup>55</sup> Local authorities need to consider, therefore, whether optimum efficiency ought to be traded to help promote diversity in the market and support a wider mix of providers.

<sup>55</sup> See Resolution Foundation (2008) *Innovation and Efficiency in Care – discussion paper*

#### 4) Sharing information with providers

The tools outlined above to shape local markets each involve a clear role for a market “shaper”, whether that shaper is the local authority or some other agent in the future. However, the basic nature of markets (i.e. that supply responds to demand) means that the care market can be relied upon to “shape itself” to a certain extent: as long as demands are expressed clearly and supply is able to identify these signals and respond, then the market will help create its own levels of volume, diversity, quality and affordability.

Market shapers therefore have an important role in facilitating the effective communication between supply and demand, by improving the quality of information being collected regarding the functioning of the market, and ensuring providers have access to this information.

Sharing market intelligence from its comprehensive market analysis (see above) can help providers identify unmet need or opportunities to diversify or expand into niche markets. Sharing information can, therefore, stimulate both the volume and diversity of supply in specific areas to better match pockets of need. It could be argued that providers should carry out such market research as good business practice anyway – but many care providers are small and may not have the resources or capability to carry out this type of analysis. Market shapers therefore have an important function in supporting supply through their “intelligence gathering” role.

This strategy is also an effective way of encouraging providers to act in a more pro-active, responsive and adaptable way to new and changing demand. This type of skill, more prevalent in companies operating in private markets, is something which many care providers would benefit from developing. As the number of personal budget holders grows, and new generations of older people expect more personalised and responsive services, care providers will have to adopt a more pro-active approach to marketing their services to individuals, rather than relying on local authority contracts. Local authorities can help providers learn this valuable business skill whilst sparing them the considerable cost (relative to a small care agency’s budget) of carrying out their own market analysis. CSCI also points out that providers who are armed with solid business cases based on market analysis are more likely to attract investment from banks or private equity companies.<sup>56</sup> Local authorities would therefore also be encouraging inward investment into its local care market by acting as intelligence gatherer for providers.

#### 5) Providing services in-house

Another way of shaping local markets is for local authorities to simply provide care services themselves. This represents

a direct and instant way of changing the volume and types of care in an area, but there are a number of disadvantages to shaping a market directly in this way.

Firstly, providing services in house is almost always more costly than outsourcing them to the third and private sectors: CSED reported that the unit costs of domiciliary care are on average 76% higher when provided in house.<sup>57</sup> In-house services can also act as rival employers to the independent care sector, often offering better wages, terms and conditions.<sup>58</sup> Given that the overall shortage of staff can prove a significant obstacle to delivering sufficient affordable services in the care market, increasing in-house provision and a two-tier workforce is only likely to exacerbate this problem.

Nevertheless, many local authorities are still providing a range of in-house services, and some are adding to this with new build residential, and particularly extra care, facilities. This is not necessarily reticence on the part of the local authority to give up control of the care market, but rather, a result of public consultation. Many local authorities, in line with the good practice outlined above, consult care users and the wider community regarding how care services should be delivered, and have encountered strong community resistance to the council outsourcing services.

#### Underexplored market shaping tools

Many of the market shaping strategies outlined above are being used by different local authorities across the country. The Foundation, in its consultation with local authorities, care providers and groups of care experts have been able to synthesise these instances of good practice and demonstrate the variety of options that local authorities (and indeed, any “market shaper” in a future care system) could adopt to ensure the volume, diversity, affordability and quality of care for older people meets local needs.

There are, however, other market shaping methods which are less well utilised. Few local authorities have considered them as possible tools, and those who have are in the very early stages of development. They could, however, prove a valuable addition to the tools outlined above, particularly as some (e.g. purchasing) become less viable in the future. Local authorities and other market shapers should consider the potential of using the following tools more closely.

##### 1) Market shaping on a larger scale

Foremost amongst these under-explored strategies is the potential for an alternative “scale” of market shaping. In a future architecture for care, local authorities are likely to have a key shaping role, but alongside other market shapers at regional and national level. In some instances, shaping on a multi-authority or regional scale may be more effective:

<sup>56</sup> CSCI (2007) *Safe as houses - what drives investment in social care?*

<sup>57</sup> <http://www.csed.csp.org.uk/silo/files/sbtcos.pdf>

<sup>58</sup> Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York

- Older people and their families do not naturally live and work within local authority boundaries. Many older people may choose to move to a residential home in a different area, for example. This is particularly the case in London, where high property prices has led to a shortage of affordable care home places.<sup>59</sup> Therefore, local authorities cannot predict demand or ensure that the levels of supply within their boundaries will meet it, with total success.
- Some local care markets are too small for care providers to make effective economies of scale. Larger providers may secure several small contracts with neighbouring local authorities, but this is less cost effective than securing one large multi-authority or regional contract.
- We cannot discount the huge influence on local markets of regional and national activities. Unfortunately, the impact of these is uneven – those local authorities who have successfully bid for POPPs pilot status, for example, are likely to see their markets develop at a very different rate, and along a different trajectory, than those excluded from this first round of investment. There may be, therefore, the need for a strategic coordinating body at regional or even national level to aggregate the effects of such activities.

Thurrock Council has developed a draft model of a standardised regional contract for the East of England, and is currently leading an initiative to adopt this regional contract with ten local authorities. Coordinating the different working practices, contract lengths, terms and conditions and financial procedures of the ten partners is proving a challenge, but Thurrock is optimistic that soon all providers operating in the region will be given the same contract for local authority business. The coming together of performance and quality management procedures will mean less bureaucracy for local authorities, and may also improve the economies of scale of providers working in several neighbouring local authorities in the region.

Some local authorities already carry out joint purchasing of residential beds and other services with neighbouring authorities. However, multi-authority or regional activity to shape markets (i.e. beyond purchasing to the collation and sharing of regional market data, the planning of supply, and so on) remains relatively unexplored.

## 2) Overcoming barriers to market entry and growth

Another area which seems relatively under-explored by local authorities is the wide range of levers available for them to

facilitate market entry, and the subsequent growth and sustainability of care providers:

### Business support

Business and financial support are vital in a care market due to the nature of the sector: the majority of care providers in both the residential and domiciliary sectors are small, often family run organisations. These organisations are often established by former carers and so whilst their expertise in caring is excellent, the skills required to operate a viable business can be harder to come by. Yet business support from local authorities seems to be in short supply. 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>60</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 operating models and IT packages.<sup>61</sup> A lack of business skills across the sector may certainly be a contributory factor to the high turnover of care providers, a shortage of sustainable growth, and, as explained in the previous section, a lack of innovation and strategic development.<sup>62</sup>

During Oldham Council’s consultations with providers regarding commissioning strategies, some of the smaller providers told the council that they needed business advice, not care advice. As a result, the local authority is looking into providing business support loans in instances where banks (looking for a faster turnaround on their investment) may not be willing to lend to care providers.

Hartlepool reported to Hampshire County Council’s Commission of Inquiry that in place of a block contract, they had given a development loan to an organisation that provided a day centre for people with Alzheimer’s to set up new services. The loan would be paid back via reduced fees in contracts over time.

<sup>59</sup> King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

<sup>60</sup> King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

<sup>61</sup> Expert Groups hosted by the Resolution Foundation, July 2008. A note summarising these discussions can be found at [www.resolutionfoundation.org](http://www.resolutionfoundation.org)

<sup>62</sup> See Resolution Foundation (2008) *Innovation and Efficiency in Care – discussion paper*



Looking to other markets such as childcare, business and financial support from local authorities is conditional on the sustainability of the provider in question. Childcare market guidelines acknowledge that supporting providers that might otherwise be driven from the market essentially amounts to “market distortion.”<sup>63</sup> The Government suggests that direct financial intervention (essentially to prop up a failing provider) should only be used in exceptional circumstances – e.g., if the provider has suffered a rare financial shock, or if its exit from the market would have serious consequences for the sufficiency of childcare provision in a particular location or of a particular type.<sup>64</sup>

The same rules could certainly be applied to providing business and/or financial support to long-term care providers. On the one hand, local authorities must consider the consequences if a care provider is driven from the market, but on the other hand, they must recognise the risks of supporting struggling care providers indefinitely. Such a strategy can prove resource intensive, and can distort the market – maintaining a failing provider for the sake of providing continuity of care for older people may in fact prevent a new, more efficient and better quality provider from entering the market and better fulfilling these older people’s needs.

Local authorities must therefore consider a care provider’s ability to develop into maturity when providing support, and differentiate between support for a) one-off needs (such as training) to lead to self-sustainability and adaption to exceptional circumstances (such as a sudden financial shock or a shift in the nature of the market); and b) a systemic failure of a provider’s business model which would make it unsustainable without constant support.

### **Ensuring there are adequate staff in the market**

It is very difficult to ensure sufficient volume, quality, and diversity in a care market without considering the local care workforce required to deliver this care. A shortage of qualified care staff can prevent existing providers from growing to meet demand, and may even drive some providers from the market or discourage new providers from entering. Recruitment and retention are, in fact, key problems in the care sector. Providers report this acts as a barrier to their growth and diversification, and as a drain on their already limited resources.

Yet in spite of this, many local authorities do not consider tackling local staff shortages as part of their remit – outsourcing care provision to independent providers implies to many that they have also “outsourced” the recruitment and retention problem. It is certainly short sighted, however, not to consider how staff shortages might undermine the best-laid market shaping strategies. Helping care providers with recruitment and retention is clearly a central element of

the “business support” local authorities should provide. This support might take the form of promoting caring as a career, targeting school leavers in the area, recruitment drives, and advising providers of good practice regarding how they might improve staff morale and retention.

### **Promoting inward investment**

Although business support is a vital element of encouraging market entry and growth, it can prove costly. However, by helping providers tap in to some of the business support and funding available at regional and national level, local authorities can support the growth of the local market without significant investment on their part. This might include helping providers at a micro level to apply for national business support schemes, or at macro level where the authority might apply directly for schemes which require the alignment of local economic priorities with supporting the care market (see the following section).

Another important avenue of inward investment for care providers is, of course, banks and private equity firms. Local authorities can help providers, particularly smaller and voluntary sector providers, with the business skills necessary to secure such investment (e.g. the drafting of business plans based on comprehensive market analysis and projected income, and so on).

It is also important to consider that many care providers, and providers of low level services which support older people, are actually voluntary sector organisations. Market shapers could help improve the capacity and financial sustainability of these providers by identifying and supporting their applications to the large range of funding sources that exist to support the voluntary sector, including government schemes and grant making organisations such as the Big Lottery Fund and the DH’s Section 64 grants.<sup>65</sup>

### **Linking care supply with wider economic development plans**

Encouraging new providers in to a local area, supporting existing providers to grow and remain financially sustainable, and helping with the recruitment and retention of care staff are important factors in contributing to the overall economic health of a local authority. They may also help achieve a range of economic and regeneration objectives, such as: the growth of local businesses, increases in inward investment and local employment rates, improving local basic and adult skills levels, etc. Yet there seems to be very little linkage between shaping local care markets and the achievement of these wider economic development objectives. In a new care architecture, local authorities’ role of strategic oversight of local care markets must include linking care to other markets, services and wider priorities.

<sup>63</sup> Ibid

<sup>64</sup> Ibid

<sup>65</sup> <http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Section64grants/index.htm>



Mushkil Aasaan, a care agency in Wandsworth, improved its recruitment of local Asian women by offering English literacy training as part of the job package.<sup>66</sup> This initiative not only resolved a staffing shortage in this agency: it may have also improved the quality of care provided (as there were more staff able to speak the first language and offer culturally appropriate care for many of the older people looked after by the agency); helped reduce local unemployment (as unemployment rates among women in some Asian communities is very high); and improved basic skills levels in a community where English is not a first language.

The example above outlines the initiative of one care agency – however, such a coordinated approach should be adopted at a local authority (or indeed regional) level. By doing so, not only can a range of other agendas and priorities be met (local employment, adult skills training, regeneration and so on), but local authorities could also use this as a means of tapping in to existing sources of funding to help it provide business support to care providers (see above).

### Overcoming planning barriers

Although this is only a relevant issue in some areas, the difficulty in securing planning permission for new residential and extra care developments, and the length of time the process can take, can prove a significant barrier to the entry of new providers in to the market and discourage new investment. As a result, local authorities may encounter pockets of shortages in some areas, and quality and diversity of care may suffer if new facilities (i.e. offering new types of care such as extra care or telecare housing) cannot easily be built to replace or supplement existing traditional residential homes (which may no longer be fit for purpose and which may not be easily updated to meet new needs). An additional problem reported by Lang and Buisson is widespread confusion among extra care developers as to which planning category they fall in to: namely, whether extra care should be classed as a care home (planning category C2) or as a dwelling (category C3).<sup>67</sup>

In spite of these problems, facilitating market entry by smoothing local planning processes remains relatively under-explored by local authorities. For many authorities, this is because there is sufficient existing stock of residential homes, and so commissioning priorities focus on a shift away from residential to more preventive and domiciliary care. Nevertheless, the need for residential care for those with the greatest needs will always exist. The extra care

model, which combines independent home ownership (or rental) with on-site home care services and other communal facilities, is potentially a more flexible, personalised and cost efficient model, as it separates “hotel” from care costs. Yet Laing and Buisson question whether “this revolutionary model of care would fade away were it not for the continued level of government support”<sup>68</sup> in the light of the lack of private investment.<sup>69</sup> Laing and Buisson blame this lack of investment, in part, on planning difficulties. It is likely, therefore, that local authorities looking to expand their extra care provision will need to assist potential providers with planning processes if they hope to encourage developments to be built in their area as a more flexible alternative to traditional residential care models.

### 3) Securing national funding and pilot schemes

The national government already shapes local care markets to some extent through a variety of reform agendas and associated funding and pilot schemes. Some of these are applied universally, like the Transformation Agenda and national roll out of personal budgets, which are more or less beyond local authority control. However, many reforms are not automatically applied across the country: local authorities must often bid for funds or to become a pilot area for particular scheme. As such, local authorities can shape their local markets by seizing these opportunities and drawing additional funding and new programmes to their area. Those areas who have successfully applied for resources from the Department of Health Extra Care Housing Fund, for example, now have substantial additional resources to invest in building new extra care facilities in their areas, thereby improving the volume and diversity of residential care options in their local market (such as Barnsley Council, who secured nearly £3.8 million from the additional £80 million funding announced in 2008.<sup>70</sup>)

Due to budgetary pressures, North Yorkshire had to tighten eligibility for state funding to only those with FACS critical needs. The council subsequently re-evaluated its commissioning strategy and made a concerted attempt to remedy this – which included committing significant resources into ensuring they became a POPPs pilot area.

### 4) Ensuring healthy demand

Stimulating demand for care is an indirect way of stimulating supply – by supporting older people to make better care choices and have more confidence in expressing their needs, providers can respond by changing or expanding their services (contingent on them having the ability to be flexible and provided with business support, as explained above). Demand can be stimulated by:

<sup>66</sup> CSCI (2006) *Time to care?*

<sup>67</sup> Laing & Buisson, *Community Care Market News*, February 2008

<sup>68</sup> Laing & Buisson, *Community Care Market News*, August 2008

<sup>69</sup> [http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Housing/DH\\_083199](http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Housing/DH_083199)

<sup>70</sup> <http://news.bbc.co.uk/1/hi/uk/7516716.stm>

Providing information, advice, advocacy and brokerage

An important method of stimulating demand is to ensure older people and their families are “informed consumers” – i.e., that they know what services exist and what they are entitled to. This is particularly important in care markets, as the market itself is very complex; there is very little awareness among older people and their families regarding how the system works.<sup>71</sup> If local authorities could help older people and their families become better informed and more confident in dealing with the care market (i.e. actively choosing a provider to meet their needs and expressing their demands), supply would be stimulated in a number of ways:

- People would be aware of what was available – so demand and take up of services would increase, creating more business for suppliers.
- People would demand a more varied range of services, as they would better understand the role of the care system and would better be able to identify their needs. Suppliers would therefore have opportunities to expand and diversify.
- People would be able to express their demands more confidently, so suppliers would have better quality information (i.e. market data) to develop their businesses.
- With information and advice, people may become better prepared for their future care costs, thereby having more resources to spend on care when they need it.
- People would be able to hold suppliers to account more easily – by being able to identify poor quality service, and knowing how to complain or switch providers. This should help drive up quality in the market.

In addition, if local authorities commission information and advice on benefits and entitlements to promote their take up, they can help increase the disposable incomes of their local older population which in turn renders care services more affordable. This particular factor could have a significant impact – recent reports suggest 700,000 pensioners would be lifted out of poverty if they claimed all of the benefits they were entitled to.<sup>72</sup>

A range of options to create a navigation system for care, summarised above, includes local authorities acting as commissioner and coordinator of local advice services, to ensure all older people in the area can access the support they need. Local authorities’ role in commissioning or providing local first stop shops as part of a navigation service – central to the care architecture outlined above – is therefore compatible with them having an important market shaping role.

### Care intermediaries

As demand for and supply of care are often unable to communicate directly in the care market, demands may be

left unexpressed and unmet, and suppliers may be unable to identify demands (or respond to them even if they can be identified). This section outlines how many “intermediary” processes (such as commissioning and purchasing) can be improved, to ensure supply can more closely match demand; and how these intermediary functions can be supplemented by facilitating direct communication between supply and demand (e.g. through the provision of raw market data to suppliers, and the provision of better information and advice to people so that they can express their demand more clearly).

Furthermore, the future care architecture, outlined above, will help improve the transparency and simplicity of the system and create a healthier care market by ensuring supply and demand interact more effectively. Nevertheless, a number of future developments may generate a requirement for more formal mechanisms to ensure communication between the two:

- Current reforms are seeking to reframe social care into a broader concept of “care and support”. This implies the integration of a number of other related areas (such as housing, community and leisure services, etc.) which older people will have to deal with in order to secure a package of care to meet their needs.
- Relatedly, the increased number of care services likely to be available in the wake of reforms to provide more choice and personalisation will possibly serve to make the care market even more complex than it already is.
- A future funding settlement may possibly lead to the more frequent use of multiple funding sources (benefits, state funds and private funds) to purchase care, requiring a greater degree of expertise to coordinate and make the most of these resources.
- In the future there are likely to be larger numbers of: older people with complex care needs; the “very old”; and single older people (i.e. people without families to help them navigate the care system). These groups may lack the confidence or ability to express their demands and choose care effectively, even with the help of navigation services.

In the light of these factors, there may still be significant obstacles which prevent the direct interaction of providers and some groups of older people. One solution to this may be to adopt the approach developed by the financial services market – namely, the use of intermediaries which help match demands to the most appropriate suppliers. Independent Financial Advisers (IFAs) provide, for a fee, a service which begins with a thorough “fact find” of all of their client’s needs and wishes. The information is then used to put together a financial plan, with a portfolio of recommendations, including specific products to buy. The IFA then implements this plan, purchasing and investing on behalf of their client.

<sup>71</sup> Resolution Foundation (2008) *Lost: low earners and the elderly care market*

<sup>72</sup> Jenny Willott MP, Parliamentary Questions, 22 July 2008

The care equivalent of an IFA, a “care intermediary”, would combine many of the elements of roles that already exist in the care market – such as advisor, advocate and broker, but would add an element of direct representation and purchaser. So, for example, we might differentiate between a broker and an intermediary in that an intermediary would enlist the services of a local broker to provide payroll and CRB checks for their client hiring their own personal assistant.

Formalising these functions under a single representative would mean an older person and their family choosing to use an intermediary would have minimal interaction with the care market themselves, but would rather give detailed information, and develop a relationship with, a single interface (i.e. the intermediary) who would be trusted to create and implement a package of care by purchasing the best services available locally.

#### **An example of how a care intermediary might work**

An older person, Mrs X, currently needing help around the house goes to an intermediary to help organise her care.

The intermediary meets with Mrs X and her family (if appropriate), and asks them about:

- Her financial situation (e.g. level of assets and income and the benefits) to gain a picture of potential eligibility for state funding
- How much support Mrs X’s family currently provide and want to provide in the future
- Mrs X’s current care requirements, and the outcomes she hopes to achieve with a care and support package
- What she wants and expects for the future (e.g. 5 year horizon) regarding care and support services
- What she prioritises – such as: protecting Mrs X’s house, ensuring she is cared for by someone she knows, etc

This “fact find” is then laid out in a document, which Mrs X signs off so that she agrees with what was discussed and understands her position.

The intermediary then uses the fact find the set out a care plan – they identify that Mrs X is not eligible for state funded care, and owns her own home. She needs home adaptations in the immediate term, and a gardener. She also needs someone to help her out of bed during the week when her family are working. Based on these requirements, the intermediary then researches the care market, community and housing services available in the local area, in order to identify the best types of services and providers that would meet Mrs X’s needs.

*continued*

They then recommend courses of action, products and services to buy from specific providers in the immediate term, and suggestions for medium and longer term plans, such as:

- Naming a reputable local gardening service in the area
- Identifying the best care agency to meet Mrs X’s personal care needs
- Recommending Mrs X use the local authority’s home adaptation scheme
- Recommending a local Independent Financial Adviser so Mrs X can discuss how she might fund her future care needs

If Mrs X agrees with the plan, the care intermediary then implements it: contracting a gardener, establishing a care plan with the agency and arranging the necessary visits, and so on – acting as Mrs X’s representative to a range of different providers and the local authority.

There remain, however, a number of questions regarding this new role, including whether this would be a free or fee-paying service, and if it were the latter, whether this would be able to be integrated within a wider navigation service providing free information and advice. There is also a question regarding the breadth of the intermediary function: in the scenario above, the intermediary recommends Mrs X speak to an IFA to consider how she might fund her future care needs. It is possible, however, that intermediaries could recommend financial products directly. Evidence suggests that IFAs often do not recommend equity release and long-term care insurance, because they are not qualified to do this.<sup>73</sup> Care intermediaries could be specially trained to deliver advice on care related products – particularly if new products (e.g. state sponsored products) were developed as part of a future care architecture.<sup>74</sup> The drawback of such an approach is that this would mean care intermediaries would have to be accredited and regulated by the Financial Services Association – potentially increasing the costs of their services offered to older people.

<sup>73</sup> See Resolution Foundation (2008) *Funding care for older people – a discussion paper*

<sup>74</sup> Ibid

## Conclusions

As we explain in the first section of this report, care is a “social good”, which the state has a responsibility to provide (either directly or increasingly via financial contributions) to the most vulnerable in society, and those who cannot afford to buy it themselves. However, it is not a traditional public service which is delivered and managed by the state – it is delivered by a market of public, private and third sector organisations, and purchased by a combination of state and private funds. The “social market” of care, therefore, can neither be managed like a public service, nor given the freedom to function as a wholly private market (i.e. with levels of regulation and consumer protection afforded to other markets, but more or less free to develop according to market forces). Within this context, the function of “market shaping” – ensuring the care market delivers a choice of good quality and affordable care to all who need it – is critical in a future care architecture.

It is clear that the local authority has the largest number of levers at its disposal to shape current local markets. It is important, therefore, that local authorities consider the tools outlined above closely (particularly those which are underexplored) to make sure they are currently encouraging sufficient volume, diversity, affordability and quality in their local markets. However, a number of other market shapers already exist (including the care regulator and national government, but also grant-giving charitable bodies and private investors who can influence the care sector).

In the future, it is likely that the influence of these other market shapers will grow, and some of the tools available to the local authority (such as purchasing) may become less viable.

### How do the findings from this project relate to a new care architecture?

In a future care architecture, therefore, it is unlikely that there will be one market shaper, but rather a number of agents working together to influence the care market, including the local authority, regional government, national government, independent bodies and user led and community groups.

Exactly who will take primary responsibility for shaping care markets in the future can only be decided in conjunction with wider decisions regarding the roles and responsibilities of agents in a future care architecture. Most of the tools used to shape markets currently lie within the remit of the local authority, for example, but this may change as a new architecture is developed. Nevertheless, the following approach might be most compatible with a future care architecture as described in the first section of this report:

- The local authority’s role will change considerably, becoming a market shaper with strategic oversight of local care markets and how they interact with other related markets and public services at a local level
- The care and wellbeing assessment process will be a vital source of information on all older people and their carers’ needs to assist the local authority in its market oversight and analysis
- Other agents, such as regional bodies and national government, will also have an important role to play in shaping markets. Integrating their activities and other influencing factors will be an important responsibility for the local authority, through joint working with neighbouring local authorities and strategic development at regional level
- With more effective support for care consumers in a future architecture (e.g. through navigation services), service users themselves and local communities will also become key shapers of local care markets



## Project four: funding care for older people

### Aim of the research

It is estimated that public expenditure on long-term care in England in 2006/07 amounted to around £7.3 billion, while private expenditure was worth around £5.8 billion.<sup>75</sup> This level of spending is inadequate, resulting in some demand for formal care being met by informal supply, with associated economic and social consequences for carers, and some demand remaining unmet altogether.<sup>76</sup> It is clear that society needs to direct additional resources towards long-term care, particularly as demographic changes over the next 20 years are set to both increase demand for care and constrict supply of informal care. Expenditure needs to be considered within a fundamental new funding settlement which will tackle the unfair and inefficient distribution of resources which takes place under the existing funding system.<sup>77</sup> However, irrespective of the details of this settlement, it is likely that extra resources will need to come directly from individuals' paying for their own care and indirectly from individuals as taxpayers or national/social insurance contributors.

The aim of this project was to consider what collective and individual funding mechanisms would best allow society to meet the growing long-term care bill in the coming decades and what action the state and industry could take to improve the supply of, and demand for, such products. Options were evaluated in terms of their general adequacy, but with particular concern for their relevance to low earners: both today's potential long-term care users and tomorrow's.

### Methodology

This project built upon the Foundation's previous research into attitudes among the public, and low earners in particular, to the affordability of long-term care. A literature review was used to identify existing long-term care financing mechanisms in the UK and elsewhere, establish what market failures were in evidence in each instance and determine what corrective action financial providers and the state could take, including the introduction of new products. This work was supported by qualitative feedback from financial services experts in a series of group, panel and one-to-one sessions. The relevance to low earners of a number of options was further tested in focus groups.

### Key findings

The average annual cost of residential care in 2007 was around £28,000,<sup>78</sup> while an individual in receipt of ten hours

of domiciliary care each week might expect to face an annual bill of around £6,700.<sup>79</sup> Inadequate allocations of resources to long-term care mean that, in many areas of the country, it is primarily only those with both the highest level of need and the lowest level of personal resources who receive assistance with these costs. As a result, some individuals resort to selling their homes in order to finance even relatively low care needs, and so enter residential care prematurely. In addition, the low prices negotiated by resource-limited local authorities with care providers result in cross-subsidisation and higher prices for self-funders.<sup>80</sup>

In order to remove these inefficiencies and the inherent unfairness associated with inconsistently imposed eligibility criteria, we have concluded above that a minimum universal entitlement is required, with further expenditure being directed towards the most vulnerable members of society. The introduction of this model may require an increase in collective expenditure, either from general taxation or from the introduction of a new hypothecated fund. However, projected falls in the size of the working-age population relative to the older population and a general lack of appetite among the public for increased taxes mean that collective funding options will not be sufficient to provide an adequate level of care for all members of society. Direct funding by individuals will therefore also need to increase.

Differing care needs, resources, attitudes to risk and inclinations to plan mean that a single long term care funding mechanism that provides a "best-fit" for all individuals is likely to prove inadequate. Instead, development of a range of products that can exist alongside and complement each other will allow individuals to select the products most appropriate to their personal circumstances. We have identified three potentially mixed markets that could facilitate increased direct funding by individuals.

#### 1) Equity release

A sizeable number of older people are income-poor but asset-rich, with around 4.3 million people aged 65 and over estimated to be homeowners with inadequate retirement income.<sup>81</sup> The number of people falling into this income-poor, asset-rich category is expected to grow over the next 10-15 years: of those aged 50 or over who are yet to retire, 15.6 per cent are projected to have less than the amount required to secure Age Concern's Modest but Adequate retirement income despite having equivalised housing equity worth over £100,000.<sup>82</sup>

<sup>75</sup> NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2006-07*, February 2008, Table 2.1; CSCI, *Self-funded social care for older people: an analysis of eligibility, variations and future projections*, 29 January 2008, Table 2

<sup>76</sup> Resolution Foundation (2008), *A-Z: Mapping long-term care markets*

<sup>77</sup> *Ibid*; CSCI, *Self-funded social care for older people: an analysis of eligibility, variations and future projections*, 29 January 2008, Chapter 6

<sup>78</sup> Saga press release, "Final cost of long-term care predicted to double in 20 years", 11 Feb 2008

<sup>79</sup> Counsel + Care (2008), *Care Contradictions: putting people first? The harsh reality for older people, their families and carers of increasing charges and tightening criteria*

<sup>80</sup> Counsel and Care's National Survey of Local Authority Care Charging and Eligibility Criteria 2008, September 2008; NHS Information Centre, *Personal Social Services Survey of Home Care Users in England aged 65 and over, 2005-06*, 15 December 2006

<sup>81</sup> Resolution Foundation (2008), *A-Z: Mapping long-term care markets*

<sup>82</sup> The Actuarial Profession (2005), *Equity Release Report 2005*

<sup>82</sup> IPPR(2005), *Housing-Rich, Income-Poor: The potential of housing wealth in old age*



Equity release can allow income-poor, asset-rich individuals to access their illiquid savings and so potentially meet their long-term care costs without having to sell and move out of their home. However, although private products have been on the market for some time, take-up has been low and very few people have used equity release as a means of funding care.<sup>83</sup> This lack of interest can be explained by the presence of a number of market failures.

First, there is an apparent lack of trust in equity release among the public, amid concerns about value for money. Consumers' wariness is borne partly of concerns about losing their homes and leaving debts to their children, and partly of fear of compounded interest. These worries are reinforced by negative coverage in the media, with better than expected longevity meaning that equity release clients often face very large final repayments. The perceived reluctance of well-known high street providers to enter the market due to reputational issues further undermines confidence in the product.<sup>84</sup>

Secondly, access among homeowners is restricted, with individuals owning low value properties often being unable to secure equity because providers view the set-up costs as being too high relative to expected returns, especially in areas where housing is not expected to increase significantly in value.<sup>85</sup> Thirdly, the relatively large sizes of minimum initial drawdown, typically between £10,000 and £15,000, mean that many on low incomes are discouraged from accessing equity release because of the impact it could have on their eligibility for benefits.<sup>86</sup>

Fourthly, the complexity of some equity release products and the preference for face-to-face advice rather than over the telephone mean that the IFA and broker community has been reluctant to sell them.<sup>87</sup>

There is, however, some evidence of a softening in attitudes towards drawing down housing wealth in later life, particularly among younger cohorts.<sup>88</sup> By developing more flexible products and providing more assistance to brokers the equity release industry could correct a number of the supply-side failings. For example, lower initial advances would make the product more appealing to long-term care users in receipt of benefits. Capital-protection products and the development of hybrid mortgage and reversion products would also be likely to encourage individuals concerned about the prospect spending their children's inheritance. Products which offer a maintenance service might also be attractive to people with long-term care needs, particularly as they are less likely to be able to

maintain their properties themselves. At the same time, such a service would help preserve the value of the property for the equity release provider.

State support could remove further supply constraints by cutting the costs faced by providers and modifying the rules regarding benefit entitlement. For example, improved access to Money Guidance for individuals traditionally outside of IFA target groups could reduce the costs of advice associated with equity release, because a higher proportion of those approaching providers would already be "product-ready". Review of the benefits rules for those who use equity release to fund care services could also help overcome reluctance among brokers to advise such individuals to explore equity release.

The Government could also review the current level of regulation in the market. While visible regulation is beneficial for the reputation of equity release it imposes extra administrative costs for providers which are passed onto consumers, thereby making products less attractive. While removal of regulation would be likely to have a detrimental effect on demand, some relaxation might be possible without undermining the safety of consumers, particularly as the trade body SHIP already ensures stringent safeguards among its members' products. Regulation is tight in part because equity release is often seen as a "product of last resort" and is therefore purchased by clients in distress. Stimulation of the market and improved trust among potential clients could help to remove this label and so further reduce the need for such high levels of regulation.

In addition to reducing administrative costs, the state could consider making funding available to equity release providers on favourable terms or making equity release funds accessed to pay for long-term care subject to favourable taxation treatment. For example, the interest arising on equity release loans could be exempted from income assessment. Both approaches would allow equity release providers to reduce the rates of interest charged and so make the products more affordable. Any moves in this direction could be tied to conditions that providers work towards making smaller amounts available for initial drawdown and towards extending products and advice to owners of lower value properties.

Where supply-side failures mean that the private market will not function, even with support, the state can intervene more directly by providing its own low-cost alternatives, accessible to people in lower value homes and to those who want a small initial drawdown.

<sup>83</sup> Laing & Buisson (2007), *Care of Elderly People Market Survey 2007*

<sup>84</sup> CML (2008), *Please release me! A review of the equity release market in the UK, its potential and consumer expectations*

<sup>85</sup> Ibid

<sup>86</sup> JRF Product Working Group (2008), *Equity release: paying for additional help at home*

<sup>87</sup> The Actuarial Profession (2005), *Equity Release Report 2005*

<sup>88</sup> See for example JRF, *Attitudes to inheritance in Britain*, July 2005, p57-65 and Australian Housing and Urban Research Institute (AHURI) Research Report No. 088, *Ageing in place: intergenerational and intrafamilial housing transfers and shifts in later life*, October 2005, pp86-87,98

For example, reform of the deferred payments model to allow a charge to be made against the property of individuals who need domiciliary care and subsequent promotion of this option could avert premature entry into residential care for individuals who would otherwise need to sell their home. Other existing powers, such as those allowing local authorities to develop equity release loan vehicles to provide assistance for homeowners to fund repairs or improvements in their homes could also be built upon. Partnership between the public and private sectors could be promoted by centring on existing organisations such as Community Development Finance Institutions and the Home Improvement Trust.

The state could also design and introduce an equity release product specifically designed for income-poor, asset-rich individuals to fund potential care needs. For example, an easy to understand home reversion plan could be made available only to individuals looking to purchase care services or protection against care needs. Homeowners with no immediate care needs could sell up to 50 per cent equity or a maximum of £80,000 to the state-sponsored agency on the condition that they use the proceeds to purchase pre-funded long-term care insurance (LTCI). Homeowners who wished to fund domiciliary care/home modifications could sell between a minimum of 2 per cent equity and a maximum of 10 per cent equity or £15,000 each year they remain living in their home.

This product could be designed to run in tandem with the Government's affordable and social housing programmes. At death or permanent entrance into residential care, the agency could sell the property and take their share plus any deferred (interest free) administration charge. Alternatively, they could market the property as a shared-ownership home for people unable to otherwise join the property ladder or purchase the remainder and add the house to the social housing stock.

## 2) Long-term care insurance

The second market we have considered is the one for pre-funded long-term care insurance (LTCI). The risk-pooled approach afforded by this product represents a more efficient means of guarding against long-term care costs for all potential care users. In the absence of insurance, all individuals are subject to uncertainty and must therefore save or have access to sufficient funds to provide an acceptable level of care for the maximum possible duration of any care they might need. By pooling risk, insurance companies can use the law of large numbers to significantly reduce this uncertainty. Customers can therefore be charged a premium based on the average probability of their needing care and on the average duration of that care.

For example, if one in five people are assumed to require residential long-term care with an average duration of three years and a maximum duration of 20, at a cost of £28,000

each year, uninsured individuals must save an amount sufficient to provide care for the maximum duration: £560,000. In a sufficiently large insurance market, premiums take into account the probability of care and the average duration. Thus the typical customer is expected to need care for three-fifths of a year (1/5 probability of needing care for a duration of three years), meaning that their personal premium can be reduced to £16,800.

As with equity release, take-up has been low and a number of market failures are evident. First, providers face difficult pricing decisions. The probability of a long term care claim is generally higher than for more traditional insurable products and rapid increases in longevity mean there is significant uncertainty about the expected duration and size of payouts. Actuarial insurance products are designed on the basis of measurable risk and probability. To counter the uncertainty inherent in longevity projections, providers have tended to produce premiums that err on the side of caution and annual payouts that are capped. In addition, premiums are generally reviewable every five years, meaning that customers face escalating costs as they age.

Secondly, the market is subject to some adverse selection, with the average age of people taking out pre-funded policies being 67.<sup>89</sup> Insurers, concerned about the possibility of moral hazard, offer cover on the basis of tightly-specified criteria, such as failure of three activities of daily living (ADLs), rather than a more general "need for care". This can potentially leave some people facing long-term care costs being unable to claim against a LTCI policy.

Thirdly, individuals tend to underestimate the risk of needing to fund care, both because they choose not to consider the possibility and because, to the extent that they do consider it, they believe they will receive government support. As a result, the insurance products on offer appear unnecessary or overly expensive to many, as well as being long-term and complex. For many, LTCI simply appears to be out of reach because of their inability to afford the premiums from their liquid assets.

The withdrawal of all but two competitors from the market produces a fourth failing: IFAs prefer to provide a choice of at least three products when advising clients on options, and therefore will often choose to overlook LTCI offerings.<sup>90</sup>

Again, some of the supply-side issues could be corrected by insurers themselves. For example, providers could introduce dual pricing. LTCI premiums are relatively large because of the high potential payouts faced by insurers. If the risks of home care and residential care were split, then premiums could be significantly reduced. Policies could be offered that covered the need for domiciliary care at a relatively low price with individuals continuing to take the risk of needing residential care in the knowledge that they could sell their property in that eventuality and purchase an immediate needs annuity.

<sup>89</sup> JRF (2005), *Private funding mechanisms for long-term care*

<sup>90</sup> Conversation with Philip Brown, Head of Retirement & Care Product Development, Partnership

Alternatively, providers could seek to bundle LTCI with equity release so that individuals can obtain cover without facing any reduction in their day-to-day income. If provided by a single organisation, this bundling could result in reduced premiums due to the economies of scale involved and due to the payoff associated with the client entering residential care and so selling their home. There would again be scope for dual pricing. For reversion schemes, insurance for home care could be paid for at full cost, but insurance for residential care could be discounted to reflect the fact that the provider would receive a financial return at that point anyway following the sale of the property.

State support could further reduce costs to providers and therefore to consumers. As discussed, long-term care involves some measurable risks, but the uncertainty surrounding longevity cannot be modelled in the same way. By agreeing to take responsibility for longevity the state could allow insurers to concentrate on producing efficient risk-based prices. The state could undertake this approach in a number of ways.

For example, the Association of British Insurers (ABI) has proposed a co-payment model for individuals taking out LTCI. The state could agree to provide universal funding of a fixed proportion of the individual's care needs, based on an appropriate benchmark level of care subject to annual assessment, leaving the individual to insure against the remainder of their potential care costs. In all cases potential payouts would be reduced, meaning that premiums could also be reduced. Although premiums would probably be reviewable in most cases at first, an increase in the pool of clients could eventually allow for the introduction of guaranteed products.

Alternatively, the state could remove longevity uncertainty from the private sphere by introducing the limited-liability model described in the Wanless report and agreeing to take responsibility for funding the care of an individual after an initial period. Private liability would therefore be capped and insurance providers would enjoy greater certainty about costs and so be able to reduce their premiums. A reversal of this model, in which the state provides universal funding for a specified initial period before transferring the risk to the individual, would also reduce the payouts faced by insurance companies and so reduce premiums. However, the open-ended nature of this model would mean that insurance companies still faced considerable uncertainty about longevity, unless the state agreed to step in once again at a future point in the individual's care needs.

By lowering required premiums, the various risk-sharing proposals set out above could extend access to LTCI products. However, pre-funded options would be likely to remain the preserve of wealthier groups, with many low earners continuing to adopt a "wait and see" policy. In order to make LTCI attractive to income-poor, asset-rich individuals, the state may need to consider making more

direct provision. Just as private providers could consider bundling LTCI with equity release in order to reduce costs and extend access, so the state could provide a product which links the payment of premiums to the purchase of an equity stake.

The International Longevity Centre (ILC) has proposed an age-specific, income-based National Care Fund for the UK. Contributions to the proposed Fund would be sought from people aged 65 and over, thus preventing one cohort of individuals "paying twice". Enrolment would involve a one-off contribution fee at a level determined by an assessment of means, resulting in entitlement to a standard package of care paid for by the state. Crucially, participants would be given flexibility over how and when to pay their contribution, including out of their estate, with the contributions of people choosing to pay at a later date subject to inflation. As such, low earners with low levels of liquid resources but access to housing wealth would still be able to contribute and gain cover.

The poorest individuals would have their contributions met by the state, while an upper cap would ensure the wealthiest individuals do not have to make excessive contributions. The ILC believes that the Fund would require an average contribution of £10,000, although there would be a trade-off in the complexity of the means assessment used to determine individual contributions between administration costs and perceived fairness. As with the ABI co-payment proposal detailed above, the benefits of the Fund could be supplemented by a contribution from the state. Alternatively, the state could agree to fund a fixed proportion of an individual's determined contribution.

The *National Care Fund* is designed to be voluntary. Any move to a compulsory scheme would result in the scheme becoming a hypothecated tax rather than an insurance fund. However, in the absence of compulsion the *Fund* is likely to face similar issues of take-up to many private LTCI schemes, with many individuals opting out of paying a significant sum of money for an eventuality that may not happen. Given the good health enjoyed by most recent-retirees there may continue to be a tendency to underestimate the risk of needing care. Nevertheless, the option of delaying payment is likely to make the Fund a more attractive means of insuring against long-term care needs than most private policies for a large number of low-income high-wealth individuals.

### 3) Long-term saving

The third and final market we have looked at is the one for long-term savings products. Equity release may continue to be a sensible means of accessing funds for purchasing long-term care and associated insurance products in decades to come, but it is not a solution for everyone and may not be a sustainable option over time.

<sup>91</sup> Wanless Social Care Review (2006), *Securing Good Care for Older People: Taking a long-term view*

<sup>92</sup> ILC, *A National Care Fund for Long Term Care: A Policy Brief*, February 2008; ILC, *National Care Fund: Supplementary Paper One*, July 2008

Among the post-baby boomer generation, it is not clear what asset-holding will look like at retirement. A significant minority of older households are projected to have no access to housing assets, with the number of tenant households aged 60 and over estimated to increase from 2.6 million in 2006 to 3.0 million in 2026, representing one quarter of all older households. Even among the three-quarters who do own property, a number of factors mean that housing wealth gains may not be as great as those enjoyed by previous generations.<sup>93</sup> Access to the market is being delayed, with the average age of first-time buyers increasing from 29 in 1974 to 34 in 2007.<sup>94</sup> In addition, increasing family breakdowns mean that a growing number of people are “starting again” in the housing market in their 40s and 50s. Higher levels of personal debt among post-baby boomers also mean that a larger proportion may still have mortgaged property and outstanding debts when they reach retirement. Moreover, there is no guarantee that housing will continue to increase in value at the rates experienced since the middle of the twentieth century.

In contrast to equity release and LTCI, the market for long-term savings products is a mature one with significant take-up and competition between suppliers. Employers’ and private pensions, ISAs and other savings vehicles are highly visible and available to most members of society. Where the market fails is in relation to the amounts saved by many individuals and the failure to include any provision for potential long-term care costs. It has been calculated that society as a whole is saving £27 billion less every year in pension funds than is needed for a comfortable retirement, with the shift from defined benefit schemes to defined contribution ones adding another £5-6 billion to the problem each year.<sup>95</sup>

The situation is particularly serious for low earners. Work undertaken for the Foundation by McKinsey & Company in 2006 concluded that retirement income is a principle concern among low earners: 48 per cent of those aged over 40 and below retirement say they worry about not having “enough” income in retirement, compared with 33 per cent among a corresponding sample of the wider population. Just 53 per cent of low earners are members of an available employer’s pension scheme, compared with 81 per cent of those with higher incomes. Similarly, just 17 per cent of low earners have personal pensions, compared with 27 per cent of people with higher incomes.

Encouragement of long-term saving among those of working age, particularly low earners, will provide an alternative option for funding or topping-up care for all individuals in retirement and will help to guard against the

possibility that housing assets will not provide individuals with the means to fund their long-term care 30 or 40 years from now.

The Government is already making attempts to improve personal pension provision, through the introduction of auto-enrolment and personal accounts. Additional support could take the form of specific tax incentives at the point of saving and soft compulsion at the point of decumulation. For example, the level of tax relief associated with lump sum pension payments could be made conditional on a proportion of the fund being used to purchase some form of LTCI, while the state could promote the introduction of products that allow pensioners to take a reduced annuity at the start of retirement in return for an accelerated future income in the event of a need for care being established.<sup>96</sup>

### **Low earner attitudes to long-term care funding**

Concerted industry and state action could provide a comprehensive range of product options that co-exist and enable individuals with different care needs, resources, attitudes to risk and inclinations to plan to approach long-term care in a way that best suits them. However, our work with low earners suggests that the barriers to take-up of long-term care financing products are largely rooted in demand-side market failures. Individuals’ ignorance or unwillingness to consider the need for long-term care financial planning will need correcting if products are to be taken up: improved demand would be likely to stimulate supply better than improved supply would encourage demand.

While there was a pragmatic acceptance among participants of our low earner focus groups that long-term care funding needs to increase and that some of the options presented represent sensible products, there was considerable resistance to the idea that individuals should be required to fund their own care.

In general, there was low awareness of the realities people will face when they come to needing long-term care and very few said they had made any plans. There was a belief that the current system penalises people for saving and rewards those who live in the here-and-now rather than building up savings and there was a preference for collective funding, with many participants feeling they should be entitled to be looked after in their old age having paid National Insurance and tax all their lives. Other suggestions included introducing a new National Lottery game and holding a regular national fundraising event for older people much like Children in Need or Live Aid.

<sup>93</sup> CML (2008), *Prospects for UK housing wealth and inheritance*

<sup>94</sup> IFA Online, “Average first time buyer age reaches 34”, 10 August 2007

<sup>95</sup> The Actuarial Profession (2005), *Equity Release Report 2005*

<sup>96</sup> Wanless Social Care Review (2006), *Securing Good Care for Older People: Taking a long-term view*



Generally, views among home-owning low earners about equity release were mixed. Some reacted positively to the concept, particularly those without dependents. However, the attraction was largely related to the opportunity to provide for a comfortable early retirement rather than funding long-term care. Other participants were nervous about the concept of equity release. In particular, they expressed concern about taking on further debt at an advanced stage of life. Most participants were sceptical about the value for money offered by the schemes and were much more amenable to the idea of a state-run equity release scheme because they felt the profit motive would be removed. It was also felt that a government scheme would be more trustworthy than a financial provider product.

There was little appetite for LTCI. Premiums were considered too high, particularly as the potential reward of a place in a care home was not something that appealed. Reduced premiums would make LTCI more attractive, as would the option of using equity release to pay LTCI premiums. As with equity release, participants favoured the prospect of a state-run scheme. Again trust and cost issues were raised. In addition, people preferred a state-run scheme along the lines of the ILC's National Care Fund because customers could be charged on the basis of ability to pay rather than risk.

## Conclusions

It is clear that it is necessary but not sufficient for industry and the state to work towards spreading the availability of a mix of long-term care financing products by removing the supply-side failures currently evident in relation to equity release, LTCI and long-term saving. Demand also needs stimulating, however, and entrenched resistance to individual responsibility needs to be challenged. The state must take responsibility for ensuring that the reality of long-term care funding is communicated to the public with urgency and honesty. Working in tandem with financial service providers, who have an interest in increasing demands for their products, the state also has a duty to ensure that good quality, objective Money Guidance is provided that covers the full range of available products and allows individuals to select solutions most appropriate to their circumstances. Armed with this knowledge, individuals will then be better placed to take responsibility for their long-term care needs and plan appropriately.

Corrective action does not have to wait until a future funding settlement has been reached however. It is clear that any set of solutions will involve individuals accessing sources of private finance. Progress can be made in the short-term, while a national funding settlement does of course remain vital.

## How do the findings from this project relate to a new care architecture?

A new funding settlement is at the heart of a future architecture for care. Whatever the details of the architecture, it is inevitable that improvement to the system will require the allocation of additional resources.

The amount of additional funding required and the appropriate split between collective and individual sources will depend on the level of entitlement set out in the architecture and the political will for tax increases. Irrespective of the settlement arrived at, however, individuals will need to have access to products that enable them to access their own resources.

Suggestions here for corrective action to tackle the supply-side failures evident in the equity release, long-term care insurance and long-term saving markets can therefore be acted upon without delay. With support and intervention from the state, these markets can be revitalised to ensure that members of society at different generational stages and with different personal circumstances can access the products most appropriate to their needs.

Restricted supply is only part of the problem, however. Demand for financing options also needs stimulating. This research has highlighted the extent to which individuals remain ignorant of existing funding realities, resistant to an emphasis on individual responsibility and resentful of perceived inequities in the system. The future care architecture described in the first section of this report envisages a National Framework which will set out a universal minimum entitlement for all those over 65 and their carers and provide clarity over the roles and responsibilities of the state, the individual and their family. Presentation to the public of the "big picture" of a new architecture is vital to gaining buy-in and ensuring individuals take advantage of the financing options made available to plan appropriately for care.

## V – Conclusions and next steps

The aim of the Foundation's research was to create an architecture for a new care system which would be capable of creating a fairer and more efficient care market. This is important for a number of reasons:

- 1) The existing care market has a number of critical weaknesses which have a particularly significant impact on low earners (as those who tend to be self-funders, but whose low incomes make care costs a significant burden, and whose resources are difficult to access as they are mainly tied up in their homes).
- 2) The most effective way of delivering the Government's vision for care and support system which delivers choice, affordability and quality to all older people, whilst remaining financially sustainable, is via a well functioning market.
- 3) Reform of the care system is vital if it is to be "investment ready", i.e. able to make effective and efficient use of additional resources coming from a new funding settlement.

In developing this architecture, the Foundation has drawn together a number of important conclusions regarding its component parts:

### Elements of a future care architecture

- Many of the care market's weaknesses stem from a lack of clarity (for the public, care providers and local authorities). A new national framework, setting out the roles and responsibilities of everyone in the system, is therefore vital for a well functioning market
- A national minimum entitlement is required for all older people and their carers. This will provide clarity regarding what people should expect from the system, and encourage them to claim it
- The minimum entitlement ought to consist of a "care and wellbeing assessment" and free use of a new navigation service, as well as a minimum package of care and support
- The diverse needs and preference of older people, their carers and families can most effectively be met through a mixed market of care
- The care system can neither be managed like a public service, nor given the freedom to function as private market (i.e. with levels of regulation and consumer protection afforded to other markets, but more or less free to develop according to market forces). There is a vital role for market shaping in the future – an agent or agents who can ensure the care market delivers a choice of good quality and affordable care to all who need it
- The assessment of need should be divorced from a test of eligibility, by creating a new "care and wellbeing assessment", which everyone over the age of 65 and their carers are entitled to. Older people would be encouraged to have this assessment at regular intervals

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- A new navigation service must be a central component of a future care architecture, providing integrated support through local and national first stop shops
- Local variation of entitlement based on need ought to be replaced by a national benchmark, so that older people with similar needs will have them met, regardless of where they live
- A range of flexible and affordable products for individuals to fund their care will also help ensure more private investment into the market, reducing the burden on the Government, facilitated by support to ensure older people and their families are better informed of and prepared for care costs in later life

The architecture presented in this report, and the key findings from the Foundation's research projects looking in more depth at four of the architecture's principal elements, demonstrate that much can be done to improve how the current system works and achieve better outcomes for older people within existing resource constraints. The following steps for immediate action should be considered:

### Short term steps

- 1) Local authorities should grasp the challenge of market shaping, utilising the range of tools identified by the Foundation to improve volume, diversity, quality and affordability in local markets and start to adopt their new responsibility for strategic oversight. This can be done without the need for significant investment
- 2) A number of steps can be taken by local authorities, national government and the new regulator (CQC) to help support and provide the flexibility for the care sector to be more innovative and efficient, ahead of any additional resources that may flow into the market
- 3) A new, consistent model for a "first stop shop" navigation service at local level can be developed and spread, given that resources from the £520 million Transformation Fund have already been passed to local authorities for, among other things, improving their advice and information delivery
- 4) Individual funding options can be discussed between the government and the financial services industry, developing new private and state sponsored products in preparation of a new funding settlement

Nevertheless, to achieve longer term and permanent change, a number of further steps must be taken. These require challenging decisions to be made regarding the balance of responsibility between local and national government, and the resources available for a future care architecture balanced against other spending priorities:

*continued*

#### Longer term steps

- 1) **Agree a funding settlement:** define what will be publicly funded or subsidised, and what remains the responsibility of the individual
- 2) **Clarify what will be included in the national minimum entitlement:** progress towards universal care and well-being assessments and access to a navigation service can be made in the shorter term, but the package of care and support within this entitlement can only be determined in the light of the resources available (depending on a new funding settlement, above)
- 3) **Delegate roles and responsibilities:** of all strategic and delivery agents. This will require decisions to be made regarding the balance of responsibility between national and local government

In spite of these challenges, the architecture outlined above presents a range of opportunities for greater coordination and integration of its component parts, and with it, greater efficiency in its operation. More importantly, the creation of a fairer and more efficient care market as the architecture's primary outcome can help ensure that the system as a whole is "investment ready" – i.e., capable of using any increase in (government and private) investment to maximum effect. It is vital, therefore, that immediate steps are taken to improve the operation of the care market within existing resource constraints, to pave the way for a future funding settlement which can achieve the longer term transformation of the care and support system.

### Notes:

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