

Shaping care markets – a discussion paper

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Summary

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

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 left to manage itself like a private market. Within this context, there is a 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.

The current care market actually functions as a collection of local care markets, each with their own characteristics of supply and demand. These have developed according to local authority boundaries: local authorities currently have most influence over the supply, demand and price of care within their area. This situation is likely to change, however, as the roll out of personal budgets, increasing numbers of self funding older people, and in the longer term, the government's care reform agenda, changes the role of the local authority and the way in which the care market functions.

Therefore, this paper draws from current local authority good practice to identify a variety of tools that can be used to shape local markets, and could potentially be used by any market shaper(s) of the future. These include:

Market shaping tools:

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 commission 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 affordability and choice.
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.

Under-explored methods:

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.

The local authority should have a key role in shaping care markets of the future. However, given the diversity of tools available, it will be more effective if several agents – including the local authority, regional government, national government, independent bodies and user led and community groups – will all have a role to play in shaping local markets. There are also convincing arguments for market shaping to be carried out on a larger (i.e. at regional level) and smaller (i.e. community) scale.

The question of who will shape the market in the future must be taken in conjunction with wider questions regarding the future architecture of care and the delegation of roles and responsibilities of the various agents within that architecture.

We must bear in mind, however, that markets are often influenced by a range of external factors including other interrelated markets, as well as wider economic forces. As such, any market can only be “shaped” or influenced to a certain degree, and this function will always prove a challenge – the desired outcomes of market shapers of the future will often be curtailed by unpredictable and uncontrollable external factors. Nevertheless, market shaping remains a critical function in a market for a social good such as care. To be effective, therefore, market shapers of the future must seek to create an environment where care markets can “shape themselves” to achieve positive outcomes, rather than maintaining outdated strategies of attempting to impose direct control over market forces.

Introduction

The social care market

In *A to Z: Mapping long-term care markets*, the Resolution Foundation described¹ how the system of long-term care for older people operates as a mixed market of funding (coming from the state and the individual) and supply (with care provided by the state, private and third sectors). The market is mixed in this way mainly because care is a “social” good: i.e., something 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.

As such, the “social market” of care is quite different from a “private market”, supplying consumer goods. For example, the supply of care cannot be left to regulate itself with minimal state interference, as people need a “safety net” of state protection. Pure efficiency is also not desirable in a social market, as this needs to be balanced with fairness and equity. In this context, the state has a role to play to ensure that the market operates fairly, so that everyone, even the most vulnerable, can access good quality care at a reasonable price.

In *A to Z*, the Foundation also explained how the care market was highly localised – operating as a collection of individual markets with distinct characteristics of supply and demand. With this in mind, the local authority has an important role to play as an agent of the state to ensure the local care market within its boundaries is operating both fairly and efficiently.

Whilst the care market is a “social market”, and therefore requires a role for the state to ensure the fair delivery of the social good (i.e. care), the exact nature of this role can be highly variable. It could range from actively “managing” the market to ensure a set of social outcomes, through to simply creating the right economic and regulatory environment for a social market to flourish.

Our research

This report explores the range of tools available to local authorities (and potentially other agents in a future care and support system) to “shape” local markets to achieve better outcomes for older people and their families. This includes a number of tools which are being effectively used by some local authorities already, as well as some tools which remain under-explored. Before presenting these tools, the following section will describe the concept of a “market shaper”, why it is so important in care markets, and what outcomes “market shapers” should seek to achieve. 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 local level to actively influence the way the market operates.

What is an effectively shaped market?

¹ Based on analysis by Deloitte

As explained above, social care cannot be left to be delivered by the free market, but equally, cannot be provided by the state as a social good to passive recipients. 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 maintain care as a "social good": i.e. ensuring it is universally accessible and of reasonable quality and price.

This requires some degree of market shaping. A future "market shaper" has an important responsibility to ensure that the way they shape care markets deliver the best results for older people, their carers and families.

At the most basic level, care users and their families will need:

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

So, a well-shaped care market is likely to have many of the following elements:

Regarding supply:

- Care providers are supported to remain sustainable in the market and improve their services
- A wide range of different providers (large, small, voluntary and for profit, specialist and mainstream etc.) are actively encouraged
- Care providers are encouraged and rewarded for being flexible and responsive to older people's needs and reacting quickly to changes in demand and niches in the market
- Entry by new providers to meet niches and unmet demands is facilitated
- Care providers are helped to provide value for money services whilst remaining financially viable

Regarding demand:

- Care users, their carers and families 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 also helps support older people make choices (e.g. transport, housing, and mainstream services such as libraries and colleges)
- 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.

Some of these factors are addressed in more detail in other projects carried out by the Foundation – namely: encouraging innovation and efficiency in care supply; navigating the care system; and reviewing the vehicles for funding care.²

Why is market shaping important?

As explained above, care is a social good – as such, its delivery cannot be left to the free market with the associated risks this can bring; not least, the possibility that the most

² See Resolution Foundation (2008), *Navigating the way: the future care and well-being of older people*

vulnerable or poorest may not be able to access the services they need at a price they can afford. Therefore, shaping the care market is important primarily to maintain a degree of fairness. There are however a number of other reasons why this is important:

- 1) By shaping a market effectively, the range, quality and quantity of care available will meet the needs of the entire older population – local authority- and self funders alike. This will help support independence and choice, as well as achieve a range of wider goals, such as promoting wellbeing and inclusion.
- 2) This can also deliver efficiency gains: stimulating third and private sector care supply reduces the burden on local authorities to provide their care “in house”, and shaping a care market which focuses on keeping people in their homes and preventing intensive care needs can save resources in the longer term.
- 3) Market shaping can also deliver a range of economic benefits – such as bringing businesses in to the local area, creating local employment and improving adult skills.

Challenges to market shaping

Competing pressures of efficiency and choice.

In order for older people and their families to have a meaningful choice of care services in their area, 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. As Hampshire County Council’s Commission of Inquiry states, “For people in need of care and support, choice is only possible if the services they want to purchase are readily available, of good quality and have spare capacity to respond to that need. Local markets in many areas, particularly rural areas, still provide only limited choice to people.”³

However, maintaining spare capacity in any service (such as care homes or schools) 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.

There is a similar problem regarding diversity in the sector: a market with several small care providers (even at full capacity) may be less efficient than one with a smaller number of large providers – who are more likely to achieve economies of scale and possibly lower prices. From the local authority perspective, it therefore makes sense to contract with a smaller number of large providers, at high capacity. This can achieve lower administrative costs (by contracting with fewer providers), possibly lower fees, and fewer empty care beds or under-used care staff.

Unfortunately, creating a market such as this is likely to reduce the potential for user choice. Older people needing care will have fewer providers to choose from, and may find their first choice of provider too full to take their business. As Hampshire County Council’s Commission of Inquiry states: “In the case of residential care, the ‘cartelization of the market’ by a small number of large corporate providers means that being given an individual budget may be of little significance as the consumer has an increasingly more limited choice of provider.”⁴

³ Hampshire County Council Commission of Inquiry to help shape future services for people needing support and care: *Briefing Paper 7*, July 2008

⁴ Hampshire County Council Commission of Inquiry to help shape future services for people needing support and care: *Briefing Paper 7*, July 2008

Yet under pressure of resource-constraints⁵, local authorities may well favour cost savings at the expense of choice. Indeed, they are being actively encouraged, through the Gershon efficiency agenda, to take such decisions: the Care Services Efficiency Delivery Programme (CSED) recommends local authorities contract with as few providers as possible to lower administrative costs, and also discusses “zoning” of home care providers (i.e. assigning one provider to a geographical zone within the local authority to reduce travel costs across larger areas). This can significantly reduce people’s choice of provider.⁶ More worryingly, evidence suggests some local authorities may be actively distorting the market by preventing market entry, in order to keep costs low.⁷

Clearly, then, local authorities are faced with a difficult situation in attempting to deliver the government’s choice and personalisation agendas and the cost efficiencies as prescribed by Gershon simultaneously. As explained above, the former is not entirely compatible with the latter, and the discussion of effective market shaping below will need to take into account the pressures of this wider context if the suggestions made are to be practicable in the current social care market.

Looking to the future, a reformed care system may see reduced cost pressures if an effective joint funding system between the individual and the state is ushered in, making choice (i.e. spare capacity and diversity) easier to maintain in the system. Nevertheless, the imperative to make efficient use of public funds should and will never disappear entirely and, more importantly, one of the imperatives of a well shaped market is *affordability*. Increased user choice could imply increased prices, which in turn may limit user choice by making some options unaffordable.

As such, a well-shaped market must strike the optimum balance between choice and efficiency (and hence, choice and affordability) in order to deliver the sufficient choice to the greatest number of people.

One means of delivering choice, even in the face of current pressures to make efficiency savings, is by looking at choice differently. User choice need not be a choice *between* providers – often a great deal of choice and flexibility in care can be delivered *within* a single provider. If care providers are helped and encouraged to be flexible to meet a wide range of people’s needs, then only having one or two providers to choose from may not greatly inhibit choice. This approach may be particularly valuable in rural and isolated areas, where it is likely only a small number of providers may be serving a geographically dispersed population.

We should also bear in mind that choice and efficiency do not always have to be opposing forces. For example, local authorities commissioning care services from third and private sector providers, rather than providing it in-house, is both efficient and can deliver greater choice for older people. These and other methods of balancing the need for choice and affordability are discussed in more detail below.

Exogenous factors

We must bear in mind that markets cannot be shaped in a vacuum. External factors, such as the actions of other markets and agents, can have a strong influence on how the care

⁵ 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.

⁶ <http://www.csed.csip.org.uk/>

⁷ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

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.

In addition to national reform programmes, there are several other agents who currently influence current care markets:

- National government's pilots and accompanying funding can stimulate a form of provision or way of working unevenly across the country;
- Charitable grant making organisations can stimulate the capacity and sustainability of the third sector, who have a large role in providing care and related services;
- Investors in care businesses can change the structure of local care markets by creating new infrastructure and consolidating supply, often according to their own priorities and objectives.

It is clear, therefore, that there are in fact several “market shapers” already influencing local care markets, alongside local authorities. As we discuss later in this paper, the number of agents carrying out market shaping roles are likely to increase in the future.

Local markets for care – current context

In spite of the points made above regarding the influence of other market shapers, the local authority remains central to the functioning of the current care market. Its role as gatekeeper, planner and purchaser of care has created a situation whereby local authorities control many of the key features of the market environment – namely:

- Demand: by setting eligibility criteria for state funding and services, local authorities control people's access to state resources to purchase care. They can also influence levels of demand by controlling the price people have to pay for care (see next point). These both directly affect demand for care (as demand is both the need for care, and ability to purchase it).
- Price: local authorities are able to use their position as the dominant purchaser of care (i.e. the single largest purchaser of care beds and hours of home care) to set care home fees and hourly rates. They also set the prices of in-house community care services such as meals on wheels.
- Supply (both volume and type): by controlling demand, local authorities also influence supply. More directly, local authority contracts specify the *volume* of supply needed and care plans based on local authority needs assessments specify the *type* of care supply required.

As the local authority controls much of the market environment, it is no coincidence that the “care market” is in fact a collection of local markets with their own characteristics of demand and supply. Boundaries of local markets are actually demarcated by local authority boundaries, even though older people and their families' do not naturally make care choices within these boundaries, and care providers may achieve better economies of scale if they were able to supply services to populations larger than many of those managed by local authorities.

The future of care is where people increasingly plan and purchase care for themselves. This implies two potential new roles for local authorities: 1) supporting people to make their own choices, and 2) ensuring the market environment in which people do this can meet their needs.

A future market shaper

As explained above, people are increasingly planning and purchasing care for themselves. For local authorities, this implies a loss of ability to control the market environment (i.e. the way individuals access their care and what providers do in response). To ensure older people can access good quality and affordable care in this environment is a far more complex and challenging task, requiring a broad range of skills and a particular organisational culture. As such, a key question arises: whether the local authority is the most suitable agent to shape local markets, or whether this function might be more effectively discharged out on a regional or micro (e.g. community) scale.

This question can only be considered in conjunction with other decisions regarding the future architecture of the care system – in particular, which functions and responsibilities will be placed at community, local, regional and national level. The Foundation hosted a series of expert groups to discuss the future architecture of care in the light of the government's reform agenda, and whilst there was agreement that the local authority's role would change considerably, what exactly this new role might be remained the subject of much debate.⁸ It is possible, for example, that the postcode lottery of eligibility for care is judged unsustainable in a new care system. The assessment process and criteria on which this is based might be removed from local authority responsibility. If this were the case, local markets may become "regional" in scope and market shaping functions at regional level would be more appropriate.

This paper therefore assumes that local authorities will still have an important role in shaping local care markets in the future, and explores some of the tools available to them to discharge this role. However, the approaches outlined below could be employed by any market shaper or shapers in the future – whether they are single or groups of local authorities working together, community groups, or indeed regional or national government offices. This paper also considers the question of "scale" regarding certain market functions, and whether some might be more effectively discharged at a higher or lower level than the local authority.

Methodology

The Foundation has consulted a wide range of local authorities at different stages in their transformation from market "manager" to market shaper, to find out which tools they are finding effective. Current progress towards this new role remains patchy: some local authorities still tightly control many aspects of the local market (through "time and task" contracting of suppliers and a strict focus on price for example), whilst others are relatively uninformed regarding the local private market (the needs of self funders and how these are being met by existing providers) and provide little help to self funders in making care choices.

⁸ Expert Groups hosted by the Resolution Foundation, July 2008. A note summarising these discussions can be found at www.resolutionfoundation.org

As such, this paper also identifies some elements which are as yet relatively under-explored by local authorities as methods of shaping markets. Some of these methods have been drawn from market shaping practice in childcare, where the local authority has a more developed role as market shaper.

Shaping markets: some of the tools available

The following is a non exhaustive list of the range of tools that are available to local authorities to effectively shape local markets of care. The government's current care reform agenda and subsequent decisions regarding the roles and responsibilities of actors in a future care system will have a significant impact on which tools are still available to and effectively employed by the local authority, and which are more appropriately utilised elsewhere.

The following sections will make clear that market shaping is primarily a question of balance – tradeoffs between volume, diversity, affordability, quality and also market efficiency mean that there is no one perfect market for care, and subsequently, no one best method for shaping it. As such, market shapers of the future are likely to have to draw on each of the following strategies, and indeed others that have yet to emerge according to circumstances and priorities, in order to achieve the best outcomes for older people, their families and carers.

1) Comprehensive 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, will a market shaper know which of the tools outlined below to apply, and where.

The Foundation hosted a series of expert groups to discuss the future care market. During these discussions, it was strongly felt that the local authority ought to act as an “intelligence gatherer” of its local market. To achieve this, it would need to carry out a comprehensive analysis of the capacity, range, quality and affordability of existing care services in the local area, alongside a needs analysis of the entire older population. It was agreed that this analysis had to include both local authority-funded and self-funded older people. Even though collecting data regarding the needs and care choices of self funders is understandably much harder for local authorities, they can often make up a significant minority – and in many cases majority – of the local market. As we mention below, North Yorkshire is currently mapping how self funders in the area are currently using care services by talking to providers. Self funders in North Yorkshire make up around 50% of all older people – if the local authority did not carry out this assessment, the intelligence they had on the needs of older people, and local capacity to meet that need, would only be relevant to half of the population. The market shaping strategies they subsequently adopted might then only benefit this half.

As a relatively wealthy authority and an area popular with retired people moving from other parts of the country, around 50% of care users in North Yorkshire are self-funders. The local

authority is currently carrying out a piece of research to map the needs of these self funders by speaking to older people themselves as well as care providers to gain a picture of the types of services they use. Providers' sense of commercial confidence has meant some have been unwilling to share their market data with the local authority, even when the Independent Care Group (a group representing 60% of independent providers in North Yorkshire) has requested this on the council's behalf. Although progress has been slow, the council hope to have completed their "self funders map" by the end of the year.

In spite of this, very few councils collect even basic data regarding self funders: such as their number in their area,⁹ or details of their care choices or destinations (private care home, informal care, etc.) once they have been deemed ineligible for state funded care.¹⁰ This gap in intelligence will have steadily grown in most local authorities, as most have tightened their eligibility criteria for state funding and thereby increased the numbers of older people who must privately fund their own care.

An even harder group of older people to "track" are those who do not ever come to the local authority for help, and do not use formal care provision. It is estimated that around 70% of older people with care needs rely on informal care, and as such, are essentially invisible to the market. It is important, however, that local authorities make every endeavour to find out about this group and their (and importantly their carers') wider care and support needs. This is because whilst many older people using informal care do so by choice and never approach either the local authority or formal care providers, a proportion have been forced to rely on family and friends because the current market cannot meet their needs. Informal care users are, therefore, a valuable pool of information regarding unmet need, which can pinpoint gaps in the volume, type or affordability of care in the market.

By speaking to care providers, voluntary organisations, older people and carers' forums, and indeed 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 needs 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.

⁹ PSSRU (2007) *Self-funded social care for older people: an analysis of eligibility, variations and future projections* Discussion Paper 2505

¹⁰ CSCI (2007) *The State of Social Care 2006-07*

The North West Road Map, which supports commissioners of adult health and wellbeing services in local authorities and PCTs in the North West, identifies the following as possible sources of market map information¹¹:

- a) Written questionnaires to existing and potential service providers to gather basic information.
- b) Review of contracts, Service Level Agreements (SLAs) and grants from the local authority and the PCT.
- c) Mapping services by factors such as geographical area, level of need, gender, race or age.
- d) Finance and budget analysis and projection.
- e) A detailed analysis of the experience of a small sample of service users by tracking their journeys through the care pathway between different services, to identify the extent to which services have been successful in meeting their needs.
- f) Interviews and focus groups with key stakeholders to illicit information about their experience and perception of services.
- g) Interviews and focus groups with service users and carers about what services they would buy for themselves if they had access to an individual budget.
- h) Results of recent inspections, audits, complaints, self assessment and independent reviews.
- i) Patient/service user satisfaction questionnaires or summaries of regular service user feedback.

During the expert groups discussing a future care system hosted by the Foundation in October, it was also pointed out that if a national minimum entitlement for a care needs assessment became part of a future care architecture, then it would be possible for a future market shaper to have a more effective channel for collecting data regarding the needs and care choices of a larger number of older people (as those claiming their entitlement might include self funders and indeed those who have no intention of using formal care).¹²

However, creating a clear picture of the status of the current market is little more than an exercise in statistics gathering, if it is not then used to drive market shaping strategies. In particular, this market intelligence must:

- Act as the basis for evidence-led commissioning strategies
- Be shared with providers

2) Commissioning

The government's *World Class Commissioning* agenda is seeking to drive change in the way local authorities commission care, by developing guidance and a set of competencies to enable PCTs, SHAs and local authorities to become "world class commissioners". A key objective of this programme is to ensure the joint commissioning of health and social care

¹¹ <http://www.northwestroadmap.org.uk/index.php?pageNo=420>

¹² Expert Groups hosted by the Resolution Foundation, October 2008. A note summarising these discussions can be found at www.resolutionfoundation.org

services, but also to help deliver choice, control and personalisation via commissioning decisions.¹³

In this context, 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.¹⁴ For the purposes of this paper, the DCLG definition of commissioning can be used¹⁵:

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 mapping supply and demand, and 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 the issue of workforce and regeneration.

Local authorities are applying a range of methods within their commissioning strategies to shape their local markets to deliver volume, diversity, quality and affordability of care. These include:

a) *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 in several ways:

- Pinpointing shortages in the volume and type of care required in a given area ensures the *right* services are commissioned in the *right* locations to meet pockets of need. This is the most effective way of matching supply to demand and eliminating unmet need in the market.
- This approach is also more cost effective: excess care, or the wrong type of care in an area, can lead to empty care home beds for example, or providers struggling to survive.
- Commissioning based on the requirements of self funders *and* local authority funded older people ensures the needs of the wider older population are catered for (e.g., local authorities might commission a new home care provider to meet the needs of state funded older people in an area, but must ensure the provider they commission has enough capacity to fulfil the needs of privately paying older people in the area too).

¹³ <http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Vision/index.htm>

¹⁴ Workshop discussions with domiciliary and residential care providers hosted by the Resolution Foundation, July 2008

¹⁵ DCLG (2008) *Needs Analysis, Commissioning and Procurement for Housing-Related Support: A resource for housing-related support, social care, and health commissioners*

Hertfordshire

Hertfordshire has mapped accommodation (including residential homes, sheltered and extra care housing) available for older people across the local authority to identify where supply was not meeting demand. Hertfordshire uses this data to directly influence their commissioning decisions and type of contract with providers.

North Yorkshire's 2007 commissioning strategy contains the following:

- a. Population needs analyses for older people, people with a learning disability, those with mental health problems, those with a physical or sensory impairment and carers
- b. A preliminary analysis of the provider market
- c. What service users expect from care services
- d. Analysis of the social care workforce

b) Outcomes based commissioning

Studies by CSCI and SCIE have found many local authorities focus on inputs and processes when commissioning care services – for example considering the number of beds and the number of hours of care local populations will need.^{16 17}

This assessment is important in order to carry out an analysis of local capacity and, from a local authority purchasing point of view, helps with budgetary control. Nevertheless, critics argue that more effective commissioning strategies would be achieved if authorities were also to identify the desirable *outcomes* for the local older population and their families and use the achievement of these as the overall objective of commissioning strategies.

“A preoccupation on the part of many organisations with structures and processes means that structural barriers to change persist, with the result that the commissioning system is focused principally on *inputs* rather than *outcomes* for people. A tendency for organisations and the people working in them to be bound by structures means that the ‘life-needs’ of people who use and rely on services are overlooked. Focusing on outcomes rather than structures will mean shifting from a system where care is rationed to one that is genuinely needs-led.”¹⁸

There are a number of benefits to this approach:

- Identifying outcomes for the local older population gives a clear vision and statement of purpose for providers to work towards. As the Foundation’s research shows, setting outcomes for providers and allowing greater discretion over the “how” these are achieved can encourage greater innovation and efficiency in delivery.¹⁹
- Greater provider flexibility allows for more flexible and personalised services for older people to achieve outcomes, thereby improving the overall quality of care.

¹⁶ CSCI (2006) *Relentless optimism - creative commissioning for personalised care*

¹⁷ Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York and Ibid

¹⁸ CSCI (2006) *Relentless optimism - creative commissioning for personalised care*

¹⁹ See Resolution Foundation (2008) *Innovation and Efficiency in Care Supply – discussion paper*

- Outcomes are also more relevant to older people and their families (an older person is unlikely to say “I want two hours of personal care per day” but rather “I want to be able to sit in the garden.”. By listening to what older people want in terms of outcomes, services are likely to be far more effectively designed to meet actual needs.
- Outcomes can also encourage older people to gain independence and do more things for themselves, rather than maintaining existing levels of dependence.
- Outcomes based commissioning can also improve relations between providers and local authorities, and improve staff morale. PSRU found home care staff were demoralised by the way in which care was commissioned to focus on the amount of time spent with older people, rather than on carrying out tasks older people actually wanted.²⁰ CSCI also found input and output led commissioning and the wrangling over fees which accompanied this approach had undermined levels of trust and hampered constructive communications between the local authority and care providers.²¹
- Outcomes identified by older people are unlikely to focus on care alone, but rather include wider quality of life objectives. As such, outcomes can also give a clearer direction to local authorities regarding their housing, transport, leisure and other priorities, which must be part of a more holistic commissioning strategy to improve people’s wellbeing.

We must bear in mind that outcomes-based commissioning is an individualised concept – each person’s desired outcomes will be different. However, the outcomes expressed at an individual level can be recorded and aggregated, and applied at macro level. For example, the choices older people make when given more control using a personal budget can act as a guide for local authorities commissioning services for those who do not have access to, or want, personal budgets, as well as self funders.

c) 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. CSCI states: “the views and aspirations of people who use services are not yet at the heart of commissioning services for individuals. Councils need to pay more attention to what people say about the qualities that are important to them in the services they receive.”²² However, a growing number of local authorities are placing the individual user at the centre of the process when commissioning care at an individual level. This is a natural consequence of the increased use of personal budgets, which requires a self-assessment of need and user-planned care packages (with social worker support).

An extract from a paper written in 2006 by John Dixon, Director of Social and Caring Services, West Sussex County Council, for CSCI

²⁰ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

²¹ CSCI (2006) *Time to care?*

²² CSCI (2006) *Relentless optimism - creative commissioning for personalised care*

Under the traditional approach to commissioning, a council undertakes an analysis of a person's needs according to tightly defined criteria, develops a commissioning plan, and agrees block contracts with large providers. (Councils seem to be more comfortable when dealing with other large organisations.) People get 'matched' to a limited range of existing services – typically residential care, home care or day care – rather than services being developed or adapted to meet people's individual needs.

Commissioning does not have to look like that. In West Sussex, one of the Individual Budget pilot sites, the traditional commissioning model is being replaced by 'self-directed support'. Under the new approach, a person needing care does an assessment of their own needs, often through a web-based tool. The services they need are then worked out through a Resource Allocation System (RAS) and a system of support brokerage. Once the council has confirmed an individual's choices, people can then construct their own care package. People can choose a range of services that may bear no relation to the traditional 'menu'; they can design their own circle of support.

*"If what people choose is not what councils offer, councils and independent providers may not survive – the lesson is change or die."*²³

However, this approach has its limitations – firstly, self directed support will only be a reality for those with personal budgets – i.e., local authority funded older people. Self funders may not have their voices heard in the same way. Secondly, this process involves older people *at an individual level*. In order to commission effectively for the entire population, local authorities need to involve older people at a macro level too.

In addition to setting outcomes, all aspects of commissioning require the involvement of care providers and users. Without this involvement, commissioning strategies may be less likely to meet the needs of the local population, but also less likely to resonate with the realities of the local care market (for example, providers would be able to advise authorities if their commissioning plans were feasible in the light of shortages, and how plans might need adapting to make up for or remedy such problems).

Warrington

Warrington council has a provider forum, which meets regularly (at least quarterly) to discuss and monitor the council's contracting and commissioning strategy. Social workers visiting care users' homes also feed back information to the forum so that providers and the council can work out how to better meet users' needs. This gives providers "buy in" to the council's commissioning strategy, with an opportunity to suggest how better to meet the council's objectives.²⁴

d) 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

²³ CSCI (2006) *Relentless optimism - creative commissioning for personalised care*

²⁴ Community Care magazine, 10/07/08

informal care users. Without this information, local authorities will only gain a partial picture of the needs of the population, and whether current supply is meeting those needs. By using a needs analysis of the entire older population as a basis for a commissioning strategy, local authorities can ensure that the needs of self funders and informal care users (and indeed, their carers) are met. As CSCI states: “councils need to commission services for all those living within their boundaries, including those who pay for their own care and those whose voice is not heard.”²⁵

However, commissioning for self funders will clearly not involve the direct purchasing of care, and as such, some local authorities who conflate “commissioning” with “purchasing” do not recognise how else they might commission for those outside of the local authority system. As the SPRU found: “LA commissioning managers had little knowledge of the private market for domiciliary care. They did not see how they could use their LA commissioning role to ensure sufficient capacity for private clients.”²⁶

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 (i.e. self funding and state funded) population. Even if *local authority* contracts are being met in the area, the authority should ask providers if they are turning private clients away due to a lack of capacity. The scale of unmet need can be estimated and a new provider might need to be encouraged to come in to the area, or existing ones encouraged to expand.
- 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. Indeed, even if no clear unmet need was identified, the local authority might look into whether there were sufficient respite services in the area.
- Improving the social inclusion of all older people, whether care users or not, by “age proofing” public spaces and community services.

e) *Commissioning beyond care*

Many self funders and informal care users may have been deemed ineligible for state funded care because their needs did not fall into the defined categories which could be served 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.

Local authorities should also bear in mind that:

1. Few older people talk about their “personal care needs”, but rather a wider set of outcomes that improves their quality of life. Local authorities cannot focus on a narrow set of care services (i.e. residential and home care) when considering how to shape the market, as people’s actual needs will only be partially met.
2. The sufficiency of care supply can only be improved if the wider local infrastructure (e.g. housing and transport) supports it.

²⁵ *Commissioning – Getting it Right for Everyone*: ECCA/ Pavilion conference 1 June 2006 ‘CSCI’s role in improving commissioning’

²⁶ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

As such, local authorities cannot effectively shape the care market without also commissioning to meet a broader definition of care needs, as well as a range of related “supporting” services which enables better access to and use of care services.

As local authorities tighten their eligibility criteria in response to budgetary constraints, only those older people with significant care needs are given state support.²⁷ Local authorities therefore spend much of their time purchasing intensive domiciliary care packages, or residential care places, for state funded older people. Evidence suggests this is, over the long term, less cost effective than investing in lower level care services (such as home help, adaptations, and leisure), which can postpone or even prevent the need for more costly intensive care packages. It can be challenging, however, for local authorities to reverse this vicious circle and re-invest in lower level care services when their budgets are so constrained.

North Yorkshire re-evaluated its commissioning strategy when, due to budgetary pressures, the decision was made to tighten eligibility for state funding to only those with FACS critical needs. Realising its existing model of delivering care was no longer tenable, the authority looked for a way out of the vicious circle of higher needs/higher costs. The council made the controversial decision to invest £500,000 in preventative services whilst only providing FACS critical care. It gave the local Age Concern the responsibility of jointly commissioning lower level services in areas across the authority. They also committed significant resources into ensuring they became a POPPs pilot area. The effort paid off, as North Yorkshire has recently shifted to FACS low/moderate.

Yet it is this wider range of low level services which are likely to have the most significant impact on older peoples’ quality of life, by promoting independence and social inclusion. Some local authorities have opted to use their local voluntary sector as a means of increasing these types of lower level services. Some commission these services directly, whilst others opt to invest in the sector to boost capacity and allow provision of services to develop by themselves:

Oldham Council have given contracts to Age Concern and the Red Cross to provide 220,000 older people with lower level services (such as shopping and befriending) and has an active strategy of “pump priming” voluntary sector services available to improve older people’s wellbeing.

Oxfordshire County Council in partnership with the local PCT and NHS Partnership Trust, purchase a ‘Flexible Care Service’ from Age Concern Oxfordshire. The service offers a programme of therapeutic interventions for older people with mental health problems.

In Hampshire the Adult Services Department also administers approximately 70 grants worth around £600,000 a year to support voluntary and community groups who are not contracted to the Council but provide services, projects or activities for people in Hampshire that match the priorities of the Department. In the past these have included lunch clubs, information and advocacy services, day centres for older people and transport services.

²⁷ CSCI found that 73% of councils are operating at FACS substantial/critical, meaning only those with the most serious care needs are eligible for state funded care (not including means testing)

However, local authorities can also commission a wide range of services for older people without substantial investment – for example, by ensuring that existing mainstream community services (leisure, sports and social classes) are accessible to older people and provide sufficient services to meet older people's needs and interests. This may include training staff, ensuring there is basic equipment, teaching smaller and slower paced groups, or simply marketing to older people to attend specific sessions so they can join in with other people their age.²⁸

Also, and as CSCI points out, “The council, as commissioner, is responsible for ensuring a sufficiency of supply of care and support services to meet people's needs in the area they serve. The council may contract some of these services, but many – in some councils the majority – *will be bought directly by individual people*.”²⁹ Therefore, local authorities can also stimulate the supply of lower level services by ensuring that their local economies in general are conducive for new businesses to enter the private market and meet older people's needs, whether that be a new handyman service, or a dancing school, as well as for existing businesses to grow and diversify. Improving the business environment is also a key priority of local economic and regeneration strategies – an issue discussed in more detail below.

In addition to commissioning a wider range of services to improve older people's wellbeing, local authorities must also consider, when commissioning care services, older people's ability to access and use them. As Hampshire County Council's Commission of Inquiry stated, local authorities had to face the challenge of “ensuring incentives exist for quality and diversity in provision, and developing sufficient infrastructure (e.g. transport) so that choice and empowerment are tangible realities rather than meaningless rhetoric.”³⁰ Basic logistical difficulties – such as a lack of transport for older people to access community services – have the potential to critically undermine commissioning strategies. A lack of public transport, particularly in rural areas, can lead to social isolation and the inability to access day care services, leisure opportunities and health services. It can also increase the costs of care services for older people, as transport costs are passed to the care user and more services (that might otherwise be delivered in community centres) must charge for home visits instead. As such, market shapers must consider not only the health of care *supply*, but also the viability of *demand*. This requires raising awareness³¹ and promoting the use of, and facilitating access to services. There is little benefit in achieving a diverse and affordable range of high quality care services if older people cannot access them.

Camden Council campaigned on behalf of its older residents for Transport for London (TfL) to “age proof” its bus services. The council also invested in a pool of 50 personal mobility vehicles, such as electric wheelchairs and scooters, for use by older residents. A recent evaluation demonstrated a number of benefits: being able to shop independently and have more choice in shopping options; visiting family and friends (being the visitor rather than the visited); resuming use of leisure and cultural facilities in the borough; resuming social contacts in the community, and contribute as a member of the community; the ability to travel independently to hospital and GP appointments; and reduced pressure on carers and family members.³²

²⁸ These and similar recommendations were made in Audit Commission (2008) *Don't Stop Me Now: Preparing for an ageing population*

²⁹ CSCI (2006) *Relentless optimism - creative commissioning for personalised care*

³⁰ Hampshire County Council Commission of Inquiry to help shape future services for people needing support and care: *Briefing Paper 7*, July 2008

³¹ An issue discussed below

³² Audit Commission (2008) *Don't Stop Me Now: Preparing for an ageing population*

Another critical factor is ensuring the local housing market can support older people staying in their homes independently for longer, as recommended by the *Lifetime Homes, Lifetime Neighbourhoods* strategy.³³ The targets laid out in this strategy to “future proof” housing stock should go a long way to ensuring homes can be more easily adapted to meet people’s changing needs, and domiciliary care can be delivered more easily to larger numbers of older people who might otherwise have to go into residential care. In the short term, however, market shapers need to consider the commissioning of telecare, home adaptation and handyman services to support people staying in their homes for longer.

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 and forward planning to ensure the former will meet the latter over the longer term. Nevertheless, the purchasing of care is still a critical part of this activity – it is an important tool to ensure commissioning objectives are met, particularly for state-funded older people.

As the numbers of personal budget holders grows, however, it is likely that local authorities will purchase care directly from providers less frequently. Nevertheless, this is likely to be a gradual shift, and in the current system, the local authority still purchases care on behalf of the vast majority of state funded older people. Furthermore, there are still likely to be a number of older people who do not want the implied responsibility of managing their personal budget, and will prefer their local authority to purchase and plan their care on their behalf.

As such, local authorities’ purchasing practices currently have a significant impact on how local markets of care develop, and will continue to do so (though perhaps to a lesser degree) in the future. Local authorities’ focus on inputs and processes when commissioning care is also prevalent in purchasing. A significant body of research demonstrates that input based and cost focused purchasing has had a number of adverse consequences regarding the volume, diversity, quality and affordability of care in the market:

- “Time and task” contracts and care plans in domiciliary care can undermine the **quality** and flexibility (and subsequently **diversity**) of care provided to state funded older people, as care workers are only contracted to carry out a set of pre-determined tasks in a set time period (which can be specified as 15 minute, or even one minute, blocks). Many providers and care users report this means carers are often rushed, and unable to respond to people’s needs or changes in conditions.³⁴
- A focus on keeping prices low in both domiciliary and residential care can lead to lower **quality** of care, and recruitment problems for providers unable to pay more than minimum wage to staff.³⁵ Some providers report that pressure to win contracts by cutting costs means they cannot always afford to recruit sufficient staff to subsequently deliver the contract.³⁶

³³ DCLG (2008) *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*

³⁴ CSCI (2006) *Time to care?* And Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

³⁵ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

³⁶ Ibid

- Local authorities' pursuit of low prices in their own contract can potentially price self funders out of the market. This is because both residential and domiciliary care providers charge private clients more in order to cross subsidise the shortfall in local authority paid fees.³⁷ Local authorities' quest for "affordability" for their own contracts can therefore undermine **affordability** for self funders.
- Local authority contracts can also affect the availability (**volume**) of care for self funding older people – under-resourced providers have been known to be discouraged from taking on "private" clients for fear of risking local authority contracts. Others report not advertising services which local authority funded older people are not eligible for (i.e. low level services), to prevent unrealistic expectations amongst them. This means, however, that self funders may not be aware of the range of services that might actually be available to them.³⁸
- To reduce travel costs in domiciliary care contracts, many local authorities divide the authority into zones, and use a "preferred provider" in each zone. Whilst this can improve the **quality** of care by reducing carers' time pressures, zoning can lead to some providers being driven from an area due to a loss of local authority contracts, and also encourage providers to recruit and operate in very small areas and therefore be unwilling to provide services to older people outside of their "zone." As such, zoning can undermine choice for both state funded and privately paying older people, by reducing both the **volume** of providers willing to operate in a given area and also the **diversity** of providers to choose from (as there may only be one or two).³⁹

CSCI identified a number of features which would improve local authority purchasing, making specific reference to the need to consider more than just price, and balancing the pressures of efficiency with choice and diversity⁴⁰:

CSCI recommendations for better purchasing:

- Involving people who use services in the contracting process, including the drawing up of specifications, the evaluation of bids, and the monitoring and evaluation of services.
- Getting the balance right between having a few preferred providers, and nurturing valued small – including specialist – agencies.
- Where geographical areas are divided into zones, getting the size of each zone right, so there is competition but also enough business for each provider to ensure viability and economies of scale.
- Commissioning realistic and adequate time for care workers to carry out their job without rushing.
- Being clear about the true costs of providing a service, and having mature discussion with providers about this issue.
- Giving attention to quality as well as cost, finding better ways of measuring and specifying quality, and finding ways of linking the two.
- Having regard to the impact of low fees on care workers' wages and terms and conditions, and to the impact of this for people using services. (In particular, being concerned with how workers' travel costs and travel time will be funded).

³⁷ Wanless, D (2006) *Securing Good Care for Older People*, Kings Fund London, and Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

³⁸ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

³⁹ Ibid

⁴⁰ CSCI (2006) *Time to care?*

- Being prepared to specify standards relating to the workforce.
- Ensuring that any new arrangements continue to offer choice to older people, including the option of using a direct payment or individual budget to purchase from a different provider.

Some of the local authorities consulted by the Foundation have already embraced these recommendations by adopting purchasing practices which helped ensure volume and diversity, and encouraged quality and affordability. These include:

a) Outcome based purchasing

Outcome based purchasing, like outcome based commissioning, establishes the desired outcomes to be achieved rather than the inputs or processes required. In the context of purchasing care, this means basing a contract on a set of outcomes and leaving the “how” of achieving those outcomes 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. This approach can help positively shape the market in a number of ways. First, it gives providers more flexibility to carry out a wider range of tasks for their clients, and adapt to changes in need more easily. This improves both the quality and diversity of care provision, as providers can depart from the “set menu” of care tasks that might otherwise have been specified by the local authority and expand their range of services to meet a more diverse set of needs. This can have a positive effect on self funded older people too, as providers are more likely to advertise a wider range of services and adopt the more flexible approach for all clients. Resolution Foundation research also found that giving more flexibility over how outcomes were achieved also encourages more innovative practice.

Outcomes based purchasing can also help address the tension between choice and efficiency, outlined above – that is, to ensure older people have a good choice of different service providers, some excess capacity needs to be maintained in the market and some less efficient providers may need to be supported. Both can detract from market efficiency. However, 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. This is likely to be particularly useful in rural or remote areas, where a dispersed population of care users may mean several providers cannot operate sustainably in one area. There will, of course, always be a need for some choice between providers in a care market, to both deliver a range of choices for those with specialist needs (e.g. BME groups), as well as means of driving up quality in the market (see below).

Examples of outcomes based commissioning in practice:

Oldham

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

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

Thurrock

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

- The care user decides the outcomes they value and how they want them achieved;
- The provider decides with the care user what tasks need to be carried out to achieve the outcomes;
- The local authority agrees resources to carry out these tasks.⁴¹

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

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

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

b) Balancing the advantages and disadvantages of 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. Cost-volume contracts combine elements of the two.

CSCI’s 2007 self assessment survey found that the majority of local authority contracts were “spot” contracts (79% in residential care, 40% in domiciliary). This is in line with CSIP’s recommendation of a “staged reduction and individualisation of existing block contracts”⁴² to prepare for the increased use of personal budgets and the individual contracts this will entail.

⁴¹ Documentation kindly provided by Les Billingham, Contracting and Commissioning Services Manager, Thurrock Council. September 2008

⁴² CSIP (2008), *Commissioning for Personalisation: A Framework for Local Authority Commissioners*

There is, however, considerable geographical variation, with block contracts still proving popular in London for both types of care.⁴³

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.⁴⁴ Block contracts can, therefore, improve the affordability and quality of care being purchased in the market.

On the other hand, block contracts are less flexible than spot contracts, and more likely to lead to a pre sent “menu” of care options for local authority-funded individuals. An individual’s outcomes cannot be specified in a block contract and will not be suitable for use as the number of personal budget holders increases. Block contracts can, therefore, detract from the quality and diversity of care being provided.

When purchasing care, therefore, local authorities need to balance the benefits and disadvantages of block versus spot contracts, and consider the unintended consequences purchasing decisions can have on their wider commissioning strategies. A block contract can achieve a low purchasing price for the local authority, but this might undermine the affordability of services for self funders. At the same time, a sudden shift to large volumes of spot contracts may increase administrative overheads and increase the costs to personal budget holders and self funders alike. Without transitional business support (see below) this shift may also risk smaller providers’ financial stability and drive them from the market. CSIP suggests a possible middle way between spot and block purchasing to achieve the benefits of both:

Flexible block contracts based on volume of business may prove practical. Such arrangements might involve the council agreeing a minimum amount of business with a provider based on previously high demand, with any additional business coming directly from personal budget holders opting for their provision.

Preferred provider lists are a means for commissioners to negotiate deals with providers regarding the hourly rates for the services they deliver and the charges passed on to individuals purchasing them with their personal budgets. This is one possible way of both guaranteeing supply at an agreed cost to people directing their support and ensuring providers have a degree of confidence in predicting their level of income. People must also be able to exercise their choice to opt for providers and services outside of these approved lists.⁴⁵

c) Balancing the advantages and disadvantages of zoning

As mentioned above, 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”. CSCI recommends (above) that local authorities consider the appropriate size of each zone, so there is competition but also enough business for each provider to ensure viability and

⁴³ CSCI Local Authority Self Assessment Survey Results, 2007

⁴⁴ CSCI (2006) *Time to care?*

⁴⁵ CSIP (2008), *Commissioning for Personalisation: A Framework for Local Authority Commissioners*

economies of scale. This recommendation demonstrates that CSCI recognises the risks that a lack of competition may bring – creating monopolies which can undermine the quality of the care being provided (as there is no one else to compete with for potential clients).

However, using zones to shape the market actually requires a much wider set of considerations than the risk of a monopoly affect on quality: Zone purchasing strategies may also significantly reduce choice (**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, covering all local authority business in a given area, may discourage other providers from operating in the same area (given that they may only compete for self funders which, particularly in disadvantaged areas, could be a very small proportion of the potential market). The SPRU found evidence that zoned providers were increasingly recruited from within their zone, and so "a short visit to a single client in an out of zone area was reported by agency managers to be no longer cost effective."⁴⁶

As a result, local authority funded older people and personal budget holders may only have one provider to choose from in their area, and, due to market distortion, self funders may also find they can only access one agency in their area too. The improved choice and independence personal budgets represent will be severely curtailed in such an environment: the SPRU found that "There was also a view that for agencies with a zone contract from the LA there was no need to advertise for direct payment users as they had no choice of another agency – no other nearby agency would provide services to a single client in another agency's zone because of the excessive travel times."⁴⁷

Having only one provider in an area will also significantly limit the range of services on offer, particularly if the monopolistic position of the zone provider makes them more complacent regarding responding to different users' needs. At worst, zoning could lead to market failure – namely an absence of supply to private clients: if a zone provider has staff shortages and limited internal capacity, it may only be able to meet its local authority contract obligations but have no spare capacity to take self funders' business. The SPRU found evidence that some providers were already reluctant to take on private clients if they felt there was a risk of disrupting local authority contracts.⁴⁸

Most concerning, however, is the evidence from SPRU which suggests some local authorities use the market distortions of zoning to actively exclude providers from entering the market, in order to keep costs down: "the other had introduced zone contracts in part to deter new agencies entering the market and offering higher wages... the LA was having to pay higher prices for spot contacts with the new agencies because established agencies no longer had sufficient capacity."⁴⁹

Local authorities must carefully consider the implications of zoning, therefore, and balance this with the potential benefits a zoning strategy can bring: it can improve the affordability and quality of care, by reducing providers' overheads (something local authority and private

⁴⁶ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

⁴⁷ Ibid

⁴⁸ Ibid

⁴⁹ Ibid

purchasers 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 size market). Methods to mitigate the negative effects of zoning might include:

- Outcome based purchasing: by contracting providers to deliver (user defined) outcomes, rather than strictly defined tasks in a care plan, providers are encouraged to become more flexible in order to meet the needs of older people in different ways. As explained above, more flexible providers can help mitigate the negative effects of having a limited choice between providers.
- Commissioning for the entire population: as explained above, local authorities must understand the needs of self funders, and establish whether supply is meeting these needs. In areas where self funders are under-served, local authorities need to encourage providers in to the area, and/or contract with providers with sufficient capacity to deliver both local authority contracts and a proportion of self funding older people.
- Use two or three (smaller) preferred zone providers, so people have more choice, or use larger zones with several zone providers.
- Combine one zone provider with a number of “floating” providers who can be spot purchased over a number of neighbouring zones to provide an alternative source of care.

More fundamentally, local authorities should also consider the argument that potential economies of scale can be achieved on a multiple local authority, or even regional scale.⁵⁰ 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. Combining a small preferred zone provider with a larger area provider may be an effective compromise: this would allow for a degree of choice, creating a diverse and “mixed” market of small and large providers, as well as give extra support to a small provider in a micro market who might otherwise lose out to a larger rival able to make economies of scale and lower prices.

d) Purchasing to drive up quality

By carefully choosing the care providers it contracts with, a local authority can do much to influence the nature of the care being provided to both those older people it purchases for, and self funders.

As the largest single purchaser of care in most parts of the country, local authorities have within their power the ability to potentially 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. CSCI's 2007 self assessment survey provides evidence that many local authorities are doing this:

Incentive payments and variable fees are used in residential care mainly for quality reasons (16% of contracts) and to encourage particular types of service provision (11% of contracts). There are wide regional variations including high level of incentives for

⁵⁰ See below

particular service provision in Eastern region (31%) and for quality in North East (41%) and Yorkshire & Humber (35%).⁵¹

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. This is because purchasing decisions which reward high quality are by their nature likely to "punish" poor quality.

For example, care home X receives a poor inspection report, and subsequently a "one star" rating from CSCI. The local authority responds by terminating their contract with X, and as a result, a large percentage of the home's future income disappears. This home may now be in financial difficulty, and so unable to make any of the improvements that CSCI recommended to gain a two or three-star rating at next inspection. Worse yet, the lack of funding actually sees X's quality deteriorate, and some self-funding older people decide to leave, new ones do not arrive due to its poor reputation, and the local authority may decide to move existing state funded residents into better quality homes. Care home X will continue on with fewer and fewer residents, and poorer and poorer quality care, until it is driven from the market.

Whilst some may believe that adopting this "sink or swim" approach will ensure only the best quality providers survive, as we discuss below, the care market is not a "naked" market – it deals with often quite vulnerable people. It is important, therefore, that market shapers consider the impact on residents of care homes such as X. Financial decline is often a slow process – in the period preceding X being driven from the market, there is likely to be a long tail of poor quality care for residents (self funders and state funded alike), who might be unable or unwilling to move until its closure. Older people value continuity and familiarity and are unlikely to act as perfectly "rational consumers" and switch care homes easily.

Such an approach may also risks creating a two-tier market of under-resourced, poor quality homes, and well paid, financially rewarded high quality homes. As local authorities will only contract with higher quality homes, care places will be filled with state funded older people. Self funders (at least those unable to pay the high fees of "top end" private homes) may then only be able to find care places in second tier, poorer quality homes (given that care home capacity is consistently between 90 and 95 per cent across England).

Consider the scenario if market shapers adopt a more supportive role for struggling providers to protect older people in the market: care home X receives a poor star rating, but the local authority keeps its contract with X on condition it drafts a comprehensive improvement strategy and commits to improvement targets which would achieve noticeable progress within, say, six months. The local authority might provide business support, or even short term funding, to facilitate the turn-around. This would mean the residents in X would not be subject to a slow decline in standards, but would see a speedy improvement of current provision. Residents would not be forced to move, and consistency of provision would be maintained.

⁵¹ CSCI Local Authority Self Assessment Survey Results, 2007

Local authorities must therefore consider how to encourage high quality provision, whilst taking in to 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. 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, which are discussed in the “business support” section, below.

Somerset – combining approaches

Somerset council announced in July that it will pay higher fees for residential and nursing care placements in homes which achieve higher CSCI star ratings. Homes rated as having one or more stars *already contracted with the authority* will receive weekly bonus quality payments of £22 per person for residential care and £23 per person for nursing care above current baseline fees of £319 per week (residential care) and £522 (nursing care). Any new contracts will only be made with two or three star ratings before they receive the bonus payments.

No new contracts will be made with homes receiving no stars, and state funded residents currently living in these homes will be able to request a transfer to another home in the area if the home is unable to achieve a better rating at a subsequent inspection. The council also announced that homes which have failed to achieve any stars will be offered improvement funding under a separate programme.⁵²

Another risk of purchasing based on quality ratings is that local authorities might use them to drive down fees. Laing and Buisson highlighted this problem in its analysis of funding uplifts for 2008/09, which found that rather than giving *extra* funding to the best providers, some local authorities were giving *full* funding *only* to the best providers, and reduced funding to those with lower quality ratings. “What this may mean is that a ‘declared’ fee uplift of a given percentage may be accompanied by new or amended quality criteria which effectively reduce the uplift available to an individual home, or possibly even turn it into a fee decrease.”⁵³ This would certainly make the “vicious circle” and two tier market problems outlined above even worse.

e) Purchasing for diversity

As we explain above, local authorities have within their power the ability to drive providers from the markets by cutting off all contracts with them. This is because local authorities are often the single largest purchaser of care services in their areas: indeed, many providers rely on local authority contracts to survive – the UKHCA estimates that 60% of domiciliary care agencies rely on the local authority for more than 75% of their business, and nearly 15% of providers rely on the local authority as their only customer.⁵⁴ As such, a local authority’s purchasing decisions have a fundamental effect on the very structure of the market by favouring certain types of provision or provider. This level of control over the nature of local markets is likely to wane over time, as the roll out of personal budgets, and increasing number of self funded older people purchasing care, reduces local authority dominance. However, this is likely to be a gradual shift. For the time being, local authority purchasing

⁵² Laing & Buisson, *Community Care Market News*, July 2008

⁵³ Ibid

⁵⁴ www.ukhca.co.uk/pdfs/homecare_stats.pdf

remains a powerful market shaping tool, and as such, local authorities must consider carefully how the care they purchase, and from who, can have a dramatic effect on which providers enter and survive in their local markets.

Local authorities can use their purchasing power to improve diversity (i.e. 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 would support, with local authority contracts, a wide range of organisations. 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 achieve this. 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 create a mixed market to meet as diverse a range of care needs as possible.

However, there arises a tension, alluded to throughout this paper, between efficiency and diversity. Current Department of Health guidance suggests that local authorities contract with a fewer number of large providers to help meet Gershon efficiency targets.⁵⁵ Contracting with fewer providers means lower administrative costs and potentially more sustainable and predictable capacity – but runs counter to the principle of a diverse, mixed market. Purchasing only with efficiency in mind not only leads to fewer providers to choose from, it also favours larger providers, who have the capacity to take on large local authority contracts, make economies of scale and charge lower fees than their smaller rivals. Larger providers, and those in the private (for profit) sector, also do well in more competitive markets because they have more resources to commit to winning contracts, more experience and often better business skills compared to their smaller and voluntary sector counterparts.

Yet as the Foundation's research demonstrates⁵⁶, smaller and voluntary providers are a valuable source of innovation in the market and are often better at providing personalised, "hands on" care to meet specific needs. Local authorities need to consider, therefore, whether some efficiency can be traded when purchasing care from providers, to help promote diversity in the market and support a wider mix of providers. Commissioning to encourage smaller and voluntary sector providers (e.g. by involving them in the commissioning process, and sharing information with them so that they can respond to niches in demand) will only go so far in the current market: local authorities remain in most areas the single largest purchaser, and so they will need to support smaller providers not just with commissioning strategies, but with actual contracts. Putting business their way may be the only way of ensuring their continued survival in the current local authority-dominated market.

With this in mind, local authorities should look closely at their contracting processes, to ensure there is a level playing field for those without the business skills and experience of putting together a complex bid. As the Third Sector Commissioning Task Force explained: "It is not always cost-effective or feasible for very small organisations to put themselves forward for complex and rigorous commissioning procedures for small contracts."⁵⁷ The taskforce recommend a range of measures to encourage less experienced and smaller providers, including streamlining and simplifying the bidding process and associated contracts, making technical language more user friendly, etc., to encourage less experienced and smaller

⁵⁵ www.csed.csip.org.uk

⁵⁶ See Resolution Foundation (2008) *Innovation and Efficiency in Care Supply – discussion paper*

⁵⁷ DH (2006) *Report of the Third Sector Commissioning Task Force – Part II Outputs and Implementation*

providers.⁵⁸ The Taskforce also suggests that longer contracts can improve voluntary sector providers' financial stability.

Hertfordshire council 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.⁵⁹ This gave stability of income, whilst allowing for renegotiation of services to respond flexibly to changes in need.

The local authority must, therefore, strike a balance between maintaining a degree of diversity in the sector by purchasing from a variety of providers, whilst also considering the need to keep costs at a reasonable level – contracting with a larger number of providers can increase administrative costs and also implies that not all will be the most efficient in the market. In addition, it is possible that by trying to maintain too many providers with small local authority contracts, there will simply not be enough business to share between them and sustain them financially over the longer term.

As we explain above regarding outcomes based commissioning, by encouraging providers to be more flexible to meet a wider range of needs, choice between providers becomes less of an imperative to meet diverse demands. Nevertheless, some degree of diversity will always be required in a market, to meet niche and specialist needs, and to prevent the complacent behaviour that might occur in semi-monopolistic situations (a risk in zoning, described above).

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 can identify these signals and is able to respond, then the market will help drive its own volume, diversity, quality and affordability.

However, analysis carried out by Deloitte for the Foundation found that the communications channels between supply and demand in the care market were limited, due to a range of factors, including:

1. Poorly informed consumers who lack the ability and/or confidence to make an active choice of care provider and express their needs clearly
2. Poor financial preparation for care costs on the part of consumer, leading to financial constraints among those financing their own care.
3. Local authorities acting as purchaser on behalf of state-funded older people, meaning needs are aggregated into a fixed “menu” of services, thereby obscuring real demands from providers.

⁵⁸ DH (2006) *No excuses: embrace partnership now: step towards change. Report of the Third Sector Commissioning Task Force*

⁵⁹ Expert Groups hosted by the Resolution Foundation, July 2008. A note summarising these discussions can be found at www.resolutionfoundation.org

4. As local authorities are often the single largest purchaser in an area, providers focus their time on winning council contracts rather than identifying and responding to individual consumer needs.
5. Overall, there is little information collected regarding the needs and purchasing behaviour of older people, particularly self funders, so suppliers have poor market information.
6. Reliance on informal care can mask unmet need in the market and makes it harder for providers to identify potential new niches and clients.

Market shapers have a clear role in helping reduce these potential obstacles and facilitating the effective communication and relationship between supply and demand. Improving commissioning and purchasing practice will go some way to achieve this – particularly regarding points 3) and 4) above. The roll out of personal budgets will also be hugely important in bringing (state funded) older people's demand in more direct contact with supply. Nevertheless, market shapers also have a vital role to play in improving the quality of information being collected regarding the functioning of the market, and ensuring providers have access to this information (to address problems 4-6)

There are two forms of intelligence that should be passed to providers:

- 1) Commissioning strategies, which should be formed in consultation with providers and then disseminated widely once it has been finalised
- 2) Market intelligence gathered by the local authority (as explained above), which is passed directly to providers in its raw form.

Sharing commissioning strategies

We explain above that commissioning is most effective when service users and providers are involved at the outset to help develop a commissioning strategy. This iterative process is likely to involve representative groups and forums of local providers. However, it is also important that commissioning priorities and intentions (including outcomes) are shared much more widely with the entire care sector once these have been finalised. The wider dissemination of commissioning priorities and future desired outcomes give providers a clear sense of direction regarding the future activities and purchasing decisions of local authorities. This “market signalling” was identified by the Kings Fund as something which few local authorities carried out effectively, but which providers saw as vital to enable them to know which services to develop to meet future local authority demands.⁶⁰ As the Resolution Foundation explains in more detail in *Innovation and efficiency in care*, clear market signals from the local authority are key in encouraging new and innovative practices in care: a lack of guidance regarding what local authorities want to commission or purchase leads to risk aversion by providers, who will offer “tried and tested” services which have been previously commissioned, rather than trying something new.⁶¹

Oldham

⁶⁰ King's Fund (2006) *Steps to develop the care market*. London: King's Fund

⁶¹ See Resolution Foundation (2008) *Innovation and Efficiency in Care Supply – discussion paper*

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

Hertfordshire

Hertfordshire uses provider forums, bringing together care providers from across the area, to discuss the council’s purchasing intentions based on local needs and the shortages in current supply identified by their mapping of the market (see above.) The local authority gives clear requests for the volume and type of services needed in different locations. Flexible contracts allow providers to then respond to this information and expand, adapt or diversify their existing services to better meet needs.

Sharing market intelligence in its raw form

Shaping a local care market to ensure adequate volume, diversity, affordability and quality can only be achieved if a comprehensive analysis of current market conditions is carried out. However, we explain above how this data is only as useful as the way it is applied. It is valuable, for example, as an evidence base on which local authorities develop their commissioning strategies. However, it is also extremely valuable if it is shared with providers in its raw form, and allowing supply to “shape itself” in response.

Providing information about the needs and preferences of the local population, demographic information, and the location of shortages or over-supply in care services helps providers spot unmet need or opportunities to diversify or expand into niche markets. Sharing information can, therefore, stimulate both the volume and diversity of supply, and in specific areas, to better match pockets of need. The Department for Children, Schools and Families (DCSF), in its guidance to local authorities regarding the shaping of local childcare markets, also points out that information sharing can also have a positive effect on the affordability of services: “Local authorities can share information about unmet demand for childcare which could be met at a lower but still sustainable price, encouraging providers to enter the market or revise their business model.”⁶²

It could be argued that good providers would 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. 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 – particularly smaller and voluntary sector providers, and those who currently rely on local authority contracts for the majority of their income. 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 spotting new opportunities and marketing their services to individuals, rather than winning 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

⁶² DCSF (2007) *Securing Sufficient Childcare: Guidance for Local Authorities Childcare Act 2006*

carrying out their own market analysis. CSCI also points out that providers who are armed with solid business cases based on market analysis and future demand are more likely to attract investment from banks or private equity companies.⁶³ Local authorities would therefore also be encouraging inward investment into its local care market by acting as intelligence gatherer for providers.

Sharing information to shape childcare markets

Statistics and maps produced by Rochdale Council are used to demonstrate areas of under and over supply of childcare by ward, sector and type/time. This information is then used to start a process of local providers looking at meeting local needs, and who might best meet those needs, as distinct from local providers looking at individual needs. For example, in one area it was agreed with local providers that the best solution to an out of school demand was a childminding network and not a school based after school club.

5) In-house provision

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 the area, and also enables the local authority to guarantee the quality and affordability of the services provided more effectively. However, there are a number of disadvantages to shaping a market directly in this way.

First local authorities are currently attempting to shape markets within a wider context of constrained budgets and strong pressures to make efficiency savings as laid out in the Gershon Review. 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.⁶⁴ The UKHCA's survey figures also showed consistently large differences in hourly rates across the county (for example, in-house domiciliary care cost councils in the South East £30.38 per hour, but just £14.01 per hour when they bought this from the independent sector.⁶⁵) So maintaining in-house services, or indeed adding to them to remedy shortages in supply, is less cost effective than enabling independent organisations to do so.

Another disadvantage of offering in-house services is that they can act as rival employers to the independent care sector. Many domiciliary agencies report that significant numbers of their staff are lost to in-house re-enablement teams (i.e. home care workers who provide short intensive periods of care to older people discharged from hospital to permanently reduce their dependency), due to better wages and better terms and conditions.⁶⁶ 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

⁶³ CSCI (2007) *Safe as houses - what drives investment in social care?*

⁶⁴ <http://www.csed.csip.org.uk/silo/files/sbtcos.pdf>

⁶⁵ Homecarer Magazine, May 2008

⁶⁶ Glendinning, Clarke et al (2006) *Outcomes focused services for older people*, SCIE, University of York and Ibid

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. It was clear from the Foundation's own consultation of low earners⁶⁷ that the idea that "the government" or "the council" should own care homes and run care services is still very popular, particularly among older people. It is understandable then that some local authorities are placed in a difficult position if their local populations want them to maintain in-house services, even if this is the least efficient option in the long run.

Oldham council explained how it had intended to out-source all home care services, but its consultation with the older population (via their "Forum for Age", representing the over 50s in Oldham) had demonstrated a clear preference for some in-house provision. Oldham reserved the more cost intensive re-enablement services for local authority care teams as a means of making best use of the higher cost in-house staff.

North Yorkshire local authority still owns between 5-10 per cent of residential care provision in the area, representing around 20 care homes. These tend to be located in rural market towns across the local authority, where the care home may be one of the few remaining signs of local authority presence in the area. As such, local communities tend to be against the closure or change of ownership of these homes, and so they have remained in local authority control.

However, there is an alternative option to maintaining strictly in-house services for those local authorities faced with strong community sentiment to keep care services under council control – at least in the residential sector:

Following a public consultation which found that nearly a half of the local population wanted residential care services managed by the local authority, the London Borough of Camden sought a compromise which allowed it to retain ownership of the land upon which new care homes would be built and run by a contracted provider. The council will have the opportunity to change the use of the site after 30 years, bringing it back in as a purely in-house service or extending its relationship with an existing or new independent provider.

In addition to allaying community fears that their council would lose control of its residential homes, this compromise has a number of other benefits – it allows for cost efficiencies by outsourcing the building and management of care homes, but also gives Camden the ability to specify the volume and nature of the care being provided as a condition of the lease of the land. As long as this specification is based on a comprehensive analysis of supply and demand (see above), this should lead to a more effective use of resources and the matching of provision to local need.

As Camden's adult social care head Martin Davies said: 'We know that not everyone is happy with the proposed option and we will work through each of these concerns, however we are confident it provides the best balance between value for money, quality, cost, continuity of care and opportunities to remain in control.'⁶⁸

⁶⁷ Focus groups hosted by Opinion Leader on behalf of the Resolution Foundation, September 2008

⁶⁸ Laing & Buisson, *Community Care Market News*, August 2008

Hertfordshire Council also effectively uses this method of maintaining ownership but leasing out council land banks for the building and operation of care services. This approach has, among other things, helped its drive towards more extra care provision and a more flexible mix of residential options, as new facilities have been strategically built to meet the shortages identified by its comprehensive mapping exercise of elderly accommodation options across the area.

In the context of childcare, legislation is actually in place⁶⁹ to prevent local authorities from providing care directly. Local authorities acting as commissioner and provider of childcare services is seen as a potential conflict of interest, and as such, legislation states that childcare can only be provided by local authorities “when there is no other person or provider willing to provide it.”⁷⁰

The same approach could be applied to care for older people, making the creation of in-house provision only an option for local authorities as a measure of last resort – for example, in response to market failure (i.e., if the independent care sector has failed to respond to other market shaping methods to support and incentivise them to adapt or expand to meet unmet need).

Even for those local authorities faced with strong community sentiment to keep services in-house, alternatives do exist which deliver the efficiencies of outsourcing whilst maintaining overall “control” of the service being provided. In instances where this is less viable, (e.g. where local authorities do not own land to lease to care providers and in domiciliary services), it is important that the local authority addresses community concerns regarding independent ownership of care services – such as the fact that these services are still monitored by the local authority and independent regulator to ensure high quality services. Some of the other market shaping strategies (such as business support, commissioning in consultation with providers and incentives to improve quality) also need to be shared with the community to demonstrate that independent sector providers work closely with the local authority and share the overall vision of improved care outcomes for the local population.

Underexplored avenues

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 expert groups 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.

⁶⁹ DCSF (2007) *Securing Sufficient Childcare: Guidance for Local Authorities Childcare Act 2006*

⁷⁰ Ibid

1) *Market shaping on a larger scale*

Foremost amongst these under-explored strategies is the potential for an alternative “scale” of market shaping. As explained above, the architecture of a future care system remains undecided, but it is possible that the role of the local authority will change considerably as personal budgets are rolled out and the “postcode lottery” of care eligibility comes under scrutiny⁷¹ as part of the government’s forthcoming care and support Green Paper.

If local authorities no longer control market conditions so directly in the future (i.e. influencing the supply, demand and price of services as the largest single purchaser of care services and deciding eligibility for care and funding within its boundaries), it is possible that the role of “market shaper” will also no longer be appropriate for local authorities, and the boundaries of local markets will no longer match local authority boundaries so closely.

Indeed, there are a number of reasons why local authority-level market shaping may already be inappropriate for *current* care markets:

- 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.⁷² Therefore, Local authorities cannot predict demand or ensure that the levels of supply in their area will meet it, with total success. It is for this reason that local authorities’ market mapping must also take into account the trends of supply and demand in neighbouring local authorities and consider information such as the “home” local authority of care home residents to gain a clearer idea of movements in and out of the area.
- Some local care markets, artificially constrained by local authority boundaries, are too small for care providers to make effective economies of scale. This may particularly be the case where local authorities contract with several providers in an area to give people choice, thereby reducing the size of the potential business to be won. Larger providers may secure several small contracts with neighbouring local authorities, but this is far less cost effective than securing one large multi-authority or regional contract.
- Even though local authorities currently have many market shaping tools at their disposal, we cannot discount the huge influence on local markets of regional and indeed national activities. National investments in schemes such as POPPS, Lifetime Homes Lifetime Neighbourhoods, the Extra Care facilities fund, and the Transformation Agenda are all having a huge impact on the development of care markets at local level. Indeed, the most significant recent change in the structure of local markets – the roll out of personal budgets – is a nationally directed programme. Unfortunately, the impact of such programmes is uneven – those local authorities who have successful bid for POPPs pilot status and investment in new extra care projects, 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

⁷¹ CSCI has recently reported on its review of eligibility for social care, *Cutting the Cake Fairly*. This report recommends a national resource allocation system and replacing the four FACS bands with three “priorities for action”.

⁷² King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

investment. There may be, therefore, the need for a coordinating body at regional or even national level to assess the differential impact of such schemes.

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. Thurrock Council is also considering a single outcomes strategy, and hope the single procurement standard will facilitate joint commissioning across 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.

During discussions with expert groups hosted by the Resolution Foundation, it was debated whether regional Government Offices ought to have a more formalised role in helping to shape markets at a regional level. Some argued that the nine Government Offices would be able to take a more strategic role in market development, and consider longer term growth as they were one step removed from the day to day running of such services. The Government Offices are also in the process of appointing Deputy Regional Directors of Social Care, suggesting a move towards greater regional coordination of care in line with similar moves in health services and public health.⁷³ On the other hand, some argued that involving Government Offices would simply add another level of complexity to an already complex and bureaucratic system, and that joint working between local authorities would be a more effective method of carrying out larger scale market planning.

However, deciding whether regional market shaping, or joint local authority shaping, would be more appropriate for a future care and support system can only be made in conjunction with broader decisions regarding the overall architecture of a new care and support system. Most of the tools used to shape markets currently lie within the remit of the local authority, but this may change in the light of the roll out of personal budgets, the review of local eligibility criteria, and other reforms associated with the forthcoming Green Paper. As we discuss in our conclusions below, it is possible that in the future there will be no single “market shaper” but rather a number of agents – including the local authority, regional and national government and potentially independent bodies – each using the levers at their disposal to promote sufficient volume, diversity, affordability and quality of care services at local (but not necessarily “local authority”) level.

2) Overcoming barriers to market entry and growth

⁷³ DH social care bulletin no 7, July 2008

Another area which seems relatively under-explored by local authorities is the range of levers available for them to facilitate market entry, and the subsequent growth and sustainability of care suppliers. For example, market entry in domiciliary care is relatively easy, given the low upfront costs, and so the current domiciliary care market is characterised by large numbers of small agencies. On the other hand, growth is much harder, as these small agencies can lose financial stability quite easily with the loss of just one or two contracts. It is for this reason that the domiciliary care market is also characterised by high levels of turnover, with large numbers of new entrants to and exits from the sector each year.⁷⁴ Conversely, care homes can find it much harder to enter the care sector, due to the large up front capital cost required to buy or construct new facilities. Local authorities ought to consider whether their local markets are difficult to enter or to grow in, and the implications this might have for the consistency and volume of care available. There are a number of tools available to facilitate entry and growth, depending on the specific local needs of the area:

Business support

Business support for both new and existing providers is seen as a vital component of shaping childcare markets, and providing this support is considered one of the principle duties of a local authority to ensure sufficient, high quality and affordable childcare in its area.

Examples of business support for childcare providers – market entry:

“Local authorities must secure the provision of information, advice and training for existing and prospective childcare providers in their area to support them in entering the childcare market and in meeting the registration and regulatory requirements.”

This will include:

- training and support for childcare providers and prospective childcare providers on registration procedures and the prescribed requirements of registration; and
- information on the significance of registration.

Examples of business support for childcare providers – sustainability:

“The local authority must secure information, advice and training to support the economic sustainability of providers, including business planning, financial management and marketing.

Local authorities should, so far as is practicable, ensure that information, advice and training address the needs of the sector from pre-start up phase through to business maturity.

When businesses become self reliant and able to determine their own business development activities, local authorities should review the need to secure continuing training but ensure that ongoing information and general advice is available.”⁷⁵

In addition to business support, childcare commissioning guidelines also allow for local authorities to provide financial support where necessary:

⁷⁴ CSCI (2007) *The State of Social Care 2006-07*

⁷⁵ DCSF (2007) *Securing Sufficient Childcare: Guidance for Local Authorities Childcare Act 2006*

One-off financial support – capital or short-term pump-priming linked to a business plan for ‘self sustainability’, particularly for groups or areas where there is unmet demand.

Long-term financial support – exceptionally, and in the light of available resources, where market failure will lead to supply disappearing in a key area unless the local authority intervenes.⁷⁶

Business and financial support are vital in the context of care for older people due to the nature of the sector: the majority of care providers in both the residential and domiciliary sectors are very small, often family run organisations, sometimes described as “cottage industry” agencies or “mom and pop” homes. These organisations are often established by former carers and so whilst their experience and 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.”⁷⁷ Several larger care providers consulted by the Foundation similarly expressed concern at the lack of business support and start-up help given to smaller operators. It was felt these providers ought to be supported in entering and operating sustainably in the market, with a “backbone” of standardisation in areas such as business support, operating models and IT packages.⁷⁸ 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 the Foundation’s research demonstrates, a lack of innovation and strategic development.⁷⁹

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 market 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 contracts over time.

To help support its childcare market, Rochdale Metropolitan Borough Council has produced a Marketing Toolkit and a Business Toolkit, which they send to all providers and distribute at pre-registration and daycare guidance sessions for new providers.

⁷⁶ Ibid

⁷⁷ King’s Fund (2006) *Steps to develop the care market*. London: King’s Fund

⁷⁸ Expert Groups hosted by the Resolution Foundation, July 2008. A note summarising these discussions can be found at www.resolutionfoundation.org

⁷⁹ See Resolution Foundation (2008) *Innovation and Efficiency in Care Supply – discussion paper*

Pre-registration sessions, follow-on training for childminders and day care briefings also include specific sections relating to business and financial issues.⁸⁰

Business and financial support for *childcare* providers is conditional on the sustainability of the provider in question. Market shaping guidelines acknowledge that by providing support to providers that might otherwise be driven from the market essentially amounts to “market distortion”, and guidelines warn local authorities not to “buck the market”, and bear in mind that the childcare market has a natural turnover rate of 12-14%.⁸¹ 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.⁸²

The same rules could certainly be applied to providing business and/or financial support to long term care providers. As explained above, there is a tension in a “social market” such as care to balance efficiency, with the need to ensure all older people can have a choice of affordable and high quality care services. On the one hand, local authorities must consider the consequences if a care provider is driven from the market. A James Churchill, chief executive of the Association for Real Change (ARC) stated: “In a competitive market the weak go to the wall, but that means the people they are serving go to the wall as well. What happens to the people in a care home that's now closed?”⁸³ Clearly, providers cannot be left to “sink or swim” in a social market – as John Dixon, vice-president of the Association of Directors of Adult Social Services said, “This is not a naked market. We're not dealing in widgets; we're dealing with human beings.”⁸⁴

On the other hand, providing stability and support for providers above all else can be taken too far. Local authorities must recognise the risks of supporting struggling care providers indefinitely – such a strategy can prove resource intensive, and can distort the market – for example, 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 makes it unsustainable without constant support. In the latter case, the natural course of the market should only be interfered with in extreme circumstances – if the provider is actually the only one of its kind serving a niche need, or in an under-served (probably remote) location, and its closure will see needs go unmet rather than a new provider entering the market in its place.

The national roll out of personal budgets is a good example of a shift in the nature of the care market, where short term and targeted business and/or financial support may prove

⁸⁰ DCSF (2007) *Securing Sufficient Childcare: Guidance for Local Authorities Childcare Act 2006*

⁸¹ Ibid

⁸² Ibid

⁸³ Guardian, 6 February 2008, *Will Care Become a Commodity?*

⁸⁴ Ibid

valuable in preventing otherwise viable care businesses from being driven from the market unnecessarily.

Personal budgets represent both a challenge and opportunity for care providers – on the one hand, providers must learn to manage dozens or hundreds of individual contracts, each specifying their own needs. This is a significant change, particularly for those providers who may have only dealt with one or two local authority contracts in the past. On the other hand, providers will have the opportunity to expand and diversify into new services to meet the much more varied requirements that personal budget holders might express. No longer bound by local authority care plans, providers may diversify into low level services, outings and social visits, as well as traditional personal care.

Local authorities need to support providers to develop the skills which will allow them to seize the opportunities personal budgets bring – for example by ensuring staff are trained in a wider range of caring roles to meet the possibly wider demands of personal budget holders. The SPRU also found providers were unprepared for the changes personal budgets would bring and few had considered how they would market their services to individuals who had personal budgets.⁸⁵ Local authorities also therefore need to help providers improve their marketing strategies, and share data with them to help them identify who personal budgets holders are (as there is no mechanism currently to enable providers to know who to target). Providers will also need help developing contingency planning skills to deal with the increased risks of bad debt and abruptly terminated contracts that personal budgets might bring. Providers suggested to the SPRU that local authorities ought to act as “under writer” to personal budget holders, agreeing to pay the care provider should the personal budget holder default on a payment. Another suggestion was for local authorities to send personal budgets direct to care providers, or issue top-up cards to older people so that they can only use the personal budget credit to pay a recognised list of companies.⁸⁶

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 caring workforce required to deliver this care. A shortage of qualified care staff can prevent existing providers to grow 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.

As such, staffing problems can be a potential threat to volume and diversity in the market, but may also undermine quality (high staff turnover and overworked staff are two areas of complaint by older people identified by CSCI⁸⁷), and the affordability of care (if recruitment and training costs are driven up due to poor retention, these may be passed to the care user in fee rates).

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

⁸⁵ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

⁸⁶ Ibid

⁸⁷ CSCI (2006) *Time to care?*

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, area wide recruitment drives, and advising providers of good practice regarding how they might improve staff morale and retention. The PSRU found evidence that where local authorities were dealing with staff shortages, the methods used were far less constructive: the research team found some local authorities were using zoning strategies (see above) to actively exclude new providers from entering the market, in case they took staff away from the already short-staffed existing providers.⁸⁸ Helping increasing the overall supply of available care staff would certainly be more beneficial to the health of the care market than capping the number of potential employers.

Liverpool City Council has taken the local staffing problem seriously, with a member of staff charged with in-house *and* external provider workforce development.

To tackle staff shortages, 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.

Liverpool has also pioneered a modular training course for *informal* carers, which covers basic care skills such as lifting and handling, first aid and medication giving, as well as health and nutrition and dealing with stress. The local authority believes informal carers could be the workforce of the future, particularly as personal budgets become more widely used. Investing in training informal carers now could potentially help develop a pool of accredited personal assistants in the future.

An intrinsic part of retention and job satisfaction is adequate staff training and support. Having brought together a forum of representatives from the PCT and acute trusts, representatives from the independent care sector and others, the Council is better able to identify the range of training needs required by the sector.

As a result, the local authority offers Lunchtime Learning courses, which are “bite-sized” courses that can be attended by busy carers in lunch breaks. For longer courses, the Liverpool Council enables providers to attend by arranging the venue/instructor, and organising for staff from several providers to attend in order to meet minimum course numbers. They also help organise cover so that staff can be released to attend the course. For many courses, local authority and independent staff are trained side by side, as a way of improving relations between them, and also so all staff have “shared messages”.

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

⁸⁸ Baxter, Glendinning et al (2008) *Domiciliary care agency responses to increased user choice: perceived threats, barriers and opportunities from a changing market*. SPRU, University of York

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), such as:

- The Local Authority Business Growth Incentive (LABGI) scheme: councils that promote economic growth can retain a share of the increase in their Uniform Business Rates (UBR) revenue. The LABGI has recently been reformed so that money is awarded to “real economic areas”, with local authorities grouped together in sub-regions. Larger scale market shaping would be able to take advantage of this.
- The Community Investment Tax Relief scheme, Early Growth Funds, Enterprise Capital Funds, Support for Community Development Finance Institutions, and the Small Firms Loan Guarantee
- Support from Regional Development Agencies (RDAs) could also be sought, as their priorities (to further economic development and regeneration, to promote business efficiency, investment and competitiveness, to promote employment, to enhance development and application of skill relevant to employment and to contribute to sustainable development) can all be closely linked to supporting care providers enter and grow in the market.

North Yorkshire local authority is currently trying to secure business support for care providers from their RDA. The NHS and care services are the second largest employer in the area, but business support focuses on tourism, agriculture and manufacturing. The social care team within the local authority are trying to redress this balance to channel RDA support and funds towards care providers.

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).

A benefit of this approach (in addition to it being relatively low cost) is that inward investment can be promoted in a wide range of areas – not just care provision, but in those services which support and promote the wellbeing of older people more generally (everything from local cleaning services to over 50 dance schools).

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 in their local market 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 grants⁸⁹.

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

⁸⁹ <http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Section64grants/index.htm>

shaping local care markets and the achievement of wider economic development objectives – something local authorities should consider more carefully.

In Liverpool, this connection has been made by the care workforce development team working with the adult skills teams, Train to Gain and Job Education and Training (JET) teams to link, for example, the take up of carer training with the meeting of adult skills training targets. The training of informal carers in basic caring skills (see above) has also lead to the take up of further adult skills courses among some attendees, so these carer training courses have acted as a gateway to improving the take up of educational opportunities.

By establishing a social work placement scheme and targeting school leavers to consider a career in care, this local authority can also help meet school leaver/NEET targets as part of its strategy to address care staff shortages.

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.⁹⁰ 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 could 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 be no longer fit for purpose and which may not be easily updated to meet new needs).

The Kings Fund's investigation in to the London care market focused on this issue in particular, stating: "Planning barriers, especially the absence of clear guidance from central and regional government, are a major hurdle for the development of extra care housing in London – and in England generally. Public sector land banks could be used for large-scale

⁹⁰ CSCI (2006) *Time to care?*

(and therefore less costly) mixed developments. The Greater London Authority could play a role in facilitating extra care housing through the planning system.”⁹¹

In the light of this conclusion, they recommended:

- The Greater London Authority should give higher priority in its planning guidance to the development of new care homes and extra care housing (both rented and leasehold) in those parts of London where the current supply is insufficient to meet the needs and preferences of older Londoners.
- Local authorities should make greater use of their planning gain powers to encourage the development of more supported housing and care homes in areas where the current supply is insufficient. In partnership with PCTs, local authorities should create land banks to be used for these developments and form public/private partnerships to lever more capital investment into housing and care services in London.
- Local authorities and their PCT partners with the Association of London Government should develop capital investment plans on a pan-London and/or a sub-regional basis. This will help to ensure that new care homes and extra care housing are located where the need is rather than where land is cheapest.⁹²

Hertfordshire County Council made effective use of its land banks by selling the leasehold specifically for care provision. The sale specified how much care was to be provided and at what cost by the facilities built on the land, and developers were invited to bid for the leasehold. The Council reported they received less than market value for the land, but would have had to have increased the fees they paid to residential care providers across the county if they had not remedied the care shortage, so saved money in the longer term.

North Yorkshire County Council is also in talks with the Planning Authority to reallocate council land previously zoned for other purposes, so that new extra care facilities can be built. North Yorkshire see their sizeable land banks as a lever for negotiation in order to ensure appropriate care services are built to meet local pockets of unmet need.

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). The latter category is subject to Section 106 of the Planning and Compensation Act 1991, which requires new developments to have an element which is beneficial to the local community – usually affordable housing. Being placed in one category rather than another can therefore imply a significant increase in costs to developers. Yet developments for extra care have successfully been built and rejected in both categories, thereby increasing the uncertainty around the planning process.⁹³

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

⁹¹ Laing, W (2005) *Trends in the London Care Market 1994–2024*, King’s Fund

⁹² Banks, P *The Business of Caring*, King’s Fund 2005

⁹³ Laing & Buisson, *Community Care Market News*, February 2008

on a shift away from residential to more preventive and domiciliary care. If anything, these authorities may be looking to decommission residential care, not build more. 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” costs and management from care. Yet Laing and Buisson question whether “this revolutionary model of care would fade away were it not for the continued level of government support”⁹⁴ in the light of the lack of private investment in to such schemes compared with the Department of Health Extra Care Housing Fund, worth £247 million from 2004-2010.⁹⁵ Laing and Buisson blame this lack of investment, in part, on planning difficulties:

“much of this slow take up continues to be blamed on a poor understanding among both long term care providers and potential users as to what extra care constitutes and some difficulties in placing these kinds of concepts within existing planning permission structures. This is certainly something that appears to be keeping private companies at bay.”⁹⁶

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*

As mentioned above, 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 (an issue we discuss in the conclusion of this paper). 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 2008.⁹⁷)

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*

⁹⁴ Laing & Buisson, *Community Care Market News*, August 2008

⁹⁵ http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Housing/DH_083199

⁹⁶ Laing & Buisson, *Community Care Market News*, August 2008

⁹⁷ <http://news.bbc.co.uk/1/hi/uk/7516716.stm>

As explained above, analysis carried out by Deloitte for the Foundation found that the communications channels between supply and demand in the care market were limited, due to a range of factors, including:

1. Poorly informed consumers who lack the ability and/or confidence to make an active choice of care provider and express their needs clearly
2. Poor financial preparation for care costs on the part of consumer, leading to financial constraints among those financing their own care.
3. Local authorities acting as purchaser on behalf of state-funded older people, meaning needs are aggregated into a fixed “menu” of services, thereby obscuring real demands from providers.
4. As local authorities are often the single largest purchaser in an area, providers focus their time on winning council contracts rather than identifying and responding to individual consumer needs.
5. Overall, there is little information collected regarding the needs and purchasing behaviour of older people, particularly self funders, so suppliers have poor market information.
6. Reliance on informal care can mask unmet need in the market and makes it harder for providers to identify potential new niches and clients.

Some of the tools identified above address problems 3 to 6, and require a focus on stimulating or otherwise supporting market supply. However, we must remember that a market can “shape itself” to some extent, in that supply can respond to demand automatically if demand is stimulated. The following methods therefore explain how demand in the care market can be increased, improved, or expressed more clearly.

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.⁹⁸

This has a number of negative effects:

- Older people and their families are unprepared for needing care – many are shocked to find they are ineligible for state funded care, and have not made financial preparations for purchasing care themselves.
- Lack of information means many older people are simply unaware of the services available in their area, and so do not use them or know to ask for them.
- Low awareness and a lack of information regarding how the system works means people also lack the confidence, or do not know how, to express their care needs effectively to either the local authority or directly to providers.

These factors combined can serve to dampen demand: people do not have the money, awareness or confidence to access the services they need.

⁹⁸ Resolution Foundation (2008) *Lost: low earners and the elderly care market*

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,⁹⁹ whilst research from Age Concern England (ACE) found that older people spent the additional money they received thanks to ACE's work securing the benefits they were entitled to on home adaptations, heating and social outings. 56 per cent of older people reported using their money on practical help around the home (such as a cleaner or gardener), whilst nearly a quarter of older people reported spending their extra money on care services – thereby stimulating the formal care market.¹⁰⁰

Unfortunately, the current provision of information, advice and advocacy (IAA) from the third sector and local authorities to help people navigate the care system does not meet demand. For example, most advice organisations specialise in one or two areas and are unable to provide the range of integrated information regarding care, health, housing, finances and benefits that older people actually require in order to make effective care decisions.

The Foundation's paper, *Navigating the Care System*, presents a range of options to address this and other weaknesses identified. These options include the possibility for local authorities to act as commissioner and coordinator of local advice services, to ensure all older people in the area can access the support they need. Local authorities could act as "first stop shops" to provide a single interface between a person needing advice and the variety of organisations providing such help in the local area.

Local authorities could also ensure (as it should do with care services), that the provision of IAA was sufficient to meet the needs of the entire local population. This means identifying and taking steps to remedy situations where needs are not being met. Local authorities would also have an important role in promoting the use of IAA services and referring people to them.

⁹⁹ Jenny Willott MP, Parliamentary Questions, 22 July 2008

¹⁰⁰ Age Concern (2008) *Transforming Lives - Tackling Poverty and Promoting Independence and Dignity through Information and Advice*

In the future, local authorities will also need to consider how to support the increasing numbers of older people using personal budgets. Personal budget holders are currently being supported by in-house “brokers”, who, as part of a personal budget package, will work with an older person to complete a self assessment of need, draw up a care plan, and help an older person purchase services accordingly. However, specialist independent brokers are also emerging to meet these needs, as well as providing professional services such as payroll, record keeping, and so on, for those people employing their own personal assistants.¹⁰¹ Local authorities may expand into these services as more people become personal budget holders, but there are clear arguments why it may be preferable for local authorities to support and encourage the development of an independent market of brokers instead:

- Firstly, future demand for brokerage may not only come from personal budget holders. Self funders may take advantage of the growth in personal assistants, in the light of increasing numbers of single older people who may not be able to rely on informal care. These people 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. If brokerage services behave in the same way as care, then in-house provision is also likely to be more costly than independent sector alternatives.

Care intermediaries

As demand for and supply of care are often unable to communicate directly in the care market, demands are often left unexpressed and unmet, and suppliers are unable to identify demands (or respond to them even if they can be identified). This paper has outlined 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 IAA to people so that they can express their demand more clearly)

Nevertheless, communication channels between supply and demand may potentially become more tenuous in the future – even though the roll out of personal budgets is intended to address this very problem by removing the local authority’s role of aggregating and expressing demand on behalf of older people. This is because:

- 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.

¹⁰¹ *Going for Broke*, Community Care Magazine, 11 September 2008

- 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 IAA services.

In the light of these factors, there are still likely to be significant (and possibly growing) obstacles which prevent the direct interaction of supply and demand. Whilst increasing choice (of services and funding vehicles) is a positive step, a subsequent increase in support to make these choices may also be required. 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. In the financial services market, 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.

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 to 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.

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 key questions regarding this new role:

Firstly, there is an issue as to where this new intermediary role might “sit” within the architecture of a new care and support system. There are two principal options: for intermediaries to be some form of free service, integrated as part of a wider “navigation system” of information, advice and advocacy, which the Foundation explores in the paper *Navigating Care*. Alternatively, intermediaries could be developed as a private market (which, like IFAs, charge for their services), in the same way as brokers might.¹⁰² As an intermediary would research and directly recommend services, this may not necessarily fit well within the more generic advice and guidance offered by a navigation system. Access to navigation services may become part of a future minimum entitlement for all older people, while intermediaries are more likely to be specialist services required only by certain groups.

A second question, then, is whether intermediaries would charge for their services, and how. IFAs are paid for their services either by charging their client a fee, or charging a commission from the providers whose products they recommend. In the context of care intermediaries, charging commissions may not be a viable option:

- Receiving commission from care providers whose services have been recommended might imply that the intermediaries do not have their clients’ care needs as their first priority. Whilst the sales element of IFAs is acceptable in a private market such as financial services, this may be less acceptable in a social market such as care. In

¹⁰² See Resolution Foundation (2008) *Navigating care – a discussion paper*

addition, IFAs are strictly regulated by the FSA, to ensure independent advice can still be delivered within a commission-charging structure. Regulating care intermediaries sector would potentially require a new body to be established, or a significant new role for the CQC to be created, and may increase the cost of the service.

- Care services are delivered by a large variety of organisations – from small “cottage industry” voluntary sector agencies, to private equity backed care groups, operating hundreds of care homes nation-wide. Whilst the latter may be able to pay commission, the former are unlikely to be able or willing to pay such fees. This may create a two-tier market which favours larger and for-profit providers.
- Care intermediaries are also likely to recommend a variety of services falling outside narrowly defined “care” services. This is very different to IFAs, who operate in a well defined financial services industry where each type of provider has their own distinct category. Due to the wide and varied nature of care and support, care intermediaries must be far more flexible and consider a much more diverse range of services that would meet the outcomes identified in the “fact find”. It would be both extremely complex, and not particularly feasible, to expect each of these services (which may include a self employed gardener, a local charity like Age Concern, and the local authority itself) to pay a commission to a care intermediary should he recommend them to his client.

Care intermediaries may need to charge a fee for their services instead. However, this could potentially lead to intermediaries only serving better off older people, leaving those on lower incomes without this option. Intermediaries could offer their services free, or at a nominal charge, but to achieve this, intermediaries would have to be voluntary, or at least sourced from voluntary organisations. This is likely to increase the burden on an already stretched sector. Another option would be for the government to subsidise intermediary fees for those on low incomes, although this would imply a new means testing system and associated complications and costs. If we consider the future vision of a care and support system, however, it is possible that greater financial preparation and a wider range of funding options may make the payment of a reasonable fee for an intermediary viable for larger numbers of older people and their families. This might then be supplemented by voluntary sector intermediaries helping those on very low incomes.

A third question is 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. The intermediary has judged, based on their fact find and understanding of Mrs X’s financial situation, that she needs to prepare for when her care costs increase.

It is possible, however, that intermediaries could recommend financial products directly – based on Mrs X’s fact find, the intermediary might suggest that Mrs X use equity release to pay for the home adaptations and domiciliary care she needs now, or possibly that she buy care insurance, to pay for any residential care she needs in the future. There might be a number of benefits to this approach: evidence suggests that IFAs often do not recommend equity release and long term care insurance, often because there are too few care insurance providers in the market and equity release products have a poor reputation.¹⁰³ Care intermediaries could be specially trained to deliver advice on care related products –

¹⁰³ See Resolution Foundation (2008) *Facilitating increases in long-term care funding – a discussion paper*

particularly if new products (e.g. state sponsored products) were developed in the future.¹⁰⁴ 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.

It is clear that there are a number of outstanding issues that would need to be addressed before the function of a care intermediary became a serious proposition in a new care and support system. These should not, however, act as insurmountable obstacles, given the potential benefits of such agents. In a market that will remain complex regardless of reform, and which deals with on the one hand very vulnerable people, and on the other very small voluntary providers, intermediaries could be an invaluable method facilitating the communication between the two, acting as a direct agent for suppliers (i.e. by recommending products to clients) as well as consumers (by acting as the representative of their demands in the market). Care intermediaries could also have an important “aggregating” function. Local authorities can currently negotiate low fee rates with care providers via bulk purchasing. These favourable rates are unavailable to individual self funders, and personal budget holders are also unlikely to have this negotiating power. However, if intermediaries aggregated their client’s demands and purchasing choices when dealing with suppliers, they might be able to negotiate lower fees, which could be passed back to the client.

It is also important to bear in mind that the care intermediary function is almost present in the existing system already: some solicitors already discharge many intermediary functions for their clients, as do many social workers who act as advocates and representatives for older people when dealing with care providers. The emerging market of independent brokers also already offer to “hold” personal budgets for their clients and spend them on behalf of their clients if they so wish. The idea that local authorities could have an intermediary function and connect older people to providers more directly has also been raised: “Do we need to set up a sort of ‘dating agency’ for carers and users? Do we need to advertise? Do the CRB checking. A bit like a nursing bank. Because if the users can’t manage it then maybe that’s what we do to develop the markets and then we try and match the people ... because definitely we can’t go on just thinking the users are going to advertise individually and get someone, because that’s not worked.”¹⁰⁵ Creating a formalised “care intermediary” function could represent an integration and evolution of existing arrangements in the care system.

Concluding thoughts

This paper identifies a number of possible tools than can be used to help shape local care markets to deliver sufficient volume, diversity, affordability and quality of care and support services. The specific tools employed, however, must depend on the nature of the care market in question – each tool can affect a different change, and needs to be selected appropriately according to how the market needs to be shaped. For example, a care market with a severe shortage of *affordable residential care* due to a *shortage of land* will require a very different shaping strategy (and therefore levers used) compared to a market without a capacity problem, but with several small domiciliary agencies all offering *identical services* to

¹⁰⁴ Ibid

¹⁰⁵ Hampshire County Council Commission of Inquiry to help shape future services for people needing support and care: *Briefing Paper 7*, July 2008

the local population. Similarly, rural care markets are likely to face very different challenges from urban ones, and wealthy areas will face different challenges from poorer areas.

Given that, in fact, no two local care markets will be the same in terms of their supply and demand characteristics, it is important that the full range of levers outlined here are explored and put to use by market shapers of the future. This list is by no means exhaustive, however, and new strategies and methods will evolve in line with changes to the structure of the care system. In reality, market shaping requires the application of several tools simultaneously. Using the example of childcare, where the concept of market shaping is more mature, we can see how councils will regularly use several tools at once, and in different orders, to achieve their desired outcomes.

An example of childcare market shaping by Rochdale Metropolitan Borough Council¹⁰⁶

- Statistics and maps produced by Rochdale Council are used to demonstrate areas of under and over supply of childcare by ward, sector and type/time [comprehensive market analysis]
- This information is then used to start a process of local providers looking at meeting local needs, and who might best meet those needs [involvement of providers in commissioning strategies]
- This information is also used to target start up funds at particular areas. For example, grants to out of school clubs and to childminders to encourage them to offer atypical hours are only given in target areas. [financial and business support to boost capacity]
- Additionally, funding from the General Sure Start Fund is also used for short term funding for providers wishing to offer inclusive services. This funding is linked to attending relevant training. [accessing national schemes for inward investment into the sector]

A future market shaper?

In the current care market, it is clear that the local authority has the largest number of levers at its disposal to shape local markets. However, the effect of social care reform and the resulting changes in the architecture of the care system is likely to see some of these levers wane (e.g. purchasing), or more effectively applied by other agents (such as commissioning by regions).

Although there are convincing arguments for market shaping to be carried out on a larger scale (e.g. regional body) in the future, in reality it is unlikely that there will be one “market shaper”. Given the diversity of tools available, it is more probable that several agents – including the local authority, regional government, national government, independent bodies and user led and community groups – will all have a role to play in shaping local markets, depending on which levers are available to which agent.

Exactly who will shape care markets in the future, and how, largely depends on the roles and responsibilities of actors in a future care system. Whilst the vision behind the government’s care reform is quite clear, what a care system capable of delivering that vision will look like remains unresolved. As such, until fundamental questions are answered regarding the role of the individual, local, regional and national government and the regulator in a future care system, it is not possible to predict who will have access to which market shaping “levers”.

¹⁰⁶ <http://www.everychildmatters.gov.uk/search/?asset=document&id=42606>

A balancing act

Nevertheless, the function of shaping care markets, whilst crucial, will very much remain a significant challenge regardless of who discharges it. We have seen throughout this paper how a number of often contradictory considerations must be balanced when shaping a market – in fact, market shaping can be seen mainly as a succession of trade-offs between, for example:

- Different group interests (the best outcomes for state funded older people and self funders are not always mutually reinforcing)
- Efficiency and diversity – sometimes a less efficient system is necessary in order to deliver more choice for older people
- Diversity and affordability – maintaining high levels of choice risks spiralling costs for certain groups of older people
- Quality and capacity/diversity – whilst driving up quality is important, providers cannot always be left to “sink or swim”

Market shaping will always be more of an “art” than a “science”, therefore, and each local market is likely to be shaped differently. Nevertheless, a range of analytical tools do exist, and the government could make their application easier by providing clearer guidance regarding the balance to be struck between conflicting priorities. Current Department of Health Guidance states, for example, that:

It has been recognised that actions to deliver efficiencies are inextricably linked with wider business change to deliver improved services in line with the Green Paper “Independence, Well-being and Choice” which was published by the Department of Health in March 2005.¹⁰⁷

This implies that there is no inherent tension between achieving the efficiency targets as laid out in the Gershon strategy and supported by the latest CSR, and the social care agenda seeking to deliver choice and preventative care. In fact, local authorities are experiencing huge difficulties in delivering the two simultaneously, and guidance from the DH very clearly implies a priority towards efficiency savings at the expense of choice, diversity and flexibility. It is hardly surprising, then, that many of the possible tools available to market shapers (such as commissioning beyond care, commissioning for all older people, contracting smaller providers, providing business support for failing providers and outcomes based purchasing) are being under-utilised due to the implied risk to meeting efficiency targets. The government should perhaps recognise the potential conflict between its social care reform and efficiency agendas, and provide clearer guidance on how the two ought to be balanced in the future.

The Gershon efficiency agenda is just one example of an external factor which local authorities have little control over even though it has significant impact on local markets. Indeed, even though local authorities are in a relative position of power, other market shapers often bring their influence to bear:

- National reform programmes, pilots and accompanying funding can all have a huge impact on the structure and function of care markets. The government’s drive to roll out personal budgets is perhaps the most graphic example of this.

¹⁰⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081430

- Charitable grant making organisations and government schemes can influence the capacity and sustainability of the third sector, which in turn helps shape local care markets.
- Investors in care markets can change the structure of local care markets by creating new infrastructure and consolidating supply, often according to their own priorities and objectives.

Thurrock council explained how, due to their location, many care homes are built in the area to cater for older people coming from London (due to the cost of land in London, there is a shortage of residential homes and many London residents are placed by London Boroughs into neighbouring counties). With only limited influence over planning decisions, Thurrock cannot prevent these facilities being built, although local older people already have sufficient supply of care homes. This has led to a number of problems for the council – first, care homes need to be served by a local GP, and Thurrock is struggling with its existing local supply of GPs to meet this increased need. Second, care homes serving older people funded by London Boroughs often get higher fee rates than those serving Thurrock residents, and as such, can pay higher salaries to care staff. The new care homes have therefore increased staff shortages in the homes and agencies serving Thurrock residents.

We should bear in mind, however, that the whole concept of market shaping implies an “uphill struggle”, in that it attempts to shape and change an entity (a market) which is by its nature is influenced by a range of internal and external forces which are difficult to predict or change.

Shaping care markets will therefore always prove a challenge, and the desired outcomes of market shapers of the future will often be curtailed by a range of external factors. Nevertheless, market shaping remains a critical function in a market for a social good such as care. To be effective, market shapers of the future will clearly need to create an environment where care markets can flourish, and put strategies in place to help markets “shape themselves” to achieve positive outcomes, rather than maintaining outdated strategies of attempting to impose direct control over market forces.