TRANSFORMING THE MARKET FOR SOCIAL CARE

The background to market facilitation

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One in a series of seven papers on market facilitation

institute of public care

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PREAMBLE

Government activity since the publication of the 2006 *White Paper Our health, our care, our say* has increasingly focused on the demand side of the social care transformation equation. It has done this by encouraging better estimates of demand through the new local joint strategic needs assessments (JSNAs) and through promoting a shift in who acts as the purchaser of care via direct payments and personal budgets.

However, recognising that accurate estimates of demand are important and giving people greater control over the services they receive can be both empowering and ethically sound, it also needs to be recognised that if social care is to be transformed then the supply side of care also has to change. Some believe this will occur through users flexing their new purchasing muscles, others argue that this has not been true in the past and in a market where increasingly demand is chasing static or diminishing supply, combined with diminished government funding, then this is unlikely to be true in the future.

Consequently, the importance of local authorities influencing supply is increasingly recognised. The government circular *Transforming Adult Social Care* lays down a requirement that authorities develop a clear approach towards the social care market.

"Councils will also be expected to have started, either locally or in their regions, to develop a market development and stimulation strategy, either individually or on a wider regional basis with others, with actions identified to deliver the necessary changes."

This set of papers lays out an approach designed to underpin the market development and stimulation strategy sought by the transformation circular, and in the context that the future role of the local authority towards the market should be one of 'facilitation'. The seven papers outline the following.

- The background to market facilitation.
- A model of market facilitation.
- The views of local authority commissioners and providers towards the market and current policy issues.
- An exploration of whether the focus of the relationship between commissioners and providers within the market should be on outcomes or outputs.
- An improved approach to contracting where the local authority still acts as a purchaser.
- A set of principles by which individuals may contract for services.
- An annotated bibliography detailing some of the key documents relevant to the development of the social care market.

Each of the papers is designed to be free-standing but contribute overall to a new approach to facilitating the social care market.

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The views expressed in the papers are entirely attributable to the Institute of Public Care. They are not necessarily the views of the Care Services Improvement Partnership or the Department of Health or those of the local authorities that participated in the activities that have led to their publication.

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Care Services Improvement Partnership CSIP

1. INTRODUCTION

This paper, the first in a series of seven papers concerning market facilitation in social care, looks at the background to the complex relationships between commissioners of social care, predominantly based in local authorities, users of social care services and the range of organisations that provide such services. It briefly explores the policy background to social care commissioning and looks at the current position of the various stakeholders in the social care market and the issues that they are currently facing and likely to face in coming years.

The route to a social care market

The Griffiths Report published in 1988[1] laid the foundations of a market in community care that was seen as the best way to achieve government objectives. Griffiths sought to "encourage a proportionate increase in private and voluntary services as distinct from directly provided services", and saw the purchase of services from these sectors as the model for development. He identified four gains flowing from pluralism – choice, flexibility, innovation and competition – concepts that have recurred in ministerial speeches about non-statutory services over the last 20 years.

Following on from the Griffiths report, the NHS and Community Care Act 1990 transferred resources from the social security budget to local authorities. At the time there were serious political reservations about such a large increase in local government resources and responsibilities. The outcome was not preordained and the implementation of the legislation was deferred for two years to give time for local authorities to gear up to a change that generated considerable anxiety among providers.

The fear that some authorities might seek to use the transferred funds to 'municipalise' care provision was addressed by the requirements of the special transitional grant – the transfer mechanism for social security funds – that 75 percent, and later 85 percent, of the grant had to be spent in the independent sector. Providers in that sector were further buttressed by the continuation of the residential care allowance.

The outcome of these twin financial levers was a remarkable explosion in the sector with local authorities rapidly divesting themselves of directly managed care homes to housing associations, voluntary and private sector providers. In 1990 20 percent of residents in care homes were in the independent sector; that proportion now stands at 90 percent.

The pace of change in domiciliary care was slower, given that the financial incentives were less well developed. There was no scope for capital appreciation, no residential care allowance and a high turnover of staff. The motivation for local authorities was often the cheaper unit costs of private, as compared to that of in-house, provision. After a slow start the latest figures still show that 75 percent of hours funded by local authorities are bought from independent care providers compared with five percent in 1993.

Since Griffiths there has been a wide variety of White Papers, circulars and guidance focusing on social care. However, all have continued with the original theme that social care has a plurality of funding (mixing state support with that funded all or in part by those receiving such care) and of provision.

1 I Community care: Agenda for action The Griffiths Report London: HMSO 1988

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As can be seen above, the social care market is not new. There are long-established providers and long-established relationships between those providers and local authorities. It is also a highly fragmented and diverse market. In 2007/08, there were 4,897 registered home care agencies, the majority privately run, providing support to people living at home, and 18,541 registered care homes for adults of all ages, offering nearly 450,000 places[2]. Given such diversity of provision it is important to start this consideration of the market by exploring the diversity of participants and the roles they undertake.

The private sector

Since the Griffiths Report, the private sector in social care has grown and diversified. In recent years the strong asset base of residential care providers has attracted public companies and subsequently private equity into the market. They have demonstrated that high-quality care and the profit motive are not incompatible. In a quest for a market edge or unique selling points, some private providers have led the drive for improved quality and innovation.

Despite this, many on the state side of social care still struggle with the ethics of shareholder interests assuming primacy over client interests, as they must under company law. For instance, the 2007 collapse of the Sedgemoor Group, one of the UK's biggest private providers of residential care, foster placements and education for looked-after children prompted serious questions about whether private equity companies, whose prime duty is to maximise profits for their shareholders, should be allowed to provide education and care to some of the most damaged children in society[3].

Nonetheless the private sector, particularly in adult care, is here to stay. As stated above, not only does it control 90 percent of the residential and 75 percent of the home care market, within those figures 27 percent of people in care homes are self-funders[4], a proportion that is on the increase. In the transformation of social care the approach and attitude of the private market will be key to delivering genuine change.

The voluntary sector

In many ways the term ‘voluntary sector’ is an oxymoron, in that it is hardly a unified sector and its funding is not solely from voluntary sources. For example, membership of the National Council for Voluntary Organisations ranges from large children’s charities with multi-million pound turnovers to small community-based groups with budgets in the thousands and one or two staff. As in the private sector there has been much debate about both consolidation of charitable bodies and the spreading of risk through diversification.

Government funding now accounts for nearly 40 percent of total voluntary sector income, with the remainder being accounted for by charitable trusts, the National Lottery, corporate donors, individual donations, fees and charges. Diversity in income streams is seen as an important element in protecting independence.

There are still those within the sector who debate whether voluntary bodies should embrace the ‘contract culture’ or recoil from it, especially as the sector tends to fiercely guard its independence. However, there is an evident shift in central government’s view of the importance of the voluntary sector.

From social exclusion to regeneration to improving public services, the voluntary sector is seen as having a vital role. In 1998 the Home Office Compact[5] set out a framework for managing the relationship between central government and the voluntary sector, and successive White Papers have stressed the wish of the government to harness its innovation, creativity and flexibility.

The community sector

While the community sector has sometimes been folded into the voluntary sector, it is now developing a separate identity by virtue of different governance structures. Social enterprises have become the flagships of change. They are defined as “a business with primarily social objectives, whose surpluses are principally reinvested for that purpose in the business or the community rather than being driven by the need to maximise profit for shareholders and owners”[6]. Social enterprises range in

2 I The state of social care in England 2007-08 Commission for Social Care Inspection 2009

3 I A world shattered The Guardian 5 February 2008

4 I A fair deal for self-funders Community Care 30 April 2009

5 I Compact on Relations between Government and the Voluntary and Community Sector in England Home Office 1998 http://www.thecompact.org.uk

6 I Social Enterprise: a strategy for success Department of Trade and Industry 2002

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type from the Big Issue Foundation for the homeless to the environmental Eden Project, but it is their potential in social care and health which has excited the government as they combine the financial disciplines of the commercial sector with the values of the public sector. Consequently there is now a Social Enterprise Investment Fund (SEIF) of over £100 million over a four-year period from 2007/08 to 2010/11.

Social enterprises promise a commercially minded and entrepreneurial approach to the delivery of public services. Many PCTs have established provider services boards to operate at arm's length from commissioning so that the cost and value of in-house services can be tested against other providers. One difficulty is that the public sector is not a natural breeding ground for entrepreneurs, given probably both the inclination of those who choose to work there and its rather risk averse nature. Decision-making tends to be a paper-driven process and independent leadership is not a quality that in the past has been highly sought.

Another difficulty is one of dependency. Providers whose existence depends on a single contract are extremely vulnerable to shifts in the market with the emergence of other providers and shifts in the resource availability for the commissioning body.

Service users

For a long time service users' wishes did not really play a major part in the development of the social care market. People either received the services they were assessed for or purchased their own care. For the former, assessing quality or delivering choice was mainly within the provenance of professionals, provided in the main to a generation that felt 'grateful' for what they received, many of whom would have had memories of state provision prior to the creation of the National Health Service.

Equally, those who purchased their own care were scarcely regarded as consumers in the same way as, for example, the retail sector would view shoppers as customers. Although some advocates of the personal budget approach seek to emulate the retail sector as the route to creating a vibrant and diverse social care market there are some key differences that would need to be overcome for this to occur. For instance, the retail sector provides for the whole population, it embodies plentiful competition between providers, an excess of supply (of goods) over demand and competitive pricing. None of these characteristics is really true of the social care market and consequently the capacity of consumers to control or influence the market is much diminished.

If both state and self-funders have had difficulty in influencing the market, the latter group has also often been ignored by the state sector. A government report in 2007 estimated that 50 percent of those self-funding their place in residential care had not received a social care assessment, to which they would have been entitled, prior to their admission[7]. However, the proportion expected to fund their own care has also increased as eligibility criteria have tightened, particularly among older people, until it focuses only on those with 'critical' or 'substantial' needs. In addition, as the Office of Fair Trading reported in 2005, many older people get little information about care homes and are often subject to unfair contracts on entry[8].

It is hoped much of the above would be changed by the Transforming Social Care initiative and by the agreement between stakeholders as embodied in *Putting People First*[9], the joint ministerial statement published in 2007. However, putting in place approaches that give service users greater freedom to purchase, and widening the options of intervention to embrace more of a preventative agenda, do not fit easily with reductions in local authority funding and continuing fair access to care policies.

Social care commissioners

While the local authority role of purchasing social care services has accelerated from the time of the Griffiths Report, the role of strategic commissioning as distinct from contracting or purchasing is a much more recent phenomenon. The Department of Health's *Commissioning framework for health and well-being* outlines the role as follows:

7 I A Fair Contract with Older People Commission for Social Care Inspection 2007
8 I Care homes for older people in the UK Office of Fair Trading 2005
9 I Putting People First: A shared vision and commitment to the transformation of Adult Social Care HM Government 2007

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"Commissioning is the means to secure the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services for users that:

- *deliver the best possible health and well-being outcomes, including promoting equality*
- *provide the best possible health and social care provision*
- *achieve this within the best use of available resources."*[10]

As indicated above, commissioning is a role still subject to change and discussion. In 2000 commissioning in social care would have been seen as synonymous with purchasing. Commissioners were the people who organised the block contracts for care and secured on a day-to-day basis the range of placements needed. It was essentially a reactive role with few predictive skills required. Gradually that has changed, with a recognition that commissioners need to take a more strategic long-term view of both demand and purchasing requirements. Now, given the possibility that many more service users will purchase their own care rather than through the local authority, commissioning is being encouraged to become a role designed to ensure sufficiency of supply rather than purchase it. As the 2008 *Transforming social care* circular puts it, the role of social care commissioners in future will be to:

"… work to shape and develop local and regional markets with the capacity and the variety to offer the range of options the population demands. This will include a mixed economy of care providing a range of services delivered by organisations across all sectors."[11]

However, achieving this new commissioning role is unlikely to be easy, as the King's Fund argues:

"Even the most skilled and experienced commissioners face considerable challenges in forecasting, whole-systems working, supporting cultural change, managing fragmented markets across numerous boundaries, decommissioning, and managing demand." [12]

The local authority

Social care commissioning does not take place in an environment completely under its control given that it operates as part of the local authority. Therefore, while the Department of Health defines how it would wish social care to be commissioned, in terms of a generic local government approach towards the market, and notwithstanding the personalisation agenda, the Department for Communities and Local Government (DCLG) also has additional targets it wishes local councils to achieve. For example, the 2006 White Paper *Strong and prosperous communities*[13] includes the following targets.

- Ambitious efficiency gains to be achieved by local authorities as part of the Comprehensive Spending Review, necessitating a more radical and ambitious value for money programme, with effective and direct challenge for poorly performing or coasting services.
- Secure more collaboration between local authorities and across all public bodies, where this improves effectiveness and efficiency, and ensure that administrative boundaries do not act as a barrier to service transformation and efficiency.
- Drive a more extensive use of business process improvement techniques, including new technology, to transform service delivery and focus services around the needs and preferences of users.
- Ensure greater contestability through the use of fair and open competition in local government services markets.

In its guide to the market, on procuring care and support services, the DCLG suggests a number of activities designed to assess markets and source suppliers prior to making purchases[14]. The intention is that these activities lead to commissioners producing an overall market analysis report that brings together an examination of current supply and looks at how the market can be improved. One of the activities it endorses is 'market sounding', which poses the following potentially challenging set of questions for social care.

10 I Commissioning framework for health and well-being Department of Health 2007 p11
11 I Transforming Social Care LAC (DH)(2008)1 Department of Health 2008
12 I Commissioning care services for older people: Achievements and challenges in London King's Fund 2005 p5
13 I Strong and prosperous communities Department for Communities and Local Government 2006
14 I A Guide to Procuring Care and Support Services Department for Communities and Local Government 2006

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- Maturity: Is the market ready to deliver what is required?
- Feasibility: Will the market be technically capable of delivering?
- Competition: How many suppliers provide what is required? Will procurement be sufficiently competitive?
- Capacity: Are there enough suppliers with sufficient capacity to meet the requirements?
- Working together: Will the requirements bring suppliers from different sub-sectors together in a new way?
- Traditions and prevailing attitudes: How will they affect the requirement and the procurement approach?

The need for compatibility across local government is not only an issue of governance around who controls the commissioning agenda, but an increasing recognition, as represented by the inter-departmental statement *Putting People First*, that personalisation and the transformation of social care cannot be driven by social care alone but will need the co-operation of several local authority departments, in particular housing, planning and leisure services.

The health service

The 1989 Department of Health White Paper *Working for Patients*[15] set out plans for the creation of the internal market in health. Since then there has been a series of reforms and reconfigurations but the separation between commissioners of services and providers in health remains. However, it has yet to be as productive as the government desired, as the *Commissioning framework for health and well-being* points out:

"Our health service is still too focused on commissioning for volume and price, rather than for quality and outcomes. Too much long-term care is provided in institutional settings. Health inequalities still exist. There is too much of a focus on treating illness rather than preventing it. There are too few providers, and we need to do more to incentivise innovation and join up services. Excluding elective care, individual choice for many patients remains limited and we need to strengthen local voice."[16]

Since 2007 attempts to improve commissioning in the NHS have been made through the development of World Class Commissioning (WCC). One of the WCC competencies is to stimulate the market:

"Commissioners will need a choice of responsive providers in place to meet the health and care needs of the local population. Employing their knowledge of future priorities, needs and community aspirations, commissioners will use their investment choices to influence service design, increase choice, and drive continuous improvement and innovation."[17]

In its guidance on WCC competencies, the Department of Health outlines the skills needed by commissioners and defines the overall task as one of stimulating the market to meet demand and secure required clinical, and health and well-being outcomes. The necessary skills for stimulating the market are described as follows:

- Establishing and developing formal and informal relationships with existing and potential providers.
- Patient, public and staff engagement skills.
- Signalling to current and potential providers their future priorities, needs and aspirations.
- Provision analysis and monitoring skills (including gap analysis), risk assessment and management, market segmentation, simulation tools.
- Project management skills, including change management support for provider organisations where required.
- Negotiation skills.
- Presentation and influencing skills.

Given the synergy of commissioning skills required by primary care trusts (PCTs) and local authorities, it might be expected that there would be an increasing convergence between social and health care commissioning. However, the personalisation agenda may yet act to create a distinction between health with its universal, free services, commissioned by managers and a social care, selective, chargeable service where funding is disaggregated down to its users with commissioners mainly playing a market planning and stimulation role.

15 I Working for Patients Department of Health London: HMSO 1989 (Cm 555)
16 I Commissioning framework for health and well-being Department of Health 2007 p7
17 I World Class Commissioning: Vision Department of Health 2007

3. HOW HAS THE MARKET DEVELOPED?

In the past the social care market has been influenced in a variety of ways – by government regulation, by inspection, by giving grants to local bodies and latterly through the local authority acting as a direct purchaser of social care. However, relationships within the market place have not always been equitable. For instance, a 2006 Commission for Social Care Inspection review of home care provision concluded:

"There is considerable scope for improvement in the way services are commissioned. Councils and their partners need to grasp the 'big picture' and plan for the medium term. Whilst some councils have developed constructive partnerships with independent sector providers, many do not engage well enough. Better results could be achieved through stronger collaboration that makes the most of providers' experience and expertise."[18]

The same pessimism can also be found among residential care home providers. A 2005 report into relationships between commissioners and providers[19] produced the following findings.

- Relationships between commissioners and providers were improving overall but from a low base. A lack of trust between the sectors was cited as the main obstacle to progress.
- Relationships between the independent sector and local authorities were relatively mature, although not without differences, while PCTs were hard to engage and greater tensions appeared to exist, possibly due to the relative newness of the agenda.
- Meetings with domiciliary care and residential care providers were usually conducted separately and, while there were sound reasons for this, it was perceived to be a possible barrier to better strategic commissioning.
- The independent sector felt as though they were only consulted after decisions had been made. Better communication on future planning and involvement in the decision-making process was seen as a requirement to improving relationships.

The *Commissioning framework for health and well-being* summed up current relationships in the marketplace when it stated:

"Commissioners can find that existing providers are unwilling or unable to provide appropriate and innovative services. Providers may feel that their scope to innovate is restricted by overly prescriptive approaches to commissioning, focused on inputs. Traditionally, health commissioners have been wary of using community and voluntary groups to deliver services. Potential new providers, particularly third sector providers, may find it difficult to enter new areas without active support because the barriers to entry may be too high."[20]

Providers have raised a range of issues that local authorities appear to have been reluctant to address, including the following.

- While contractual variation may reflect local need and conditions, for provider organisations who work with more than one council with social service responsibilities (CSSR), it has meant having to comply with a wide range of contracts, terms and conditions, sometimes for very small volumes of care such as a single out-of-authority residential home placement.
- Some providers have felt excluded from influencing the contracting approach and that local authorities are not very transparent in their policies and purchasing intentions.[21]
- In some instances the absence of close working relationships has led to providers cutting costs in unsustainable ways or by failing to invest adequately in their staff, or attempting to be unrealistically price-attractive and competitive. Providers may also have been complicit with bad practice to keep costs down and maintain contracts in order to stay in business.

Conversely, local authorities have felt that some providers have sought to increase margins without fully explaining the rationale behind them, or the size and purpose of their profit. There have also been concerns that private care home and home care providers give their staff few of the benefits accorded to local authority staff and do little to train or support their employees.

An Office of Fair Trading report in 2005[22] highlighted concerns about residential care homes across all sectors,

18 I Time to Care? An overview of home care services for older people in England Commission for Social Care Inspection 2006

19 I Building Bridges Developing relationships between commissioners and independent providers of care services Department of Health Change Agent Team 2005

20 I The commissioning framework for health and well-being p39 Department of Health 2007

21 I Domiciliary Care Providers in the Independent Sector Personal Social Services Research Unit (PSSRU) 2001

22 I Care homes for older people in the UK Office of Fair Trading 2005

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including lack of information for older people prior to entering a home, lack of transparency about pricing, and complex terms and conditions that did little to emphasise older people's rights.

4. ISSUES FACING THE MARKET

As has already been identified in this paper, social care faces considerable challenges in a market where there are a number of unresolved tensions between the various stakeholders in the commissioning process, combined with a series of new expectations from both government and service users. This final section outlines what some of those challenges are and how they might be resolved.

Demography

The potential impact of demographic change has come to increasing prominence in recent years. It was highlighted in the Cabinet Office Strategy Unit's 2008 paper on the 10 key challenges facing Britain[23], it features heavily in both the Green Paper *Independence, Well Being and Choice* and the White Paper *Our Health, Our Care, Our Say* and underpins the focus on why change is needed in *Transforming Social Care*. Its potential impact is further emphasised when expenditure on health care is taken into account. For example, in 2003-04, of all health care expenditure, 43 percent was spent on the over-65 population,[24] a proportion that is rising year on year.

Yet how demographic change will impact on the social care economy is subject to wide variation. For instance, while Hackney faces a potential diminution in its population of older people aged over 80 over the next 17 years, Northumberland faces an almost doubling of its numbers for the same age group[25]. In general, shire counties face the largest old age population increases, which are then further exacerbated by their comparatively large rural populations, making service delivery more expensive, combined with a diminution in its younger age population from which carers may be drawn.

Older people are not the only group subject to demographic change. Although smaller in numbers, people with a learning disability are also on the increase through greater longevity. For instance, the population in Nottinghamshire of people aged over 55 with a learning disability at a moderate or severe level, and likely to require social care services, is predicted to rise from 1,119 to 1,371 over the next 17 years, an increase of 22 percent [26].

To be set against this trend is a growth in personal resources. The comparative growth in wealth for many older people through occupational pension schemes and greater housing equity is likely to lead to an expectation that more people will be able to pay a greater proportion of their own health and care costs. In addition, more people with a learning disability could potentially inherit property assets from parents who they now outlive. The issue of affording care services was recognised in the Wanless review of social care[27].

While the overall demographic rise is significant, what proportion of that increase will transfer into demand for services is harder to predict given that demand can be influenced by a wide variety of factors. For instance, changes in wealth, in health care treatments and interventions, and in the price, perception by the public and accessibility of services on offer can all influence who comes through the front door of social care requesting a service.

Therefore, the substantial increase in the numbers of older people, together with the smaller but still significant increase in the population with a learning disability, is going to act as a powerful driver for change within the market.

Personalisation

The government has become firmer in promoting personalisation and self-directed care as the future for social care. The 2008 circular on transforming social care clarifies the scope of personalisation:

"If personalisation is a cornerstone of the modernisation of public services, what does it mean for social care? What it means is that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered."[28]

A report by research institute Demos[29] looks at how personalisation will change the relationships between service users and other stakeholders and suggests it will:

- cause a change in people's attitudes toward themselves and their role from being recipients to participants

23 I Realising Britain's Potential: Future Strategic Challenges for Britain Strategy Unit Cabinet Office 2008
24 I Departmental Report 2006 Department of Health 2006 p24
25 I Projecting older people population information system (POPPI) 2008 http://www.poppi.org.uk
26 I POPPI 2008
27 I Securing Good Care for Older People: Taking a long term view Wanless Social Care Review King's Fund 2006
28 I Transforming Social Care LAC (DH)(2008)1 Department of Health 2008 p4
29 I Making it Personal Demos 2008 http://www.demos.co.uk

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- ensure service users' relationships with professionals will change
- bring in new knowledge and information from users, families, peers and friends about what is important and how it could be done
- make the supply side adjust to user demand
- drive a shift in power towards users as the focal point of the service.

Many of these benefits may well occur, and there is evidence from the In Control pilot schemes, which aimed to enable people with learning disabilities to plan their own care using personal budgets, to support some of them. An evaluation of the pilots found:

"For some outcomes, people with learning disabilities and people with physical disabilities were more likely to report improvements than older people, although the small numbers of people involved made it difficult to know why this might be."[30]

Whether the benefits will hold true across the whole spectrum of adult service users, as a 2008 report on individual budgets queries,[31] remains to be seen.

The variation in outcomes found in the In Control evaluation is perhaps not so surprising given that for older people there are potentially a number of contrary indications.

- Personalisation assumes that all people want greater choice and control. While there are many examples where this is true, there are also those where older people do not see self-directed care as an option they can or would wish to pursue, either because they are satisfied with existing arrangements, do not want to make what might be perceived as additional effort, or are too incapacitated.
- In some more rural parts of the country, the problem may not be offering a choice but getting any agency or individual at an affordable price to deliver the services needed.
- For some older people the desire for choice may not be between service providers but between care workers, eg who might wash and bathe me, who will be my key worker in a care home?
- The continued application of means testing to a direct payment or individual budget will mean that some people receive a lesser amount than they need to spend. However, they may be reluctant to top up this amount from their own resources. Indeed, some older people may not be aware of what they need or their expectations of recovery may have been diminished by others, and consequently dependency services are purchased where rehabilitation or re-enablement services would have delivered a better and cheaper outcome.
- Greater family involvement is not always welcomed by either the carer or the cared for person. A Care Services Efficiency Delivery (CSED) programme report states:

"The message about older people wishing to remain in their own homes has been well voiced by a wide range of studies over the years. Equally clear is that many people do not wish to rely on their own family members for care and support. Yet nonetheless many people end up doing the opposite of their stated wishes, ie rely on family members to support them and end up in care homes when death is near."[32]

- Equally being offered a direct payment or an individual budget may not necessarily lessen the need for family members to continue to offer support. An evaluation of individual budgets found that:

"There were conflicting views about the possible impact of individual budgets (IBs) on informal carers and families. On the one hand, IBs could give more opportunity for longer-term support to help relieve the pressures on informal carers – 'family can become family again'. But for others, the management of support arrangements required even greater input from families and friends, and this was a particular problem when the IB was less than the value of existing support services." [33]

While none of the above is an insurmountable barrier to change, they do represent problems and issues to be recognised and resolved. Providers also have additional concerns about the mismatch between an unregulated

30 I A report on In Control's Second Phase: Evaluation and learning 2005-2007 In Control 2008 http://www.in-control.org.uk

31 I Evaluation of the Individual Budgets Pilot Programme: Final Report Individual Budgets Evaluation Network 2008

32 I Anticipating Future Needs toolkit CSED 2007

33 I A summary of early findings Individual Budgets Evaluation Network 2007

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workforce of personal assistants compared to a regulated market for home care, plus the potential for a rise in expenditure due to increased transaction costs.

On the basis of such arguments, simply allocating personal budgets to all, with a drop of brokerage thrown in, and believing choice and control will automatically be delivered seems a false assumption to make.

Financial stringency

After many years of economic growth, the bank crisis of 2008/09 is likely to herald much tighter control of local authority expenditure and hence less money available for either the local authority or service users in receipt of a direct payment to spend in the social care marketplace. However, the financial implications of recession go much further than simply the amount of money in the local authority pot.

- For care providers and supported housing developers it may be harder to fund new activities or extensions to existing projects given less liquidity in bank lending. Equally, providers may also be suffering from having made financial commitments at times when funding was more freely available, which they are now finding hard to meet.
- For service users, particularly in the case of older people, funding difficulties may arise through being unable to dispose of assets to fund residential care, or through investments not lasting as long as anticipated when purchasing their own care. Early redundancy for some people may also lead to health conditions, either mental or physical, which accelerate an early demand for care services in old age plus a loss of pension.
- For local authorities, more people may wish to enter into a charge on their property, which has become hard to sell. Plus it is likely that a greater number of older people will move from self-funding to state funding earlier than they had anticipated.

The mechanism for achieving financial balance has been through the use of eligibility criteria. Fairness is determined as everybody with similar needs being eligible for a similar volume of service. In the future if every service user has a personal budget then the 'need equals service provision' link becomes de-coupled and the basis of the transaction becomes one of 'need equals cash', which presumably may be adjusted not on the basis of level or volume of need but on the basis of funding available.

Problems arise if the numbers eligible become so great that the slice of funding individually allocated is not sufficient to buy the volume of service needed, or if too much supply within the marketplace is taken up by a higher proportion of self-funders. One solution, outlined below, is to step outside the need equals services or funding response and explore an allocation of services based on outcomes.

Outputs or outcomes

One of the sub-themes running alongside personalisation has been a focus on the delivery of improved outcomes. So although only included in the appendices in the initial *Transforming Social Care* circular, it still represents a recognition that the system needs to move away from a concentration on cost and volume. The circular states that local authorities need to:

"Change the social care system away from the traditional service provision with its emphasis on inputs and processes towards a more flexible, efficient approach, which delivers the outcomes people want and need and promotes their independence, well-being and dignity"[34]

These references to outcomes are echoed in *Putting People First*, the inter-ministerial statement on transformation, when it argues that one of the key elements of a personalised adult social care system should be:

"Agreed and shared outcomes which should ensure people irrespective of illness or disability are supported to:

- *live independently*
- *stay healthy and recover quickly from illness*
- *exercise maximum control over their own life and where appropriate the lives of their family members*
- *sustain a family unit which avoids children being required to take on inappropriate caring roles*

34 I Transforming Social Care LAC (DH)(2008)1 Department of Health 2008 p23

4. ISSUES FACING THE MARKET

- *participate as active and equal citizens, both economically and socially*
- *have the best possible quality of life, irrespective of illness or disability*
- *retain maximum dignity and respect."*[35]

The assumption is that personalisation will deliver the outcomes desired because people know what they want to achieve and, through being given access to funding, will spend money wisely in order to achieve their desires. However, making a choice as a service user is not always straightforward. For instance, if the activity was as simple as purchasing a can of soup, then people tend to be well informed in terms of what they like, price and what constitutes good service. In purchasing health care a person will know how they feel, but will inevitably have to rely on others to give advice about causation, prognosis and what the best treatment options are. The first decision calls for experience, the second for expertise. Some of these arguments are explored further in the Care Services Efficiency Delivery (CSED) programme paper *Commissioning and Contracting for Outcomes*[36].

Where social care intersects with health in terms of recovery and re-ablement, people may know the outcomes they desire but may neither know what volume or type of care to purchase to achieve those goals, or have confidence in knowing what level of recovery they may be able to reach. For instance, for a first-time stroke survivor, knowing what level of care, rehabilitation and support is required to deliver a full recovery may not be known by many in the health service let alone by service users or care providers.

Personalisation suggests these issues can be overcome by good information and effective care brokerage. However, if assessment and resource allocation only focus on determining what level of incapacity equals what level of funding, like the allocation of disability living allowance, then the only transformation likely to be achieved is in changing who holds the purse strings. The need is for an approach that financially incentivises service users to purchase, and care providers to offer, services that reduce the need for state care and support.

To achieve this means moving away from measuring service provision by counting beds, hours or treatments and instead focusing on what outcomes are desired by the service user or could, or should, be achieved independently from what offer of state help and intervention may be available. It is only if we have clarity about the outcomes to be achieved that it becomes possible to determine how, by whom and at what cost they may be met. Paper 4 in this series explores these specific issues around outcomes further.

35 I Putting People First: A shared vision and commitment to the transformation of Adult Social Care HM Government 2007

36 I Contracting for Outcomes CSED 2009 http://www.dhcarenetworks.org.uk/csed

5. SUMMARY

Influencing, enabling and developing the social care market is not going to be an easy task. There will be greater diversity through more people purchasing care whether from their own funds or those supplied by the local authority, yet the local authority will still retain a role of purchasing on some people's behalf. The market will operate in the context of increased pressure on public funds through demographic change combined with a diminution in economic wealth, but at the same time will be under pressure to respond to a population used to exercising choice and increasingly able to access information via the internet.

What all these factors point towards is the importance of commissioners and care brokers rapidly developing skills in facilitating the market. Some of the roles and tasks that this is likely to encompass include the following.

- Moving the relationship with purchasers from 'arm's length' to 'embracing' so that the best providers can have confidence in making long-term business investment decisions and local authorities can understand and support the development of good practice.
- Developing clear models of good practice, rather than just examples, and then providing funding mechanisms that not only offer choice and control to service users, but encourage providers to reshape their businesses to deliver the new approach.
- Encouraging diversity in the marketplace through pump-priming small businesses and social enterprises, enabling them to grow into quality care providers.
- Having a much better idea of the health of local care economies so that vulnerable but key service providers can be supported and those that seek to create local monopolies of care provision can be discouraged.
- Developing much improved information systems. This requires information-giving systems for users that don't start from the perspective of local authority structures but focus instead on giving potential service purchasers the information they want to make good decisions. It requires information management systems that don't just count throughput or interventions but offer commissioners and providers the information they need to make judgements about what provision delivers what outcomes, at what cost.
- Ensuring where the local authority still contracts for services on people's behalf or offers contractual guarantees of service take-up, that those contracts are fair to all parties and are designed to stimulate the market rather than impose pernicious terms and conditions.

Other papers in this series look at how some of these skills might be developed and how the problems and issues presented here could be resolved.