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Understanding Public Services and Care Markets

Ann Netten, Robin Darton, Vanessa Davey, Jeremy Kendall, Martin Knapp, Jacquetta Williams, José-Luis Fernández and Julien Forder

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This paper looks at what factors influence the 'mixed economy' of the care market – including what funding is available and from where, and how commissioning works – and the role played by service users. It also examines how markets for home care, care homes and extra care housing work; how the market performs as a whole; and how policy and practice should be developed.

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About the authors

Ann Netten is Professor of Social Welfare and Director of the Personal Social Services Research Unit (PSSRU), University of Kent. Her research interests include cost estimation and economic evaluation of health and social welfare interventions (including criminal justice), care of older people, developing theoretical approaches to the evaluation of community care and measuring quality and outcomes in social care.

Robin Darton is a Research Fellow in PSSRU, University of Kent. He has a background in psychology and statistics, and research interests in health and social services provision for elderly people. He is currently working on studies of care homes, home care and extra care housing.

Vanessa Davey is a Research Officer in PSSRU, London School of Economics. Her work has focused on the impacts of new forms of social care commissioning, particularly service user control and choice. She is leading the evaluation of the implementation of the Direct Payments Development Fund in England for the Department of Health.

Jeremy Kendall is a Senior Research Fellow in PSSRU, and a Research Associate at the Centre for Civil Society, London School of Economics. His interests include the third sector in the United Kingdom and Europe, and the theory and practice of social care and personal social services markets and their regulation.

Martin Knapp is Professor of Social Policy and Director of PSSRU, London School of Economics. He is Professor of Health Economics and Director of the Centre for the Economics of Mental Health, Institute of Psychiatry, King's College London. Current research and teaching interests are in mental health economics and policy, and the economics of social care.

Jacquetta Williams is a Research Officer in PSSRU, University of Kent. Her research interests include social care services for older people, councils' powers and duties, and service users' involvement in research. She has been involved in Department of Health research investigating care home closures and a survey of resource use by the social care regulator.

José-Luis Fernández is a Research Fellow in PSSRU, London School of Economics. His main current interests are in the areas of social care economics and the analysis of territorial justice in the allocation of social care resources.

Julien Forder is an economist and has recently completed a two-year secondment to the Department of Health Strategy Unit, where he worked on the NHS Improvement Plan and the Green Paper on adult social care. A particular interest is the operation of residential and domiciliary care markets. Julien is currently working as project manager for the Wanless Social Care Review.

Introduction

In 2004, the King's Fund established a Committee of Inquiry to consider care services for older people in London and whether there are likely to be sufficient care services of the right design and quality to meet the needs of older people in the short and longer term future. Much care provision, particularly social care services, now takes place in the context of the market. The Personal Social Services Research Unit was commissioned to produce an analysis of social care markets to inform the Inquiry, and this paper reports on the results of that analysis. A companion paper (Netten *et al* 2004a) summarises the main messages.

What is social care?

Social care for older people is primarily concerned with compensating for the impact of physical or mental impairment. In this sense, social care for older people is closely linked to, but distinct from, health care, where the focus is on the treatment or mitigation of impairment. Currently, most of the social care in this country is provided informally by family and friends. The remainder is provided formally by public- or private-sector organisations, which deliver social care services in a number of contexts – in people's own homes, in residential establishments, or in day care facilities. In response to changing policy emphasis, these services increasingly aim to help people increase or retain their independence and prevent deterioration of their condition.

The majority of formal social care provision is funded by the public sector but provided largely by independent providers in a mixed economy of care. The influence of government policies and other public bodies (particularly those charged with commissioning care) on such a market is profound. We start our discussion by considering those factors that influence the market – the sources and levels of funding, the commissioning process and regulations. We then reflect on the role of the ultimate consumer the service user – before examining the operation of the markets for home care, care homes and extra care housing. Our final section considers overall market performance and how some of the problems that are emerging might be addressed through existing and potential policy and practice levers.

Terminology

To frame the discussion it is helpful to define what we mean by the following terms.

Demand

We define the demand for care as a need that is backed by the ability to pay for the services that will meet it. The extent of the need could be assessed formally in terms of the criteria set by an agency, such as a local authority, or informally in terms of the subjective

perceptions of individuals or their families. The ability to pay could depend on an agency's willingness, having established eligibility, to purchase services from its budget, or the individual's own willingness to meet the costs of services from their own resources.

The demand for social care for older people is affected by the following factors:

- demographics – the number of older people, their levels of impairment and the availability of informal carers
- central government policies – in particular, levels of funding and boundaries around what constitutes the demand for publicly funded care
- local government policies – how they implement central government policy and whether they provide their own services or use independent providers
- other markets – for example, improvements in health care might reduce dependency, and availability of accessible housing might influence people's ability to remain in their own home.

Supply

The two dominant social care services are care homes and home care. The largest component of total public expenditure on social care services is on care homes for older people (62 per cent of the total government expenditure on older people). However, the largest group of publicly funded service users are users of home care (373,500 clients compared with 218,500 residents).

In addition, there is a developing service in the market known as extra care housing, which encompasses a variety of schemes in which housing and care are integrated. All these forms of provision are discussed in detail in Market performance and levers (*see* pp 29–33).

Commissioning

The key function that relates demand and supply is the commissioning process. Commissioning goes beyond simply procuring services and includes:

- clarifying organisational mission as it relates to purchasing and provision
- defining need
- identifying and assessing need
- clarifying the services necessary to meet those needs (that is, service specification)
- negotiating contracts with providers to deliver those services
- monitoring contracts and providers' levels of performance
- renegotiating, terminating or extending contracts (Wistow *et al* 1996).

There are a number of approaches to commissioning and these are discussed in detail in Commissioning (*see* pp 5–12).

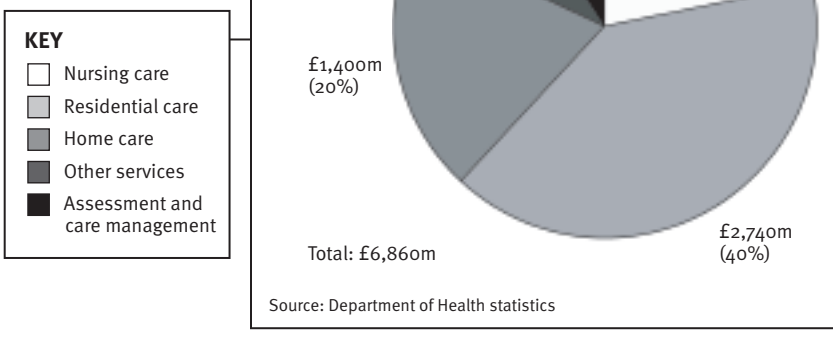
Since the 1990s there has been a growing emphasis in health and social care policy on involving service users and their informal carers in the planning, delivery, monitoring, evaluation and improvement of social care services, and consulting them about their needs, priorities and preferences. Commissioners' understanding of service users' perspectives is therefore central to delivering responsive and good quality services. The degree to which service users' perspectives are reflected in the social care market is discussed in Social care service provision (*see* pp 15–28).

Funding

Public funding of social care for older people has been increasing above the rate of inflation in recent years and it is planned that funding will continue to increase at a rate of 6 per cent above inflation until 2008. These increases are linked to long-term government objectives to improve health and social care services (Department of Health 2002a). However, funding of social care for older people is not ring-fenced and so there is no guarantee that this funding will actually be used for the care of older people. The Formula Spending Share (FSS) system provides indicative amounts for social care expenditure, but authorities are largely free to choose the amounts that are actually spent. In fact most authorities spend above their share (that is, they direct money away from other services for which they are responsible). However, a review of the FSS undertaken in 2001/02 showed a major shift in the allocation of funds away from the care of older people towards services for children. In 2002, 85 per cent of authorities reported a gap between the cost of meeting all expected demand within existing eligibility criteria and the budget available for 2001/02 (LGA/ADSS 2003).

In 2002/03, gross public current expenditure on social care was £15.2 billion, of which £6.9 billion, or 45 per cent, was on services for older people. Charges to clients recouped about a quarter of all expenditure on older people. Nearly two-thirds (62 per cent) of gross expenditure on older people was on residential provision, 29 per cent on day and home care provision and the remainder on assessment and care management (*see* Figure 1).

1 EXPENDITURE ON OLDER PEOPLE BY SERVICE TYPE, 2002/03



Source: Department of Health statistics

Competing demands on social care funds, combined with specific government policies, have placed local authorities under considerable financial pressure. For example, efficiency targets set in 1999 required local authorities to achieve a 2 per cent increase in efficiency in the years 1999/2000 and 2000/01, and a 3 per cent increase in 2001/02. Efficiency is difficult to measure and unit costs are often taken as indicators of efficiency.

In 2001, the government made increased levels of funding available to local authorities. This enabled local authorities to enter into long-term agreements with independent sector providers, and, where necessary, to increase the fees that they paid out in order to develop and improve services and help stabilise the care home sector (Department of Health 2001a, 2002b). This funding increase was mainly motivated by concern that restricted capacity in the social care system was affecting the delivery of acute health care through unnecessary admissions to or delayed discharges from hospital. Further funding was also made available as part of an initiative by which local authorities were charged for the costs of acute beds occupied by people who are ready to be discharged (Department of Health 2002c, 2002d).

Specific grants have also been made to address recruitment and retention problems among social care staff.

Commissioning

The 1990 National Health Service and Community Care Act introduced a number of changes to the provision of social care, which fundamentally changed the role of local authority social service departments. Previously, these departments had extensive experience of interacting with individual external providers of specialist services, but during the 1990s they assumed responsibility for guiding and managing local markets for social care. This resulted in a rapid growth of private and voluntary sector provision, especially in relation to services supporting older people. This growth has been based substantially on 'contracting out' arrangements by local authorities. By 1999 residential and home care was being purchased predominantly from external agencies for the first time.

Within local government there was considerable resistance to the use of a market commissioning model for securing social care services. The reasons for this were:

- general resistance to policy changes imposed by central government
- a belief that a system in which local authorities provide services offers greater scope for local democratic control
- concern that it was inappropriate to make profit from vulnerable people.

However, during the 1990s this resistance was gradually overcome. There was a broad political shift within the Left, which led to a more pragmatic view of 'what works' and less concern about state control. There was also a realisation that, although independent providers were by nature oriented towards profit, they were not simply crude profiteers (in reality, actual returns were limited), but were in fact often motivated primarily by empathetic and professional goals worthy of respect and support.

More recently, three factors in particular have contributed to the softening of opposition. First, it is just over ten years since the direct relationship between purchaser and provider was separated by the commissioner. Many policy scientists suggest that this is the length of time it takes for a 'policy community' to become 'mature' in terms of the durability of its institutions, and the mutual recognition of the beliefs and motivations of those involved (Sabatier and Jenkins-Smith 1993). Second, the introduction of national regulatory standards and a national regulator, while clearly still in their infancy, provides some assurance of minimum quality standards. Third, and most arguably, the more comfortable relationship that developed between central and local government made the latter more receptive to the former's promotion of the use of the market in social care.

However, there are some residual concerns. First, there is a general concern that the more centralised and bureaucratic system of regulation that has developed serves to concentrate power centrally. Second, there is concern among independent providers that

fees paid by social services, particularly for residential care, are unrealistically low and that there is preference given to remaining local authority services (Kendall *et al* 2002). Third, there is concern that there is a tendency for commissioners to use traditional rather than innovative services. Finally, there is concern that the commissioning of specific services for individuals – commissioning at the micro level – is fragmented, with different staff responsible for different elements, such as initial screening and assessment, devising and arranging care services, actual service provision and service review. This fragmentation has led a significant number of users to express concern about quality.

Variation in local authorities' commissioning arrangements

Although local authorities have all been moving in the same direction, they had very different starting points, have moved at very different paces and have varied considerably in their ability and willingness to change their attitudes. There are also variations between the commissioning arrangements for different types of care. Residential care is predominantly provided by the independent sector, and home care is also moving in this direction. But local authorities continue to provide most day care services, with the remainder provided by the voluntary rather than private sector (Kendall 2000).

There are also variations in the pricing strategies set by different local authorities. Some (particularly London authorities) use a flexible approach whereby the price for a particular service varies with individual clients: others use a more uniform system with fixed prices for all services.

The arrangements for conducting transactions with providers are, in the main, relatively simple, as reflected in the types of contracts used and the arrangements for payment. The box opposite describes the five main types of contract used in social care. Nationally, price-by-case arrangements (including 'spot' and 'call off' contracts) are the most commonly adopted. London makes significantly greater use of block contracts (whereby payment is made in advance for an agreed number of services, regardless of whether that service is actually used) than other local authorities. For home care services, 79 per cent of London boroughs use block contracts, compared with 47 per cent of authorities nationally, and 30 per cent of London boroughs use long-term (ten years or more) block contracts for residential care, compared with 12 per cent nationally.

Joint commissioning

During the 1990s, models of commissioning continued to diverge and the number of independent providers increased. This often made it difficult to provide continuity of care for service users, for whom the distinction between health needs and social care needs was relatively arbitrary anyway. Concern about this issue prompted the government to promote the integration of health and social care, and make integration mandatory for primary care trusts (PCTs) – the new institutions responsible for primary care and community health.

This policy of integration was formalised in the Health Act of 1999, which allowed for:

- the establishment of pooled budgets between health and social services
- 'lead commissioning' arrangements through which either the local authority or the PCT takes responsibility for commissioning services on behalf of both organisations
- integrated provision of all local authority and health services.

CONTRACT TYPES IN SOCIAL CARE

Spot contracts and call-off contracts These are price-per-case arrangements whereby prices and other terms are agreed in relation to individual units of service, usually around the person receiving care. Thus payments are made for services used by individual clients. Call-off contracts differ from spot contracts in that the price per unit of supplied service is set in advance and fixed for the contract period. Spot contracts have the price and other terms agreed in relation to particular units of service, to be consumed by specific clients. Thus, throughout the financial year the price of an hour of home care under a spot contract can vary from one client to another. With call-off contracts, prices are set in advance and cannot vary.

Block contracts These involve the purchase of the total quantity of a service expected to be required over a period of time. Payment is agreed and made in advance, regardless of whether subsequently that service is actually used. Usually, the block of supply purchased is sufficient to cover the service requirements of many users. Indeed, were block contracts used only to purchase services for a very few clients they would differ little from call-off contracts.

Cost and volume contracts These are hybrids of block and call-off arrangements: payment is agreed and made for a block of supply, but additional payment is made for service units beyond this level only if they are actually consumed.

Grant contracts For these, providers are paid a lump sum with the expectation of meeting the service needs of a nominal number of clients. However, the actual level of supply is not explicitly agreed and only broad service specifications are laid out. Essentially, therefore, it is providers who determine the quantity of service.

Taken from Forder *et al* (2004)

Implementation of these flexibilities has been relatively slow, particularly for long-term care services for older people, where lead commissioning has been the least popular of the new arrangements (Hudson *et al* 2002; Davey *et al* 2004). A study conducted in 2002/03 found that joint arrangements between health and social care agencies were held together by a belief in the importance of joint planning, prioritising and reviews of services, and the need for a simple flow of finances between health and social care (Davey *et al* 2004). However, both parties wished to be able to scrutinise the origin of funds within all transactions to ensure accountability. It was also found that social services departments that had pooled budgets with PCTs were negotiating to ensure that they took the lead on strategic aspects of commissioning services for older people. The risk of this is that the dynamics between social care purchasers and providers remain largely unchanged. Moreover, social services and primary care have limited capacity for large-scale investment in specialised integrated provision in terms of facilities, ability to secure capital, workforce supply and managerial skills.

In addition to the flexible arrangements offered by the Health Act, there are a number of new policy frameworks for planning and prioritising services. Local strategic partnerships bring together purchasers, providers and other stakeholders from a variety of areas related

to the needs of different service user groups. These forums are expected to plan together, sharing information about current activity to explore priorities, challenges and opportunities across 'whole systems' of services. As leaders of the forum, PCTs and the social services departments of local authorities are required to produce a five-yearly Local Delivery Plan, detailing how services will be delivered to meet the needs of the local population.

The increasingly broad membership of Local Strategic Partnership Boards should ensure that the preferences and needs of service users are understood more effectively. This factor, combined with pooled budget arrangements and the development of policies of social inclusion, seems to have broadened service provision. There is evidence that services are being commissioned to meet specialist needs (for example, culturally specific needs), and to tackle the problems people with such needs often face in accessing services. Furthermore, some services are challenging traditional thinking about social care. For example, there are reports that the discharge, welfare and support services provided by community and voluntary organisations have been 'surprisingly effective' in meeting needs and achieving objectives, such as reducing hospitalisation (Davey *et al* 2004). This has led commissioners to consider such services as effective substitutes for low-intensity home care, and to reconfigure home care services as a more intensive and specialised service (Davey *et al* 2004).

Since April 2003, PCTs have also become responsible for funding nursing care in nursing homes. This, together with the requirement for health and social services to integrate first-level needs assessments for older people, has led local authorities to encourage PCTs to take a lead role in micro-commissioning arrangements. This should enhance service users' experiences of assessment and continuity of care.

The area in which joint commissioning is developing most rapidly is intermediate care services. Intermediate care can be provided in a variety of community and residential settings, with large variations in therapeutic inputs and staff ratios. Social services departments tend to use intermediate care to rehabilitate people who are in crisis and at risk of requiring more intensive care packages and/or residential or nursing home care. Despite regulatory requirements that PCTs and social services departments advertise for and consider competitive tenders for intermediate care, in practice in-house staff are usually favoured as providers of care. Evidence of the benefits and cost-efficiency of intermediate care is weak and the unit costs remain high. Contractual arrangements with intermediate care providers are often weak and local models relatively unevaluated, despite a variety of good practice guides (Department of Health 2001b; Stevenson and Spencer 2002). A number of evaluations have also shown problems associated with less than optimal use of services (Carpenter *et al* 2003; Patel *et al* 2003).

However, if the role of intermediate care is increased, health and social services will need to draw on more independent care providers to provide services. Early findings suggest that, so far, social services have tended to use medium to large corporate providers of intermediate care more than small residential providers.

Direct Payments

Direct Payments is a system based on an assessment of needs, whereby the service user is allocated funds and (to a lesser or greater degree) support to organise and purchase, or commission, their own services. This system has been an option for younger disabled people for some time and became available to older people in 2000 (Department of Health 2000a).

Direct Payments have a number of perceived benefits. They:

- offer choice, control and flexibility to service users
- provide more efficient and effective matching of resources to needs with potentially improved outcomes
- expand the potential pool of caregivers by offering flexible working arrangements and an option to use personal contacts
- involve lower administrative costs than local authorities' service packages
- serve to increase the number of consumers in the market place, with the result that there is an increase in competitiveness, which can improve the quality, responsiveness and/or prices of services.

To date, take-up of Direct Payments among older people has been very slow. By the end of 2002 only 1,032 older people were receiving cash payments in lieu of social services. Some local authorities operate Direct Payments as a way of reducing the cost of care packages (through providing a lower rate for a direct payment than they would pay to a service provider). These authorities argue that this is equitable as it involves a reduction equivalent to overhead costs; however, it places service users at a disadvantage as independent purchasers in the marketplace.

Some commissioners are seeing Direct Payments as the spot purchasing for the future. Some authorities are promoting Direct Payments for call-off contracts that would otherwise be arranged by the local authority (such as periodic respite services). While this enables the service user to achieve increased flexibility, it also shifts the burden of responsibility for arranging services on to service users.

Scottish research suggests that local authorities with a high rate of block contracts are disinclined to promote Direct Payments for fear that they will end up paying twice for services (Direct Payments Scotland 2003). This is considered to be one of the main reasons why take-up has remained slow, and commissioners are discussing the need to free up resources from block contracts.

Potentially, Direct Payments could have a profound impact on the market for social care, as personal commissioning can support more informal approaches to care – for example, allowing for the possibility that family members could be paid for providing care. However, there are dangers of exploitation on both sides and, in many instances, older people themselves (for example, those with dementia) are not in a position to or do not want to manage their own care.

Regulation

Regulation plays a key role in the protection of service users and in raising quality of care. The current regulatory framework has had an important impact, particularly on the care home market, which will be discussed in detail in Market performance and levers (*see* pp 29–33).

The creation of the National Care Standards Commission (NCSC) in April 2002 established a national system for judging service quality across home and residential care services for adults and children. From 2004, the Commission for Social Care Inspection (known as CSCI or Commission) took over the work of the NCSC, as well as that of the Social Services Inspectorate (SSI) and the Joint Review team of the SSI/Audit Commission.

Proposed national minimum care standards for care homes were published in September 1999 and subsequent standards were amended in March 2003 (Department of Health 2003a). As a result of the amendments, some standards are not mandatory for homes that existed prior to April 2002. For example, since April 2002 all new homes, extensions and first-time registrations are required to provide single rooms for all occupants. Existing homes are required to maintain the proportion of single rooms at the level that they had in August 2002.

It was not until 2003 that regulations required home care providers to register and comply with care standards. In part, this reflects the fact that until recently most home care was provided by local authorities, which were not themselves subject to regulation of their services.

Impact of regulation on the market

Regulation has a direct influence on market supply. Services are required to register, thus regulating the quality of new services, and inspection ensures that existing services of poor quality are de-registered.

One standard in particular that has a direct impact on the market is that related to the care workforce. By April 2008, 50 per cent of direct care workers should be qualified to National Vocational Qualification (NVQ) level 2 or above (Department of Health 2003b). Providers have a number of concerns about this, including the cost of the training required and the potential for increased turnover of staff as those who do not wish to be qualified leave for other types of work or retire, and those who do become qualified leave for better paid work in other agencies.

One clear objective of regulation is to maintain or improve the quality of care provided. There was some concern that the introduction of care standards may have contributed to the closure of care homes between 1998/99 and 1999/2000 – not because the homes in question were of poor quality but often because they were smaller homes that could not afford to implement the new standards. It is too early to tell whether regulation has improved the quality of care provided by homes that are continuing to operate. The first year of inspections has usefully identified the most common deficiencies (Dalley *et al*

2004), providing benchmark information against which future changes can be judged. However, it will be difficult to establish the degree to which any future improvement in quality can be attributed to the process of regulation, or to other factors shaping the market. Moreover, the CSCI is reviewing the existing regulatory approach.

The costs of regulation will also have an impact on the market. The government has adopted an explicit policy to pass on the full costs of regulation to those regulated, and this has resulted in a substantial, although phased, increase in fees being paid by care homes. From 2002, the estimated costs of regulation were based on a study of the resources used under the regime prior to the NCSC (Netten *et al* 1999), although a subsequent study of the resource requirements of the NCSC found that the time taken to carry out inspections had increased substantially compared with the time taken by local authorities and health authorities in 1998/99 (Netten *et al* 2003a). This increase in the resources used to carry out inspections suggests that the CSCI may need to consider whether to modify or streamline its approach in order to operate within resource constraints and/or whether to pass on the additional costs to the providers who are being regulated in the form of increased fees.

Incentives and sanctions

The range of incentives and sanctions available to secure compliance will also influence the impact of regulation. There is a lack of formal incentives, although homes can be judged as 'exceeding' specific care standards, and this information is in the public domain. There is some evidence of informal incentives, in that a positive relationship between regulators and providers can encourage good practice, and that managers in large-scale organisations can use regulations as a lever within the organisation to institute improvements in the care homes they manage.

Sanctions available to the CSCI include statutory notice of the changes required to comply with a regulation or law, notice that action is required within a given timeframe (urgent actions), and prosecution and/or the closure of a service.

During its first year the NCSC took a light touch approach towards enforcement action and closed only four care homes for adults (National Care Standards Commission 2003). Clearly this approach cannot continue given that one in ten of the 12,685 complaints received by the NCSC during 2002–03 made a specific allegation of abuse (Health Select Committee Inquiry into Elder Abuse 2004) and one in eight (12 per cent) care homes for older people failed to meet the standard for medication (Davies *et al* 2004). The Health Select Committee on abuse of older people made the following recommendations: the introduction of a regulatory requirement for all providers to report adverse incidents occurring in home care (the most common setting for abuse); the introduction of performance indicators to measure the amount and impact of adult protection work; the speedy introduction of the planned Protection of Vulnerable Adults (POVA) list; and the registration of all social care workers including those employed through Direct Payments (House of Commons Select Committee on Health 2004).

Providers' perspectives

How do providers feel about the current regulatory regime? Unpublished Personal Social Services Research Unit Commissioning and Performance Programme research has confirmed that no providers contested the basic legitimacy of developing a strong national regulatory framework. However, although the Fit for the Future consultations (Department of Health 1999b) had claimed to be comprehensive and inclusive in breadth and depth, small providers in particular felt that their concerns had not been adequately captured. A number referred to 'poor planning', regulations 'not thought through' and spoke of government modifications to regulatory requirements between 2000 and 2002 as panic-driven 'back tracking'; easily avoidable if only the initial consultation exercise had been undertaken more intelligently and systematically. In the light of the initial regulatory requirements, an alarming 46 per cent of small home operators had actually considered leaving the business (for both medium-sized and corporate homes, the proportion was 25 per cent).

The way in which inspections are conducted and relationships developed also shapes providers' assessment of their regulatory environment. Four factors seem to contribute to positive assessments:

- sustained feedback and communication between inspectors and providers in and around the regulatory process
- 'realism' in inspectors' approaches – for example, where they set timescales for implementation that err on the side of generosity
- appropriate distribution of inspectors' time during inspections, in particular, the allocation of a significant amount of time for speaking to residents, present relatives and staff
- effective personal style on the part of the inspector – one that is conducive to mutual professional recognition and respect.

Service users

In theory, consumer choice should promote competition among providers and drive up quality, efficiency and responsiveness at the local level, although the link between choice and improved quality is not guaranteed (Appleby *et al* 2003).

The choices potentially available to individuals include:
- the right to choose the type of care received
- the right to make an application for a particular provider
- the ability to choose the content, level and timing of care provided
- and/or the ability to purchase care directly using Direct Payments.

However, service users may not be taking part in a voluntary exchange, may not pay for services, may not receive services because they fail to meet eligibility criteria and may find it difficult to change providers when standards or preferences are not met (Needham 2003).

There is also some evidence that some choices are more important to some service users than others. For example, research suggests that for service users in the community, choice between providers of home care is of less importance than choice about the content, timing and duration of services (Hardy *et al* 1999). Service users exercise their choice differently depending on whether they are self-funded or publicly funded. For example, publicly funded service users choosing a care home are restricted to homes that do not cost more than councils would usually pay, unless their relatives are able to contribute additional payments.

A lack of choice of care home has been attributed to financial restrictions, the availability of places, the admission criteria of homes, and limited information about homes or how to choose between them (Myers and MacDonald 1996; Davies and Nolan 2003). A reduction in the choice of provider and care home size has also been attributed to market competition, as smaller providers are squeezed out of the market by an increasing number of corporate providers (Hardy *et al* 1999). Block contracting arrangements, and cheapest or in-house-first policies have been identified as restricting users' choice of home care services, and tight eligibility criteria as removing the scope to choose the content and timing of services (Ware *et al* 2003).

To date, there is limited information about the choices available to, or influence of, users of sheltered housing and extra care housing. For the most part, studies investigating people's experiences of moving to such schemes identified a similar pattern to those admitted to care homes: people said it was not a positive option at the time of making the decision, and felt pressurised by relatives to do the right thing (Oldman 2000; Bartholomeou 1999). An important exception was an evaluation of the Joseph Rowntree

Foundation continuing care community in Yorkshire where people who had not previously considered moving decided to move on hearing about the scheme (Croucher *et al* 2003).

Direct Payments brings choice 'closer to consumers' (Policy Commission on Public Services 2004) and so should strengthen their market power. However, direct choice increases the need for information and the need for councils and providers to consider the diversity of service users' needs, attitudes and empowerment levels (Policy Commission on Public Services 2004). Provision and use of Direct Payments has been geographically uneven and hampered by inconsistent implementation by local authorities, lack of information and support to help consumers deal with providers, and lack of awareness among care professionals (Carr 2004).

There is a need to establish whether mechanisms for involving older people in shaping the market, other than the choice mechanism, are working. However, a lack of evidence hampers any evaluation of the impact and outcomes of involving older people in planning and development (Carr 2004; Policy Commission on Public Services 2004). There is concern among social care professionals and older people that involvement of service users should be widened to avoid an over-reliance on the views of a small number of committed activists from local groups (Dewar *et al* 2004).

There is increasing use of service user surveys to evaluate the performance of services. The Department of Health has introduced annual surveys conducted by local authorities that feed directly into best value performance indicators (BVPI) (Department of Health 1998a). The survey in 2003 was of older users of home care services, and reflected genuine variation in people's experiences (Netten *et al* 2004b). There was, however, a much lower level of satisfaction among people from black and minority ethnic backgrounds. Generally, these groups were receiving more intensive services, suggesting that they had higher levels of physical and cognitive disability, which may in part explain their overall lower levels of satisfaction. However, the lower levels of satisfaction reported by black and minority ethnic service users related more to their views of individual care workers than to service quality in general.

Whatever the cause, the market is clearly failing to ensure that the needs of these groups are met and that services are responsive to the diversity of service users in terms of their race and culture. This is an important issue, as the proportion of older people from ethnic minorities is growing, particularly in London.

Social care service provision

The most widely used social care services are home care services and residential care homes. In this section, we will describe how each of these services has developed and is currently operating, and look at how the development of these markets has been influenced by policy, commissioning practice and the regulatory environment. We will then go on to discuss the development of extra care housing, which operates in a rather different market.

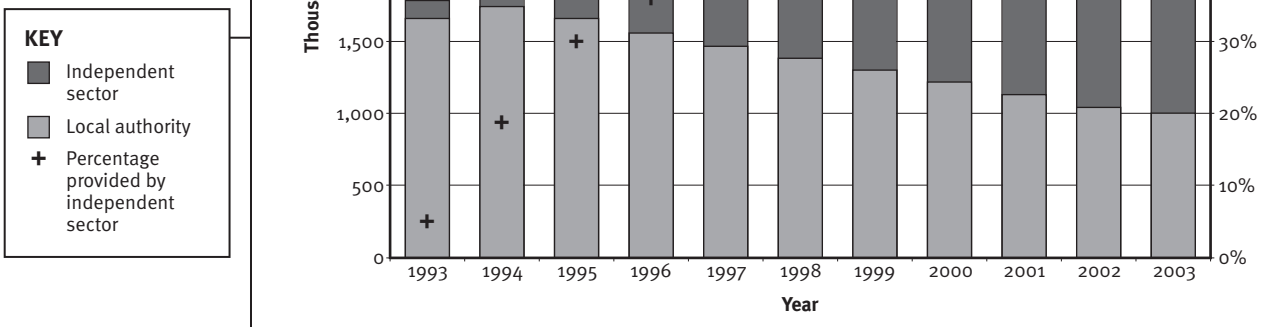
Home care services

Home care services are the key to maintaining frail older people in their own homes. Over the past 15 years there have been dramatic changes in who provides and who receives home care services and in the nature of the services themselves.

Providers

Overall levels of care purchased by health and social services rose by 75 per cent between 1993 and 2003 (*see* Figure 2). The rise was due entirely to an increase in the use of independent services; during the same period the number of hours of home care provided by in-house local authority services fell by 38 per cent.

2 **HOME CARE CONTACT HOURS[1] BY SECTOR OF PROVISION IN ENGLAND, 1993–2003**



Source: Department of Health, Annual Return HH 1, table 1
[1] Survey week in September

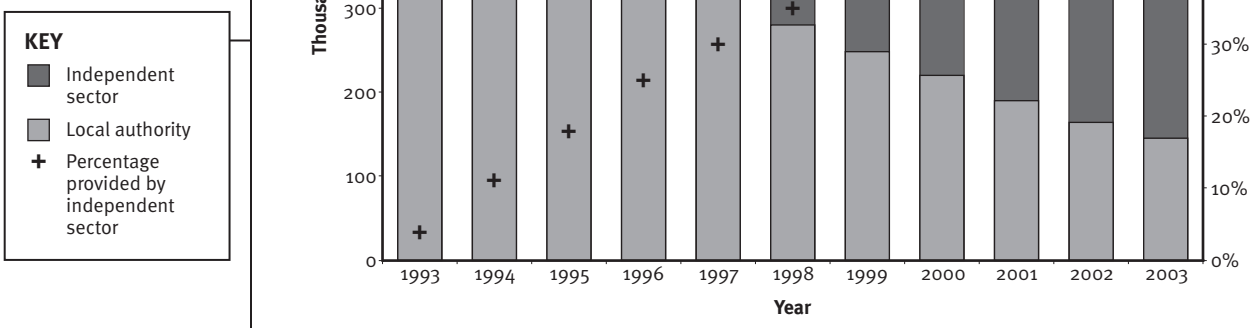
The shift to independent provision of home care led to a rapid increase in the number of providers in the 1990s. In 2004, more than 3,000 home care providers were registered with the Commission for Social Care Inspection (CSCI). Overall Laing & Buisson (2003a) describe the market as 'fragmented', with relatively few large providers and many small ones. The majority (82 per cent) of independent providers are in the private sector, half of these being sole traders or partnerships, and half private or public limited companies (Laing & Buisson 2003a). In a survey conducted in 1997, Laing & Buisson found that only 37 per cent of home care providers were exclusively providing home care. Many services developed from nursing agencies and some from care home providers. In a survey of care homes, 14 per cent of nursing homes and 19 per cent of residential homes were providing home care services (Laing & Buisson 2003a).

Intensification of services

During the past ten years, home care services have been providing a more intensive service for fewer people. While overall levels of provision have increased, the number of clients has decreased: the number of households receiving home care services fell by 27 per cent between 1993 and 2003 (*see* Figure 3 below). Furthermore, the average number of publicly funded home care contact hours per household more than doubled, from 3.5 hours per week in 1993 to 8.2 hours in 2003, and the proportion of households receiving only one visit of two hours or less decreased from 38 per cent in 1993 to 15 per cent in 2003 (Department of Health 2004a).

As would be expected, the intensive services have been targeted at those with the highest levels of need. Users of home care services who were physically and cognitively more dependent were receiving social care more frequently in the mid-1990s than in the mid-1980s (Bauld *et al* 2000). Those with lower levels of need are increasingly purchasing

3 **NUMBER OF HOUSEHOLDS[1] RECEIVING HOME HELP OR HOME CARE, BY SECTOR IN ENGLAND, 1993–2003**



Source: Department of Health, Annual Return HH 1, tables 2a and 2b and 3a (2000 onwards)
[1] Survey week in September. Households receiving home care purchased with Direct Payments are excluded. Estimates for missing data

support services independently of social services. The estimated number of older people with only one problem with activities of daily living (such as bathing, dressing, feeding, washing and getting to and from the toilet) who were receiving private domestic help increased by 151 per cent between 1995 and 1998 (Pickard *et al* 2001).

The public provision of domestic and associated help has been withdrawn in order to focus resources on providing personal care and support. Although this may have contributed to the reduction in rates of increase in care home admissions, a number of observers have identified how important domestic and associated help are to older people (Clark *et al* 1998; Hirst *et al* 1995; Quilgars *et al* 1997). The emphasis on consumer choice and control may result in another shift in what is purchased from public funds.

Self-funders

As previously mentioned, there has been a dramatic increase in the number of individuals purchasing private help. Clearly this includes private domestic arrangements between individuals. Evidence is mixed on exactly what proportion of care from home care agencies is purchased by private clients. A study by the United Kingdom Home Care Association conducted in 2000 suggested that 40 per cent of care hours were purchased privately, compared with 27 per cent estimated by a study conducted by Laing & Buisson at the same time (Laing & Buisson 2003a). Laing & Buisson (2003a) also identified the fact that self-funders are routinely charged more than local authority service users, due both to what is purchased (in terms of tasks and qualifications of staff) and to their lack of bargaining power compared with local authorities.

Contracts

Many providers of home care services have a combination of different types of contract with local authorities. The most common type of contract is the call-off contract (*see* Box, p 7) whereby prices and other terms are agreed in relation to individual units of service, with the price per unit of supplied service agreed in advance and not related to quantity of services provided. Over half of providers in a study of 155 home care providers in 1999 were entirely dependent on this type of contract, and over 80 per cent had a contract of that type with at least one authority (Forder *et al* 2004). Ware *et al* (2001), reporting on the same study, note that voluntary providers in some areas retained a protected place: grant aided or having partnership agreements with guaranteed contracts. The most preferred type of contract among providers was the block contract (34 per cent) or cost and volume (30 per cent) (Forder *et al* 2004).

Care managers often commission services for users in terms of a given length of visit for specific tasks for particular times of day. Patmore (2003) found that some providers had scope to amend the timing of visits but very few could make even very modest increases in the amount of time without express permission. In such circumstances, the level of control that the provider has is minimal, reducing scope for flexibility in responding to changes in the circumstances or preferences of the service user. We know of at least one instance (there may well be more) where a more global approach to commissioning services is being adopted, whereby a level of funding is provided and the details of service delivery are negotiated between the provider and service user. Clearly the level of trust between providers and purchasers needs to be high for this type of arrangement to work, but there is potential for delivering care in a way that much more closely reflects both user preferences and variations in those preferences.

Prices and mark-up rates

In 1999, prices of home care were related to nursing qualifications among care staff, dependency of service users and whether live-in services were provided. The mark-up rate of price over cost was estimated as about 12 per cent (Forder *et al* 2004). Demand and supply were found to be very responsive to changes in prices, with a 1 per cent price rise resulting in a 6.6 per cent reduction in demand and 8.1 per cent increase in supply (Forder *et al* 2004).

As in the care home market, local authorities have used their purchasing power to keep prices down. The prices paid to the independent sector are consistently below the estimated costs of in-house services (Netten and Curtis 2003). Pressures on providers are increased by the widespread practice of local authorities paying on a per hour rate and then commissioning care for half-hour periods or less.

This pressure on prices does not appear to drive providers out of the market but rather to affect employment conditions for care workers and the quality of care provided. For example, independent providers complain that no allowance is made in the fees for care workers' travel between visits (Francis and Netten 2004; Starfish Consulting 2003; Patmore 2003). This has implications both for the care workers (who often bear the cost in time and expenses) and for the reliability and level of service offered, especially as the trend has been to provide more and shorter visits of half an hour or even less. It is common practice for care workers to have zero hour contracts. This means that they have no guaranteed work and often take second jobs in order to secure more income (Francis and Netten 2003).

In-house provision

In-house services play a unique role in the home care market. In a 1999 survey of providers, none of the local authorities organised their in-house provision as a free-standing service that contracted on the same terms as an independent service. Independent providers suggested that local authorities gave preference to in-house providers (Ware *et al* 2001). In-house providers' costs are higher and provide better terms and conditions for staff compared with the independent sector. Probably as a result, there is also evidence that they provide higher quality services (Netten *et al* 2004b).

In-house services are sometimes used as a safety net when authorities find it difficult to find independent providers for particular types of client (such as those with challenging behaviours or those living in remote areas) or when services are required at short notice – for example, following hospital discharge. In a recent small-scale study, 5 out of 11 in-house providers were found to be negotiating new specialised roles with purchasers as short-term rehabilitation teams or providers of services for those with complex disorders (Patmore 2003).

Entry and exit

There are no data currently available on levels of exit and entry for providers in the home care market. The principal administrative barriers to entry are the registration process and the need to gain contracts or accreditation from purchasing authorities. However, the industry is fundamentally dependent on the workforce, and the labour market conditions that prevail in many parts of the country constitute a potential barrier to entry and

incentive to exit. Indeed there are few barriers to exit from the market, making it potentially unstable if subject to excessive regulation or further downward pressures on fees.

It is important for purchasers to respect the autonomy of independent providers and recognise their competence and professional achievements. There needs to be ample opportunity for communication and feedback between purchasers and providers.

Research suggests that the institutional arrangements that local purchasers have set in place for as many as half of all providers of home care services – in terms of participation in forums, review and planning processes, and contractual design, for example – have failed to create such supportive conditions (Kendall *et al* 2003). This underperformance may serve to both block desirable market entries and leave existing providers feeling trapped and frustrated.

Quality of care

Provision of high-quality care is fundamentally dependent on the nature, commitment and practices of the workforce delivering that care. For service users, the characteristics of the care worker is one of the most important aspects of quality of the service (Francis and Netten 2004). Yet this workforce is paid low wages and often receives minimal training. Recruitment and retention problems are widespread and are not helped by the generally poor terms and conditions offered by employers (Francis and Netten 2003).

The motivation and behaviour of care workers has a profound impact on the experience of service users. Often care workers will provide additional care in their own time to compensate for what they see as poor-quality care or they will be prepared to bend the 'rules' (Francis and Netten 2003). The 'rules' about what can and cannot be done are applied differently at local authority, provider and individual care worker level. Under the types of pressures that currently apply, home care is fundamentally inequitable.

Care homes

Residents of care homes comprise one of the most vulnerable groups of people. It is therefore not surprising that concerns about the operation of the care home market in recent years have received considerable public attention (House of Commons 2000; Bunce 2001; Mitchell 2001; Pollock 2001; Steele 2001). Most recently, in response to a request by the Consumers' Association, the Office of Fair Trading (OFT) has carried out a study to assess the impact of price information on competition and choice among care homes for older people (Office of Fair Trading 2005).

Development and structure of the market

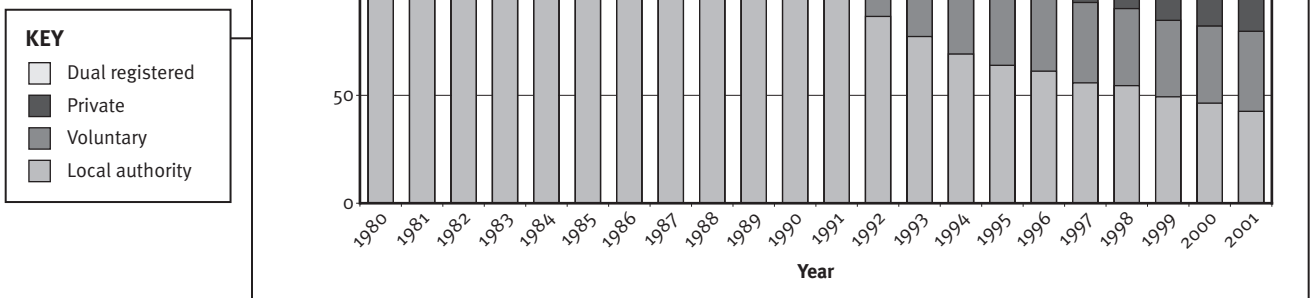
The growth and change in the structure of the market in care homes occurred during the 1980s (Darton and Wright 1993). Until the introduction of the new regulatory regime in 2002, homes were registered as nursing homes, residential homes or dually registered to provide both types of care. Figures 4 (*see* overleaf) and 5 (*see* p 21) show how the numbers of care home places rose dramatically during this period, fuelled almost entirely by the growth in the number of private places offered by independent providers. In the nursing home sector, which was dominated by for-profit providers, and which started from a lower base, the increase was even more pronounced. This was due largely to a change in

eligibility rules that resulted in an increase in the support available to residents from the social security system. However, the Audit Commission (1986) identified this increase in the availability of social security funds to residents, without any associated assessment of need, as a perverse incentive towards institutional care, contrasting with the long-standing policy objective to support people in the community with home-based care.

Under the 1990 NHS and Community Care Act arrangements introduced in April 1993, local authorities took on the responsibility for assessing all publicly funded admissions to care homes and for meeting the costs of care. Although there were some problems implementing this transfer of responsibility, it did not produce the anticipated fall in occupancy rates or closures of independent homes that had been feared (Laing & Buisson 1995). Instead, as Figure 4 below shows, the reduction in the numbers of places in local authority managed homes that predated the Act accelerated. In 1982, 50 per cent of all care home places were in the public sector. By 2001, this had dropped to less than 9 per cent of places, and the National Care Standards Commission (NCSC) estimated that in 2003 only 6 per cent of places for older people were in the public sector (Dalley *et al* 2004). In addition, the level of occupancy in independent homes declined compared with the time just before the reforms were instituted (Laing & Buisson 1997). Despite these factors, overall levels of residential and nursing home places in England continued to rise until 1998 (Department of Health 2000b, 2000c).

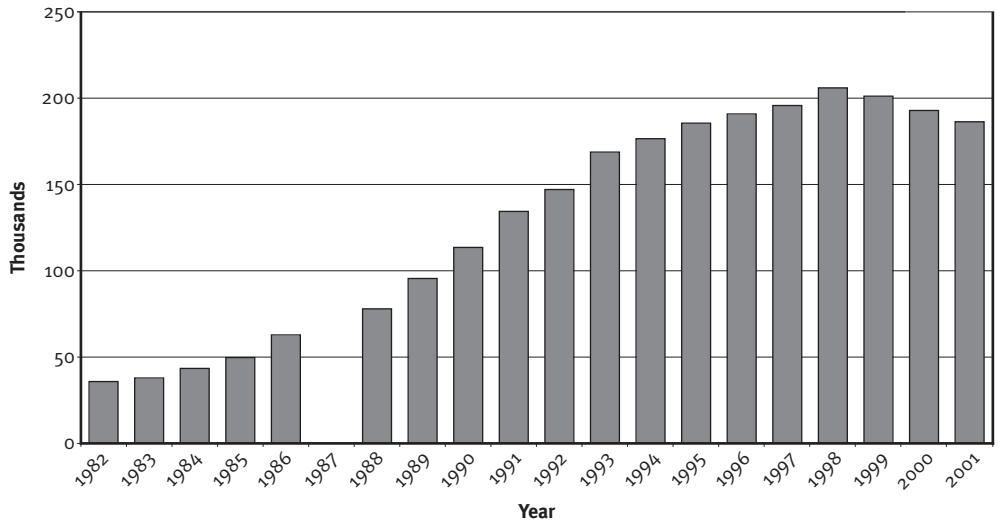
However, since 1998 there has been a downturn in the level of provision of residential and particularly nursing home care. Between 1998 and 2001, registered beds in general

4 **PLACES FOR OLDER PEOPLE AND YOUNGER PHYSICALLY DISABLED ADULTS IN RESIDENTIAL CARE HOMES IN ENGLAND, 1980–2001**



Source: Department of Health statistics

5 **BEDS IN NURSING HOMES IN ENGLAND, 1982–2001**



Source: Department of Health statistics

nursing and mental nursing homes in England decreased by 9.5 per cent (Department of Health 2002e) and places for older people and mentally infirm older people in residential homes decreased by 3.2 per cent (Department of Health 2001c). Changes in responsibility for routine data collections since 2001 make comparisons difficult. Laing & Buisson (2003b) suggested that care home de-registrations appeared to have passed their peak. However, according to the NCSC, there was a decrease of 6 per cent in the number of registered independent homes between April 2002 and October 2003 (Dalley *et al* 2004), which would suggest that homes were continuing to close at a rate similar to that in 2000.

Although care homes are no longer registered separately for residential or nursing care, it is helpful to maintain the distinction, as there are differences in terms of dependency of residents, size, costs and ownership. Nursing homes have more dependent residents, are larger and charge over £100 more per week. Major providers (those running three or more homes) run more than a third of nursing homes (Laing & Buisson 2003b), compared with 16 per cent in 1992. Ownership of private residential homes is concentrated among small organisations, with only 10 per cent of homes run by major providers in 2003.

Self-funders

Individuals whose assets exceed a certain level, £20,000 in 2004/05 (Department of Health 2004b), are required to fund their own care ('self-funders'). However, depending on local charging arrangements, those whose assets are over £20,000 and who remain in the community will often have most of the costs of home care borne by local authorities.

Although currently in the minority (about a third of residents), self-funders are a large group and are of growing importance as the rise in home ownership means that an increasing proportion of older people will be responsible for meeting their care home fees.

Self-funded residents have tended to be charged more than publicly funded residents for the same service (Darton and Wright 1992; Laing 1998; Netten *et al* 2001). Clearly self-funders have very little market power in comparison with purchasers of publicly funded care. However, local authorities still have an interest in the level of fees being paid by self-funders because once self-funders have reduced their assets (so-called 'spend-down'), their authority becomes liable for their fees. Some authorities have admitted self-funded residents to homes under the same arrangements as publicly funded residents and then recouped all the fees. Others have used their market power to keep down fees for self-funders in those homes where they purchase care for publicly funded residents. Possibly as a result of these policies there is some evidence that prices were tending to converge at the end of the 1990s (Netten *et al* 2002a). However, more recent reports suggest that self-pay fees are typically £50–100 higher than local authority fees for similar provision (Laing & Buisson 2003b).

Prices and mark-up rates

There are a number of factors affecting the prices charged by care homes. Analysis of the rates charged by independent homes in the mid-1990s found that a key factor was the dependency of residents. Dependency had a particular impact on prices through the use of nursing or residential places (Netten *et al* 2001; Darton *et al* 2003a).

In terms of the standard of the facilities offered by homes, the proportion of single rooms had the largest impact on prices in both residential and nursing homes, with a higher percentage difference for nursing homes than for residential homes (Netten *et al* 2001).

The same study also found that residential homes with fewer than ten places charged lower prices than homes with more places, single nursing home organisations charged higher prices than organisations owning several homes, and homes run by the private sector were slightly more costly overall than those run by the voluntary sector. However, the state of the local labour market was the factor that had the most significant impact on prices. The relationship between wages and prices was particularly sensitive in residential care, with a 1 per cent rise in wages being associated with a 0.81 per cent rise in prices. Overall mark-up rates were modest, estimated at about 10 per cent at the time of the study (Netten *et al* 2001; Darton *et al* 2003a).

Analyses conducted at the local authority level, based on 1998–2000 data, indicated that average mark-up rates over average costs were well below 10 per cent of total weekly revenue (Fernández and Forder 2002). This finding raises questions about the long-term sufficiency of supply.

Market entry and motivations

High house prices constitute one potential barrier to new entrants into the care market. Currently, most care homes are in converted premises, rather than newly built. In the future, however, a need for care homes to comply with National Care Standards will mean that new-build costs and availability of land will have more impact on the market. Other barriers to entry include workforce shortages, uncertainty and lack of confidence about returns on investment.

In terms of their motivation for entering the market, providers are looking for a significant degree of autonomy as well as opportunities to express their caring professionalism inside and outside the home. To meet these aims (and thereby encourage providers to remain in the market), arrangements between purchasers and providers should be set up to facilitate mutual respect and acknowledgement. Ideally, this attitude should also govern contracting and regulation strategies. For example, while block contracts have advantages in terms of risk-sharing and planning, great care must be taken to ensure they do not inappropriately stifle providers' freedom of action, and do not result in too much loss of control over the admissions process. In terms of regulation, inspections (and the arrangements that underpin them) should not only focus on homes' input and structural compliance, but should also give providers opportunities to demonstrate their empathy with residents, and express how this is reflected in their ethos and in relationships within the home.

Market exit

The reduction in care home capacity since 1998 owes less to the general government policy of maintaining people in the community than it does to the departure of care home providers from the market. The reasons for this departure are a combination of other government policies, rising costs and opportunities to exit from the market.

During the 1990s, government policies such as the National Minimum Wage, the Working Time Directive and a substantial pay award to nurses led to increasing staff costs. At the same time, central government efficiency targets, and other incentives to reduce local authority expenditure, pushed down the prices paid to providers by local authorities, with the result that fee increases for publicly funded residents were kept below the Retail Price Index level. This pressure on wage rates has had a critical impact on the survival of care homes in the market.

Other government policies have put pressure on recruitment and retention of staff in care homes. For example, initiatives aimed at tackling shortages of nurses by encouraging qualified nurses to return to the NHS (Department of Health 1998b) have reduced the availability of nursing staff. A national survey carried out by Netten *et al* (2002b) found that in areas of high employment, there were particular concerns about the supply of direct care staff. A number of respondents also mentioned problems in recruiting management staff. The potential impact of these shortages on the quality of care was particularly high in residential care homes, typically in the private sector, which were caring for a more dependent population (Netten *et al* 2002b).

These cost, policy and workforce pressures coincided with rising house prices, encouraging some owners, particularly of converted properties, to exit the care market. It was this opportunity to exit, together with lack of opportunity for selling homes as going concerns, rather than the opportunity to make a quick profit, that pushed people into closing homes.

CONSEQUENCES OF HOME CLOSURES

The rise in home closures has reduced overall capacity, leading to serious concerns, particularly in the south of England, about whether the market will be able to meet demand in both the short and long term (Netten *et al* 2002b). Closures have also had

an impact on acute beds in hospitals, as analyses have shown that there are important links between the functioning of the social care market and delayed discharges (Fernández and Forder 2002).

The issue, however, is not just about overall capacity, but also about what types of homes are being lost. Regulators have expressed most concern at the lack of specialist accommodation for older people with mental health problems, particularly dementia (Netten *et al* 2002b). Nursing homes have been particularly vulnerable to closure because of the additional costs of employing nursing staff and the reduction in demand caused by authorities placing high-dependency residents in residential homes with additional payments (Netten *et al* 2003b).

A 2001 follow-up of homes that had participated in a national survey in 1996 found that homes that were closing tended to be smaller, have lower occupancy levels, be the only home run by the organisation, and occupy converted buildings, with poorer facilities and more shared bedrooms (Darton 2004).

There are a number of reasons why smaller homes are the most likely to be lost. If larger homes are having problems, purchasers tend to be more concerned about the impact of their closure on local capacity, and are more prepared to negotiate better contracts or prices. In addition, economies of scale mean that larger organisations can bear the costs of regulation more easily than small businesses. However, the result of smaller homes closing is a concentration of ownership that reduces the choice available to prospective residents.

Standards of physical provision have shown steady improvement in response to market forces, demands from local authority purchasers and the requirements of inspecting authorities (Laing & Buisson 2001). Although homes that existed before April 2002 will no longer have to meet the national minimum standards for bedroom sizes, it is quite likely that market pressures will force them to either upgrade their facilities to compete with homes that do meet the standards, or close. The amended standards (Department of Health 2003a) indicate that care homes should specify the details of the physical environment provided by the home so that people choosing a care home can make an informed choice. Failure to upgrade facilities will lead to a two-tier system of homes that do and do not conform to the standards.

Although the physical environment of homes has an important influence on residents' quality of life, for example in their amount of privacy, it is the social climate or atmosphere of the home that has the most impact (Timko and Moos 1991). Relatives of residents have cited the atmosphere as the most important factor in selecting a home (Netten *et al* 2002b). In an analysis of data collected on social climate in the national survey in 1996, using the Sheltered Care Environment Scale (Moos and Lemke 1994, 1996), homes identified as having a more positive social environment were those occupying smaller, converted premises and having lower occupancy levels (Darton *et al* 2003b). With their more 'homely' or 'domestic' environments, these are exactly the kinds of homes recommended in a number of policy documents (Cm 849 1989; Centre for Policy on Ageing 1996; Department of Health 2001d). But given the long-term trend toward larger homes, particularly in the nursing home sector (Laing & Buisson 2003b), these are exactly the homes most likely to have closed.

Fewer homes overall, and relatively more larger homes run by corporate organisations, means a reduction in choice for future residents in terms of both type of home and location. Location is the single most important factor for residents and their relatives once the decision to enter a care home has been made (Netten *et al* 2002b). Small homes in small towns, serving largely rural areas, are the least likely to survive. Where such homes do close, residents are faced with the problem experienced in all areas with low levels of supply, such as parts of London – namely that of travelling a considerable distance to find a suitable alternative. Current residents will be placed in the position of having to find a vacancy in a limited time period, and might feel obliged to agree to the first vacancy or home that is suggested to them by a care manager due to a lack of any alternatives (Williams *et al* 2003). In cases where residents have moved to a home to live nearer to their children, they may be forced to move further away again.

THE CLOSURE PROCESS

The care home market is unique in that it has a profound effect on so many aspects of its consumers' lives. Moreover, as we have noted, these consumers are by definition one of the most vulnerable groups of service users. Such a potentially stressful and traumatic event as involuntary relocation is likely to involve health and safety risks for current residents. Given the dependence of residents, it is surprising that there are not more safeguards and guidance to ensure that the closure process is sensitively managed. There is a lack of central policy guidance aimed specifically at how independent care homes close and how local authorities might safeguard residents' welfare. Moreover, not all councils have local guidelines in place, and where they do their recommendations vary or fail to address important areas of concern for residents and relatives, such as how best to support residents with dementia (Williams and Netten 2003; Williams *et al* 2003). The way in which a home is closed is likely to determine how residents are affected by the closure, and service users should be offered access to fair, flexible and responsive help and support during such a time of upheaval and potential crisis. In practice, access to such support appears patchy. For example, case study research found there was no evidence of increased vigilance by inspectors to ensure that standards were maintained and residents' safety was protected (Williams *et al* 2003).

Extra care housing

The term extra care housing is one that has emerged in recent years. It is difficult to define this term as it covers a variety of schemes in which housing and care are integrated. The origins of housing and care schemes for older people can be traced back to the post-war reconstruction era. Although the government's primary focus at this time was on housing younger families, it also recognised the need to build different types of housing to meet the varying requirements of the population as a whole (Ministry of Health 1949). For this reason, some accommodation was built specially for older people, which in turn freed up larger houses for families (Ministry of Local Government and Planning 1951).

Sheltered housing (often referred to as retirement housing) was one of the types of housing developed at this time specifically for older people. At a minimum, these housing developments provided an alarm system and the support of a warden (or equivalent person) (McCafferty 1994). Extra care housing – often called very sheltered housing – arrived later in the late 1970s and early 1980s. These schemes had enhanced design features, more extensive warden cover and home care services to supplement the warden cover (Reed *et al* 1980).

More recently, local authorities have considered the development of integrated care and housing as an alternative to care homes, particularly for physically frail older people. For example, Wolverhampton has developed an integrated strategy involving the closure of local authority residential homes, the development of new very sheltered schemes, the establishment of resource centres for community support, and the provision of specialist centres for older people with mental health needs (Bailey 2001). Elsewhere, a number of other housing models for older people are now being developed – including the retirement community model, based on developments in the United States (Phillips *et al* 2001; Streib 2002), and co-housing arrangements, which are in use in other European countries (Brenton 2002).

A number of factors have been identified as stimulating the development of extra care housing: a need among people in existing sheltered housing for greater care and support from carers; the unpopularity of some ordinary sheltered housing schemes; poor quality local authority residential accommodation; and developments in services and buildings that enable people to remain in their own homes despite mental or physical impairment (Fletcher *et al* 1999). The government has supported the development of extra care housing by announcing plans for an expansion in provision and providing some funding for this (*see* p 28). Heywood *et al* (2002) suggest that these changes in government views on the role of housing in community care have been influenced by: the roles of home improvement agencies in enabling people to remain in their own home; the supposed potential of sheltered housing – especially very sheltered housing – to provide a cheaper alternative to residential care; and the raised profile of housing associations as reliable providers of services.

Ownership and tenure

The majority of extra care and sheltered housing is provided by the social rented sector – either by local authorities or, increasingly, by registered social landlords (RSLs). In the private sector (which includes both for-profit and not-for-profit organisations), providers offer sheltered housing for purchase by consumers on a long lease, or less often as a freehold (Laing & Buisson 2003c), although some providers also offer properties for rent. The services offered by private housing schemes tend to focus on property maintenance rather than the provision of care and support, but private providers are increasingly developing extra care housing that incorporates more intensive care services (Laing & Buisson 2003c).

The number of private sector developments declined sharply during the 1990s, following the economic downturn in the early part of the decade (Dalley 2001). The health of the private sector market is closely connected to the general housing market, since purchasers need to sell their existing homes before purchasing sheltered or extra care housing (Laing & Buisson 2003c).

In recognition of the growth in home ownership, some providers of rented schemes have considered developing mixed tenure schemes, for example the ExtraCare Charitable Trust (Appleton and Shreeve 2003). However, there are questions about the acceptability to residents of some developments, for example mixed-tenure schemes and schemes that provide facilities to other members of the community (Bessel, personal communication 2004).

Supply

Problems in defining extra care housing create difficulties when it comes to describing overall levels of provision. Sheltered housing in England – defined as accommodation with a warden – provides accommodation for around 600,000 people, of whom 86 per cent live in social or public sector schemes (Office for National Statistics 2000). This is broadly similar to overall levels of provision in care homes at that time (Audit Commission 1998; Conway 2000).

By contrast, the growth in the provision of extra care housing has been rather slower. By 1997, it accounted for only about 3.5 per cent of around 500,000 sheltered housing and very sheltered housing units in England (Tinker *et al* 1999). The government announced plans for a 50 per cent increase in the provision of extra care housing places from 1997 (Department of Health 2002a); this was subsequently quantified as an additional 6,900 places (Department of Health 2002f), suggesting the government's estimate of the number of places differed from that by Tinker and colleagues. In supporting the development of extra care housing, the government has recognised the need to identify whether this is intended to complement existing provision or to provide a substitute for residential care. However, to date the government has not clearly identified which area of the market it wants to expand (Department of Health 2003c).

Funding

The availability of Housing Benefit has been central to the development of extra care housing (Oldman 2000). However, Housing Benefit has been replaced by the Supporting People budget, a new funding stream launched in April 2003 that provides housing-related support services and is allocated by local authorities. There were concerns that local authorities might develop extra care housing in order to transfer costs to social security funding (Laing & Buisson 2003b). It is known that in at least some instances – in private schemes that previously drew on Housing Benefit, for example – Supporting People funding is being used to meet the care costs in extra care housing. There has been rapid growth in expenditure under the Supporting People budget, and any attempt to cap this growth would potentially have important implications for extra care housing schemes.

If provision of extra care housing is to expand in line with government plans, capital funding will be needed. The Extra Care Housing Fund (Department of Health, no date) is providing the opportunity for a number of schemes to obtain capital funding. However, limits on the funds available meant a large number of proposals in the first year were not successful (Department of Health 2004c). New funding opportunities using Public Private Partnerships, such as the Private Finance Initiative, are being used to set up schemes, but further development of partnerships at the commissioning and development stages and innovations in construction and remodelling are needed (Fletcher *et al* 1999).

Demand

Demand for specialised housing for older people cannot be viewed in isolation from demand for housing more generally, as developments in housing provision will have an impact on the need for specialised housing. For example, the development of Lifetime Homes (Kelly 2001; Joseph Rowntree Foundation, no date) represents a macro approach to design, which attempts to accommodate the widest possible client group in mainstream

housing, in contrast to a micro approach, which makes piecemeal adaptations and repairs to older people's homes in response to specific needs (Hanson 2001).

A number of other initiatives aim to support older people to remain in their own homes: for example, Staying Put and Care and Repair schemes undertaken by home improvement agencies (small not-for profit organisations, partly charitably funded and partly through government funding via the Supporting People budget) (Harrison and Means 1990; Oldman 1990); the development of assistive technology (Tinker *et al* 1999; Brownsell and Bradley 2003; Fisk 2003) to help to create a more responsive environment; and the development of financial products to enable people to withdraw some of the capital invested in their homes. However, these developments are not likely to have major impacts and, in the case of financial products, there are continuing concerns about their security and financial efficiency, following problems with equity release products in the past (Appleton 2003).

Extra care or very sheltered housing provides owner-occupiers with a means of safeguarding their capital and a flexible package of care based on the home care model. For older people requiring a high level of care, the overall costs of extra care housing may well be higher than the equivalent level of care in a care home, but it is likely to be a more acceptable option. The demand for this type of accommodation will grow as people become more aware of the option. The question remains, however, whether the market will respond to this demand.

Barriers to entry and exit

The market in extra care housing is currently dominated by the public and voluntary sector, where a lack of capital funding is a major barrier to expansion. However, although extra care housing developments require a larger initial investment, from the perspective of the private sector they are in theory inherently less risky than care homes because of their greater potential for alternative use (Laing 2002). Moreover, leasehold arrangements reduce the level of capital that needs to be tied up in these schemes. There are a few examples of companies converting existing homes into extra care housing schemes, but as yet there is limited provision of new developments.

Regulation may provide a barrier to entry into the extra care housing market. Where an extra care scheme provides personal care to the residents, it has to be registered as a care home (Department of Health 2003c). Currently, the burden of regulation on care homes is such that schemes often avoid providing services directly so that they don't have to register as a care home. Ideally, service developments should be driven by service user preferences and considerations of cost-effectiveness rather than regulatory concerns.

Market performance and levers

It is likely that the demand for social care for older people will increase in the future. The level and nature of this demand will depend on the boundaries set for publicly funded care and on the degree to which home care, housing with care, and care homes substitute for one another. We summarise our views of the performance of the market and then consider some levers that might be used to address the problems identified.

Market performance

A successful social care market should deliver:

- adequate capacity both overall and in terms of diversity
- value for money
- quality
- consumer power and choice.

Capacity

Although the independent sector has responded to increased demand rapidly in the past, the care market is made up of a large number of small businesses, which tend to be financially less stable and more vulnerable to closure. Moreover, the expansion has been in relatively straightforward services, such as home care and care homes for people with some level of physical impairment. Overall capacity varies widely across the country and there have been consistently fewer care home places in London. Moreover, there are widespread concerns about the market's ability to make adequate provision for older people with mental health problems or from black and minority ethnic groups.

Two key influences on the supply of care services are the availability and cost of labour and of capital. There are currently shortages in the workforce, which can impact on quality of care as well as restricting supply. Factors such as the recent enlargement of the EU may mitigate these shortages, but there is a need to establish a career structure, incentives and training opportunities that will attract the right candidates into the care workforce – developments that in turn have cost implications. In addition, there has been a shortage of capital funding in the public sector for both housing and care; and investment in the private sector has been reduced by high and rising prices in the property market, and shortages of suitable land.

Value for money

Since local authorities took on the responsibility for commissioning services, prices in the independent sector have been kept well below input price inflation (although it should be noted that the costs of the commissioning process are rarely taken into account). Value for money means getting the best from resources that are always, to a greater or lesser

degree, limited. One way to maximise the use of resources is to divert people from high-cost residential services by targeting community services at those people who will benefit most from such services. There is some evidence that services are being delivered to those with the greatest capacity to benefit; fewer households are receiving more intensive packages of home care (*see* Figures 2, p 15 and 3, p 16).

Quality

The independent sector provides both the best and the worst care in terms of quality. Standards of accommodation in care homes improved as a result of market pressures, even before Care Standards were introduced, particularly in terms of the provision of single rooms.

The National Care Standards were introduced in an attempt to address concerns about standards of care. However, as we have identified, increased regulation to enforce these standards, together with the financial difficulties facing small businesses in the care home market, can lead to standardisation of care that limits both choice and quality.

Consumer power and choice

In order to exercise power, consumers need to have diversity and availability of care provision and information about their options. As shown in previous sections, there tends to be a lack of choice and information. Some authorities have set prices too low to enable them to deliver a high-quality service and have not attempted to redesign services to reflect consumers' preferences.

Levers

Central and local government policies and practice can create levers to encourage the social care market to develop in particular ways.

Funding and financial incentives

Planned expenditure on social services is set to grow by 6 per cent in real terms over the next few years. The primary motivation for this increase is concern about the effect of restricted capacity in the social care system on the delivery of acute health care through unnecessary admissions to or delayed discharges from hospital. Whether this increase in funding will find its way through to the social care market will depend on local authorities' priorities. Even if it does get through as intended, it could be argued that a simple 6 per cent real increase in prices paid is insufficient to address current funding issues, such as rising wages and the costs associated with meeting quality standards, let alone future rises in both costs and demand.

The use of Direct Payments puts financial control into the hands of consumers themselves, thereby explicitly addressing the problem of lack of consumer power identified above (*see* p 9). These payments may also go some way towards addressing the workforce shortage by drawing people into the care workforce who would not otherwise undertake this kind of work. However, Direct Payments are not a panacea for the problem (Ungerson 2004). There are risks of exploitation on both sides of a direct employment relationship and there are no levers for ensuring good practice. Moreover, if Direct Payments became the mainstream model there would be the problem of determining the appropriate level of payments.

It will be important to fund spare capacity if people are to have a genuine choice, at least in terms of care homes and other housing and care options. The commissioning authority can achieve this through contracting arrangements, by contracting for spare capacity or indirectly by increasing the prices paid, although there is a lack of incentives to spend money in this way (*see* below).

Training is one way in which quality can be improved. We suggest that this should be substantially funded by the public sector rather than the private sector, as there is overall public benefit to the improvements in care that would result.

Targets and performance indicators

The current government has made extensive use of targets to improve performance in social care (Department of Health 1999a). Targets have been very effective at influencing the behaviour of local authorities. However, we believe that the use of specific targets based on crude unit cost comparisons is not helpful.

Performance indicators may be more helpful than targets. For example, the use of performance indicators has drawn attention to the lower levels of satisfaction identified by black and minority ethnic older people receiving home care services, as well as providing an incentive to address the problem. Other performance indicators, preferably ones based on service user views and/or related to outcomes, might help in improving the range and quality of care services and the choices given to service users.

Commissioning practice

The commissioning process can be used as a lever to ensure the market achieves the desired goals.

In England, the highest level at which commissioning for social care takes place is the local authority or trust. Elsewhere (for example, in Australia) core commissioning activities for care home places, including setting prices, take place at national level; this can improve access to services and appears to have resulted in a generally healthy financial situation for the majority of homes in Australia (Hogan 2004). However, commissioning at a national level requires heavy regulation, which can make it difficult for prospective providers to enter the market, restrict consumer choice, curtail innovation in service design and delivery, and adversely restrict enterprise mix and investment in the sector (Hogan 2004).

There may be some benefits to creating regional-level commissioning, which can offer economies of scale in terms of commissioning expertise and can also increase market power. This could have advantages in London boroughs and adjacent smaller metropolitan districts, although it might simply add another level of bureaucracy in larger authorities. In Scotland there are moves towards agreeing price levels between representative bodies of local authorities and provider groups. However, this approach restricts flexibility to respond to local markets.

Regardless of the level at which it takes place, strategic commissioning should include: assessment of the needs of the population (preferably involving consumers); workforce planning; and innovative approaches to care.

In negotiating contracts it is important that the risk does not remain entirely with providers. Long-term contracts enhance stability and enable forward planning. Joint commissioning, as discussed in Commissioning (*see* pp 6–8), provides both an opportunity and a challenge. In particular, joint commissioning of relatively marginal services to meet specialist needs can be beneficial. Differential pricing can also be used to encourage provision of specific specialist services where there are shortages, such as the care of people with dementia.

Contracts can be used to clarify the levels of quality expected and the mechanisms to assure this quality, although monitoring can be difficult and costly.

Smaller care homes are particularly vulnerable to market and regulatory pressures and, if these homes are to be supported, differential commissioning arrangements (for example, in terms of price or use of block contracts) will need to be put in place. However, such arrangements may lead to accusations of bias. In seeking to find the right balance between support for small business and the preservation of a level playing field between providers from different sectors and of different sizes, there may be unexploited potential in looking outside the social care field to other areas of policy. For example, social care commissioners and economic development experts within local authorities may well benefit from an exchange of ideas in relation to principles and practices.

There is scope for a move to contracts based on outcome rather than tasks, in which the provider has a contract to meet identified needs but has flexibility to negotiate with the older person on how those needs are met. Such contracts would require adequate levels of resources. Other approaches to client-based commissioning – for example, per capita funding to cover a certain population – would allow community groups, voluntary organisations or even private companies the flexibility to use resources to meet needs in the most cost-effective way.

Use of in-house services

Authorities often use in-house providers to ensure an adequate supply of those services that they find difficult to get the independent sector to provide – for example, care for people with dementia and short-term care. As well as ensuring provision, in-house providers may serve as exemplars for the independent sector. For example, the demand for extra care housing is uncertain and the initial investment high; if local authorities can identify potential demand and prove their cost-effectiveness, this will improve their chances of commissioning providers in the independent sector.

Provision of in-house services can be useful when crises occur – for example, where a home is closing at very short notice, experienced in-house staff can be brought in.

However in-house services are used, policies must be clear and transparent to independent providers to ensure trust.

Regulation

An obvious lever to improving quality is the introduction of National Care Standards. Traditionally standards focus on inputs rather than outcomes for service users. We believe that more focus on the outcome and process of standards would allow for greater flexibility

in the way that providers can meet the desired attributes for each service. As the standards are based around existing service descriptions (such as 'care home' or 'home care agency'), they require innovative arrangements to be classified within these categories. This can lead providers to tailor their services according to the category with the least burdensome regulations rather than according to the needs of users.

Within the regulatory framework, there is a welcome emphasis on listening to the views of service users as part of the inspection process. However, older people are often reluctant to complain, particularly if doing so would threaten the service on which they depend. Approaches used in other specialisms – for example, in inspections of children's homes (Hibbert 2002) – may offer useful alternative models for involving service users. Consistency and predictability in the design and implementation of care standards, together with good relationships between commissioners and providers, provide scope for direct improvements in quality of care.

The regulation of the direct care workforce needs to be handled carefully as this will affect both capacity and quality. The requirement for care workers to have National Vocational Qualifications (NVQs) can cause problems because a number of the NVQ assessments of competence are voluntary, the delivery of the process is variable and training is not necessarily given.

Information, advice and training

Access to good-quality information can often benefit decision-making and this information needs to be available to both providers and consumers. Commissioning authorities can provide information to providers and the Social Care Institute for Excellence (SCIE) could play an important part. For consumers, voluntary bodies are often a useful source of information and advice. Under the Modernising Local Government framework, the government is also setting up a number of one-stop shops offering advice on benefits, services and advocacy.

For some purposes, training is more appropriate than advice or guidelines. As previously mentioned, there is an argument for public funding of training for care workers. This training should address general issues, such as good practice in commissioning, and specific issues, such as care of people with dementia and care of people from minority ethnic groups.

Note

Some of the proposals put forward here are reflected in the Green Paper *Independence, Well-being and Choice* (Department of Health 2005), which was published after this paper was drafted. The emphasis on increased control for service users, strategic commissioning, shifting regulation to an outcome focus and reform of performance targets are very much in line with our proposals. However, the emphasis is on better use of existing resources rather than an increase in resources. We have identified here the impact on the market of the low prices that are currently being paid for services. It remains to be seen whether the move to an enabling ethos can be achieved without significant additional investment.

References

Appleby J, Harrison A, Devlin N (2003). *What is the Real Cost of More Patient Choice?* London: King's Fund.

Appleton N (2003). *Ready, Steady... But Not Quite Go: Older home owners and equity release – a review*. York: Joseph Rowntree Foundation.

Appleton N, Shreeve M (2003). *Now for Something Different: The Extra Care Charitable Trust's approach to retirement living*. Witney: Old Chapel Publishing.

Audit Commission (1998). *Home Alone: The role of housing in community care*. London: Audit Commission.

Audit Commission (1986). *Making a Reality of Community Care*. London: HMSO.

Bailey A (2001). *New Agenda for Older People*. Wolverhampton: Wolverhampton City Council.

Bartholomeou J (1999). *A View of the Future: The experience of living in extra care*. Staines: Hanover Housing Group.

Bauld L, Chesterman J, Davies B, Judge K, Mangalore R (2000). *Caring for Older People: An assessment of community care in the 1990s*. Aldershot: Ashgate.

Brenton M (2002). 'Choosing and managing your own community in later life' in *Our Homes, Our Lives: Choice in later life living arrangements*, Sumner K ed. London: Centre for Policy on Ageing.

Brownsell S, Bradley D (2003). *Assistive Technology and Telecare: Forging solutions for independent living*. Bristol: The Policy Press.

Bunce C (2001). 'The care homes catastrophe'. *Nursing Times*, vol 97, 31, pp 22–24.

Carpenter I, Kotiadis K, Mackenzie M (2003). *An Evaluation of Intermediate Care Services for Older People*. Canterbury: Centre for Health Services Studies, University of Kent.

Carr S (2004). *Has Service User Participation Made a Difference to Social Care Services?* London: Social Care Institute for Excellence.

Centre for Policy on Ageing (1996). *A Better Home Life: A code of practice for residential and nursing home care*. London: Centre for Policy on Ageing.

Clark H, Dyer S, Horwood L (1998). '*That Bit of Help': The high value of low level preventative services for older people*. Bristol: The Policy Press.

Conway J (2000). *Housing Policy*. London: Routledge.

Croucher K, Pleace N, Bevan M (2003). *Living at Hartrigg Oaks: Residents' views of the UK's first continuing care retirement community*. York: Joseph Rowntree Foundation.

Dalley G (2001). *Owning Independence in Retirement: The role and benefits of private sheltered housing for older people – CPA reports 30*. London: Centre for Policy on Ageing.

Dalley G, Unsworth L, Keightley D, Waller M, Davies T, Morton R (2004). *How Do We Care? The availability of registered care homes and children's homes in England and their performance against National Minimum Standards 2002–03*. National Care Standards Commission. London: The Stationery Office.

Darton RA (2004). 'What types of home are closing? The characteristics of homes which closed between 1996 and 2001'. *Health and Social Care in the Community*, vol 12, 3, pp 254–64.

Darton R, Netten A, Forder J (2003a). 'The cost implications of the changing population and characteristics of care homes', *International Journal of Geriatric Psychiatry*, vol 18, 3, 236–243.

Darton R, Netten A, Fenyo A (2003b). *Promoting High Quality Care in Long Term Care Facilities: Factors associated with positive social climates* – PSSRU discussion paper no 2051. Canterbury: Personal Social Services Research Unit, University of Kent.

Darton RA, Wright KG (1993). 'Changes in the provision of long-stay care, 1970–1990'. *Health and Social Care in the Community*, vol 1, 1, pp 11–25.

Darton RA, Wright KG (1992). 'Residential and nursing homes for elderly people: One sector or two?' in *Social Policy and Elderly People: The role of community care*, Laczko F and Victor CR eds, pp 216–44. Aldershot: Avebury.

Davey V, Henwood M, Knapp M (2004). *Integrated Commissioning for Older People's Services* – LSE discussion paper no 1833. London: London School of Economics.

Davies S, Nolan M (2003). 'Making the best of things: Relatives' experiences of decisions about care-home entry'. *Ageing and Society*, vol 23, 4, pp 429–50.

Davies T, Dalley G, Unsworth L, Waller M, Drysdale C (2004). *The Management of Medication in Care Services, 2002–03*. London: The Stationery Office.

Department of Health (2005) *Independence, Well-being and Choice: Our vision for the future of social care for adults in England*. Cm 6499. London: Department of Health.

Department of Health (2004a). *Community Care Statistics 2003: Home care services for adults, England*. London: Department of Health.

Department of Health (2004b). *Charges for Residential Accommodation: CRAG amendment no 21 – national assistance (sums for personal requirements and assessment of resources) (amendment) (England) regulations 2004*. LAC (2004) 9. London: Department of Health.

Department of Health (2004c). *Independence Not Dependence: New extra care housing places for older people*. London: Department of Health.

Department of Health (2003a). *Care Homes for Older People: National Minimum Standards*. London: The Stationery Office.

Department of Health (2003b). *Domiciliary Care: National Minimum Standards*. London: The Stationery Office.

Department of Health (2003c). *Extra Care Housing for Older People: An introduction for commissioners*. London: Department of Health.

Department of Health (2002a). 'Expanded services and increased choices for older people. Investment and reform for older people's social services' – press release 2002/0324. London: Department of Health.

Department of Health (2002b). '£200m allocated to councils to further reduce 'bedblocking'. Delayed discharges reduced by ten per cent since September' – press release 2002/0007. London: Department of Health.

Department of Health (2002c). 'Government response to Health Select Committee report on delayed discharge' – press release 2002/0453. London: Department of Health.

Department of Health (2002d). *Direct Payments Uptake: All councils, England, September 2002* – RAP returns. London: Department of Health.

Department of Health (2002e). *Community Care Statistics 2001. Private Nursing Homes, Hospitals and Clinics*, Statistical Bulletin 2002/09. London: Department of Health.

Department of Health (2002f). *Improvement, Expansion and Reform – The Next Three Years: Priorities and planning framework 2003–06*. London: The Stationery Office.

Department of Health (2001a). '£300m 'Cash for Change' initiative to tackle 'bedblocking'. Agreement with private and voluntary sectors provides foundation for radical reform programme' – press release 2001/0464. London: Department of Health.

Department of Health (2001b). *A Guide to Contracting for Intermediate Care Services*. HSC 2001/01 LAC (2001) 1. London: Department of Health.

Department of Health (2001c). *Community Care Statistics 2001: Residential personal social services for adults, England,* Statistical bulletin 2001/29. London: Department of Health.

Department of Health (2001d). *Care Homes for Older People: National Minimum Standards*. London: The Stationery Office.

Department of Health (2000a). *Community Care (Direct Payments) Act 1996: Policy and practice guidance*, 2nd edn. London: Department of Health.

Department of Health (2000b). *Community Care Statistics 1999. Residential Personal Social Services for Adults, England*, Statistical Bulletin 2000/2. London: Department of Health.

Department of Health (2000c). *Community Care Statistics 1999: Private nursing homes, hospitals and clinics* – statistical bulletin 2000/16. London: Department of Health.

Department of Health (1999a). *A New Approach to Social Services*. Consultation Document. London: Department of Health.

Department of Health (1999b). *Fit for the Future? National required standards for residential and nursing homes for older people* – consultation document. London: Department of Health.

Department of Health (1998). 'Alan Milburn to announce Action Plan to tackle Shortages in Nursing – Health Minister to speak at Keble College, Oxford' – press release 1998/394. London: Department of Health.

Department of Health (1998). *Modernising Social Services: Promoting independence, improving protection, raising standards*. Cm 4169. London: The Stationery Office.

Department of Health (1989). *Caring for People: Community care in the next decade and beyond*. Cm 849. London: HMSO.

Department of Health (no date). *Developing and Implementing Local Extra Care Housing Strategies*. London: Department of Health.

Dewar B, Jones C, O'May F (2004). *Involving Older People: Lessons for community planning*. Edinburgh: Scottish Executive.

Direct Payments Scotland (2003). *Direct Payments Finance Project*. Edinburgh: Scottish Executive.

Fernández JL, Forder J (2002). *The importance of social care in achieving an efficient health care system: The case for reducing delay in hospital discharge rates* – LSE Health and Social Care discussion paper no 7. London: London School of Economics and Personal Social Services Research Unit.

Fisk MJ (2003). *Social Alarms to Telecare: Older people's services in transition*. Bristol: The Policy Press.

Fletcher P, Riseborough M, Humphries J, Jenkins C, Whittingham P (1999). *Citizenship and Services in Older Age: The strategic role of very sheltered housing*. Beaconsfield: Housing 21.

Forder J, Knapp MRJ, Hardy B, Kendall J, Matosevic T, Ware P (2004). 'Prices, contracts and motivations: institutional arrangements in domiciliary care'. *Policy and Politics*, vol 32, 2, pp 207–22.

Francis J, Netten A (2004). 'Raising the quality of home care: a study of service users' views'. *Social Policy and Administration*, vol 38, 3, pp 290–305.

Francis J, Netten A (2003). *Home Care Workers: Careers, commitments and motivations* – PSSRU discussion paper no 2053. Canterbury: Personal Social Services Research Unit, University of Kent.

Hanson J (2001). 'From "special needs" to "lifestyle choices": Articulating the demand for "third age" housing' in *Inclusive Housing in an Ageing Society: Innovative approaches*, Peace SM and Holland C eds. Bristol: The Policy Press.

Hardy B, Young R, Wistow G (1999). 'Dimensions of choice in the assessment and care management process: the views of older people, carers and care managers'. *Health and Social Care in the Community*, vol 7, 6, pp 483–91.

Harrison L, Means R (1990). *Housing – The Essential Element in Community Care: The role of 'Care and Repair' and 'Staying Put' Projects*. Oxford: Anchor Housing Trust.

Health Select Committee Inquiry into Elder Abuse (2004). *Evidence from the National Care Standards Commission*. London: The Stationery Office.

Heywood F, Oldman C, Means R (2002). *Housing and Home in Later Life*. Buckingham: Open University Press.

Hibbert P (2002). *Voices and Choices: Young people participating in inspections*. Basildon: Barnardo's.

Hirst R, Allen G, Watson L (1995). *Now or Never: Older people's decisions about housing*. Southampton: University of Southampton.

Hogan WP (2004). *Review of Pricing Arrangements in Residential Aged Care*. Canberra: Australian Government Department of Health and Ageing.

House of Commons (2000). Parliamentary Debates, Westminster Hall, 15 February 2000. *Hansard*, vol 344, no 1850, cols 176WH–184WH. London: The Stationery Office.

House of Commons Select Committee on Health (2004). *Elder Abuse, Second Report of Session 2003–04*, vol 1, HC 111-I. London: The Stationery Office.

Hudson B, Young R, Hardy B, Glendinning C (2002). *The National Evaluation of Notifications of Use of Section 31 Partnership Flexibilities in the Health Act 1999*. Leeds: NPCRDC, Manchester University, Manchester and Nuffield Institute for Health.

Joseph Rowntree Foundation (no date). *Lifetime Homes*. York: JRF.

Kelly M (2001). 'Lifetime homes' in *Inclusive Housing in an Ageing Society: Innovative approaches*, Peace SM and Holland C eds. Bristol: The Policy Press.

Kendall J (2000). 'The voluntary sector and social care for older people' in *The Changing Role of Social Care: Research highlights in social work 37*, Hudson B ed. London: Jessica Kingsley Publishers.

Kendall J, Knapp MRJ, Forder J, Matosevic T, Ware T, Hardy B (2002). *The State of Residential Care Supply in England* – LSE Health and Social Care discussion paper no 6. London: London School of

Economics. Available at: http://www.lse.ac.uk/Depts/lsehsc/papers/Discussion_Papers/DP6_THESTATEOFRESIDENTIALCARESUPPLYINENGLAND.pdf

Kendall J, Matosevic T, Forder J, Hardy B, Knapp MRJ, Ware P (2003). 'The motivations of domiciliary care providers in England: New concepts, new findings'. *Journal of Social Policy*, vol 32, 4, pp 489–511.

Laing & Buisson (2003a). *Domiciliary Care Markets 2003*. London: Laing & Buisson.

Laing & Buisson (2003b). *Care of Elderly People: Market survey 2003* 16th ed. London: Laing & Buisson.

Laing & Buisson (2003c). *Extra-Care Housing Markets 2003/04*. London: Laing & Buisson.

Laing & Buisson (2001). *Laing's Healthcare Market Review 2001–2002*. London: Laing & Buisson.

Laing & Buisson (1997). *Laing's Review of Private Healthcare 1997 and Directory of Independent Hospitals, Nursing and Residential Homes and Related Services*. London: Laing & Buisson.

Laing & Buisson (1995). *Laing's Review of Private Healthcare 1995 and Directory of Independent Hospitals, Nursing and Residential Homes and Related Services*. London: Laing & Buisson.

Laing W (2002). *Calculating a Fair Price for Care: A toolkit for residential and nursing care costs*. Bristol: The Policy Press.

Laing W (1998). *A Fair Price for Care? Disparities between market rates for nursing/residential care and what state funding agencies will pay*. York: York Publishing Services Ltd.

LGA/ADSS (2003). *Treasurers Budget Pressures Survey Report*. London: ADSS. Available at: www.adss.org.uk/committee/resources/budjulrep.shtml

McCafferty P (1994). *Living Independently. A study of the housing needs of elderly and disabled people* – housing research report. London: HMSO.

Ministry of Health (1949). *Housing Manual 1949*. London: HMSO.

Ministry of Local Government and Planning (1951). *Housing for Special Purposes*. London: HMSO.

Mitchell D (2001). 'Care homes crisis comes to a head'. The Guardian, 4 June 2001.

Moos RH, Lemke S (1996). *Evaluating Residential Facilities: The Multiphasic Environmental Assessment Procedure*. Thousand Oaks, California: Sage Publications.

Moos RH, Lemke S (1994). *Group Residences for Older Adults: Physical features, policies, and social climate*. New York: Oxford University Press.

Myers F, MacDonald C (1996). 'I was given options not choices: Involving older users and carers in assessment and care planning' in *Developing Services for Older People and Their Families*, Bland R ed. London: Jessica Kingsley Publishers.

National Care Standards Commission (2003). *Annual Report and Accounts 2003*. London: The Stationery Office.

Needham C (2003). *Citizen-consumers: New Labour's marketplace democracy* – Catalyst working paper. London: The Catalyst Forum.

Netten A, Curtis L (2003). *Unit Costs of Health and Social Care 2003*. Canterbury: Personal Social Services Research Unit, University of Kent.

Netten A, Darton R, Davey V, Kendall J, Knapp MRJ, Williams J, Fernández JL, Forder J (2004a). *Understanding Public Services and Markets*. PSSRU Discussion paper no 2111/4. Canterbury: Personal Social Services Research Unit, University of Kent.

Netten A, Francis J, Jones K, Bebbington A (2004b). *Performance and Quality: User experiences of home care services* – PSSRU discussion paper no 2104/3. Canterbury: Personal Social Services Research Unit, University of Kent.

Netten A, Williams J, Dennett J, Wiseman J, Fenyo A (2003a). *Social Care Regulation: Resource use* – PSSRU discussion paper no 2042/2. Canterbury: Personal Social Services Research Unit, University of Kent.

Netten A, Darton R, Williams J (2003b). 'Nursing home closures: Effects on capacity and reasons for closure'. *Age and Ageing*, vol 32, 3, pp 332–37.

Netten A, Darton R, Curtis L (2002a). *Self-Funded Admissions to Care Homes* – Department for Work and Pensions research report no 159. Leeds: Corporate Document Services.

Netten A, Darton R, Williams J (2002b). *The Rate, Causes and Consequences of Home Closures*, PSSRU discussion paper 1741/2. Canterbury: Personal Social Services Research Unit, University of Kent.

Netten A, Darton R, Bebbington A, Forder J (2001). *Care Homes for Older People: Facilities, Residents and Costs 1*. Canterbury: Personal Social Services Research Unit, University of Kent.

Netten A, Forder J, Knight J (1999). *Costs of Regulating Care Homes for Adults*. Canterbury: Personal Social Services Research Unit, University of Kent.

Office for National Statistics (2000). *Housing in England 1998/99*. London: The Stationery Office.

Office of Fair Trading (2005). *Care homes for older people in the UK. A market study*. London: Office of Fair Trading.

Oldman C (2000). *Blurring the Boundaries: A fresh look at housing and care provision for older people*. Brighton: Pavilion Publishing.

Oldman C (1990). *Moving in Old Age: New directions in housing policies*. London: HMSO.

Patel A, Foster J, Martin F (2003). *Economic Evaluation of Intermediate Care Schemes in Lambeth, Southwark and Lewisham: Immediate Access Project*. London: Kings College.

Patmore C (2003). *Understanding Home Care Providers: Live issues about management, quality and relationships with social services purchasers*. York: Social Policy Research Unit, University of York.

Phillips J, Bernard M, Biggs S, Kingston P (2001). 'Retirement communities in Britain: A 'third way' for the third age?' in *Inclusive Housing in an Ageing Society: Innovative approaches*, Peace SM and Holland C eds. Bristol: The Policy Press.

Pickard L, Wittenberg R, Comas-Herrera A, Davies B, Darton R (2001). 'Community Care for Frail Older People: Analysis using the 1998/99 General Household Survey – *Quality in Later Life: Rights, rhetoric and reality*.' *Proceedings of the British Society of Gerontology 30th Annual Conference, 31 August–2 September 2001*. Stirling: University of Stirling.

Policy Commission on Public Services (2004). *Making Public Services Personal: A new compact for public services*. London: National Consumer Council.

Pollock J (2001). 'Legal challenges step up care homes crisis campaign'. The Guardian, 7 March 2001.

Quilgars D, Oldman C, Carlisle J (1997). *Supporting Independence: Home support services for older people* – CPA Report 22. London: Centre for Policy on Ageing.

Reed CA, Faulkner GJ, Bessell R (1980). *Your Own Front Door: A study of very sheltered housing in Warwickshire, 1979–80*. Warwick: Warwickshire County Council Social Services Department.

Sabatier P, Jenkins-Smith P eds (1993). *Policy Change and Learning: An advocacy coalition approach*. Boulder: Westview Press.

Starfish Consulting (2003). *Report to London ADSS Benchmarking Region*. London: Starfish Consulting.

Steele L (2001). 'Care home owners lobby for more cash'. The Guardian, 5 March 2001.

Stevenson J, Spencer L (2002). *Developing Intermediate Care*. London: King's Fund.

Streib GF (2002). 'An introduction to retirement communities'. *Research on Ageing*, vol 24, 1, pp 3–9.

Timko C, Moos RH (1991). 'A typology of social climates in group residential facilities for older people'. *Journal of Gerontology: Social Sciences*, vol 46, 3, pp 160–69.

Tinker A, Wright F, McCreadie C, Askham J, Hancock R, Holmans A (1999). *Alternative Models of Care for Older People, The Royal Commission on Long Term Care (1999) With Respect to Old Age: Long Term Care – Rights and Responsibilities, Research Volume 2*, Cm 4192-II/2. London: The Stationery Office.

Ungerson C (2004). 'Whose empowerment and independence? A cross-national perspective on 'cash for care' schemes'. *Ageing and Society*, vol 24, 2, pp 189–212.

Walshe K, Harrington C (2002). 'Regulation of nursing facilities in the United States: An analysis of resources and performance of state survey agencies'. *The Gerontologist*, vol 42, 4, pp 475–86.

Ware P, Matosevic T, Forder J, Hardy B, Kendall J, Knapp MRJ (2001). 'Movement and change: Independent sector domiciliary care providers between 1995 and 1999'. *Health and Social Care in the Community*, vol 9, 6, pp 334–40.

Ware T, Matosevic T, Hardy B, Knapp MRJ, Kendall J, Forder J (2003). 'Commissioning care services for older people in England: The view from care managers, users and carers'. *Ageing and Society*, vol 23, 4, pp 411–28.

Williams J, Netten A (2003). *Guidelines for the Closure of Care Homes for Older People: Prevalence and content of local government protocols* – PSSRU discussion paper no 1861/2. Canterbury: Personal Social Services Research Unit, University of Kent.

Williams J, Netten A, Ware P (2003). *The Closure of Care Homes for Older People: Relatives' and residents' experiences and views of the closure process* – PSSRU discussion paper no 2012/3. Canterbury: Personal Social Services Research Unit, University of Kent.

Wistow G, Knapp MRJ, Hardy B, Forder J, Kendall J, Manning R (1996). *Social Care Markets: Progress and prospects*. Buckingham: Open University Press.

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