Commission for Social Care Inspection

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Making Social Care Better for People

Safe as houses?

What drives investment in social care?

September 2007

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- put the people who use social care first
- improve services and stamp out bad practice
- be an expert voice on social care
- practise what we preach in our own organisation.

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Introduction

Aims of this Report

1.1 Private equity houses and banks invest substantially in social care organisations. These investments enable private and voluntary sector organisations, which provide by far the majority of social care, to develop, improve or expand what they can offer. This report focuses on how bankers and others view investment in social care and raises some of the implications for the future development of personalised care.

1.2 The report focuses primarily on investment decisions in social care services for older people but there are implications for all care services for adults. It does not deal in detail with the joint commissioning of health and care services by local councils and primary care trusts (PCTs), though many of its points are equally applicable in that context.

The policy and strategic context

1.3 The Government's agenda for public service reform includes creating the levers and mechanisms whereby people can participate in shaping and securing the services they want in order to achieve their aspirations. This means:

"The process by which services are tailored to the needs and preferences of citizens. The overall vision is that the State should empower citizens to shape their own lives and the services they receive... In some instances the best way of empowering users is to give them direct involvement in the commissioning of the services they receive." [1]

1.4 The Care Services Minister Ivan Lewis MP has been in the forefront of developing this agenda in social care. He said:

"Our aim is to create a system that offers high quality personalised services, where power and control are transferred from professionals and organisations to those people who use services, their families and carers." [2]

1 *Building on progress: public services*, Cabinet Office, 2007 (www.cabinetoffice.gov.uk/strategy/work_areas/policy_review).
2 Ivan Lewis MP, Minister for Care Services, speech to the 'Dignity in Care' event, January 2007.

1.5 Too often, however, there is a limited range of services available and offered to people:

"In too many places, the same traditional profile of services is being commissioned – still with an over-emphasis on institutional care. Delivering personalised care is about more than offering a choice of the same limited range of services, or indeed a choice between one home or another – it is about ensuring that care is tailor-made for individual people to meet their individual needs, often helping people gain access to mainstream services to achieve dignity, independence and choice." [3]

1.6 Direct payments, which draw on social services resources, and individual budgets, which are composed of social services and a number of other resources, help people maximise their independence and exercise choice. Both are key ways by which care can be tailor-made for those who come within councils' thresholds for support. Both are at the heart of current efforts to reshape social care. However, despite recent progress, direct payments still represent only £1 in every £100 spent on social care, whilst individual budgets are still at the pilot stage. So it is important to personalise mainstream services as well as to develop new approaches.

1.7 Issues of personal independence, choice and control apply as much in residential as in home care. It is sometimes assumed that 'independence' means people living in their own homes and 'dependence' means living in residential care. However:

"We have seen that, with the right support, people can have independence and choice in care homes." [4]

1.8 And home care can itself be inflexible, especially where the predominant model of purchasing is 'task' based and leads to it being delivered in blocks of 15 minutes, with little scope for individual negotiation to cater for the fluctuations in people's capacity and wishes.[5]

1.9 Public service reform and personalisation are not the only forces changing the nature of social care services. Tighter eligibility criteria for accessing care arranged by local councils mean that many more people than before are not supported by their councils and are therefore having to find and fund their own care.

3 Paul Snell, CSCI Chief Inspector, speech to ADASS Spring Seminar, April 2007.
4 Dame Denise Platt, CSCI Chair, speech to the English Community Care Association, November 2005.
5 *Time to care? An overview of home care services for older people in England*, CSCI, 2006.

1.10 Further pressures on council budgets are coming from increasing numbers of older people with social care needs and an increasing number of people with dementia. This trend is set to accelerate. The Wanless report[6] estimated that over the next 20 years there would be a 54% increase in the number of older people with high levels of social care need. Moreover:

- More people may be in a position to fund their own care, or be forced to do so, given councils tightening eligibility criteria for access to services.
- People who are due to retire in the foreseeable future are unlikely, if they have social care needs, to be content with the quality of life or care standards of those who are now retired.

1.11 The Wanless report identified a present and future funding gap but recommended that additional funding for social care should be conditional on reconfiguring services. The Commission for Social Care Inspection (CSCI) called for a national debate on the relative contributions to social care funding of the state, families and individual citizens.[7]

1.12 Whatever the new compact between the state and the individual over the future funding of social care services, it is evident that for personalised care to be made a reality, current ways of commissioning services will need to change. The challenge facing councils is how to engage effectively with people who use or might in the future use social care, and their families, so as to develop a strategic, long-term view of what sort of services need to be developed for the whole community, based on aggregating individual – and changing – preferences.

1.13 So the overall context for this debate can be summarised as:

- policy development towards personalisation of care services
- growing pressures on councils' social care budgets
- a growing number of individual purchasers, using public funding allied to new mechanisms (direct payments and individual budgets)
- increasing numbers of people using their own resources to pay for their social care.

Market consolidation

1.14 Over recent years there have been a considerable number of mergers and acquisitions in the **care home** market, resulting in fewer homes being

6 Wanless, Sir Derek, *Wanless Social Care Review: Securing good care for older people,* King's Fund, 2006.
7 *The state of social care in England 2005-06,* CSCI, 2006.

registered with the Commission but with slightly more places[8]. According to Chris Bartlett[9], a specialist healthcare relationship manager, just four operators – compared with 10 in 2004 – own some 80,000 places, or nearly one-fifth of those for older people. Southern Cross chief executive, Phillip Scott, reported that:

"This year and next year, there's a window of opportunity to consolidate the sector at a quicker pace."[10]

"The fundamentals in our sector remain strong and we fully expect to be at the forefront of consolidation activity in what remains a fragmented industry."[11]

Chris Bartlett indicated that small and medium-sized operators were also consolidating.

1.15 Yet despite such recent consolidation, a considerable number of single homeowners remain in the market, with some 70% of providers owning fewer than three homes. Indeed, some analysts[12] have said that the care home market is hollowing out, with larger and very small players predominating and fewer medium-sized operators. The **domiciliary care** sector comprises primarily small operators, often highly dependent on a small number of council contracts.

1.16 A 2006 King's Fund report[13] drew attention to a number of key aspects of developing a successful care market, including developing consumer power; measures to support businesses and innovation, for example social enterprises; improving commissioning; and investing in the workforce.

1.17 Given this overall policy and market backdrop, the Commission wanted to look at the key factors driving new investment in social care, to consider what was behind the consolidation in the market and to open up for debate where future investment would come from in order to reconfigure and 'personalise' services in ways that individuals want.

The seminars

1.18 The Commission therefore ran two seminars – in December 2006 and March 2007 – to explore what encouraged investors to put their money into social care services and what drove innovation. One seminar involved corporate

8 Ibid – see chapter 4.
9 As reported in *Healthcare Bi-Weekly*, 15 February 2007.
10 As reported in *City A.M.*, 15 May 2007.
11 As reported in *The Financial Times,* 15 May 2007.
12 eg Laing and Buisson.
13 Banks P (2006), *Steps to develop the care market*, King's Fund, 2006.

providers, analysts and investors, as well as national policy makers. The other, involving members of a regional care association, provided a different and more local perspective on the issues. The seminars were run on a 'Chatham House' basis, ie no comments in this report are attributed to individuals, in order to encourage openness.

1.19 Amongst the key issues discussed in the seminars were:

- What influences current decisions to invest in care?
- How do investors view risk?
- Is the approach of investors different as between the care home market and the domiciliary care market?
- Do investors have a sufficient appetite for risk to support innovative developments?
- How do they view the future?
- What market signals do they look for?

1.20 The full list of participants is at **Annex A**[14]. Whilst this report does not seek to be a comprehensive statement about investment in care, it draws out – using the views of seminar participants – some of the relationships between people who use care services, councils, providers, investment and innovation.

14 CSCI would like to thank all those who took part for their frankness and willingness to share information and experiences.

2

Current investment decisions

2.1 As is well known, investment banks and venture capitalists, including private equity houses, think primarily in terms of the return on their investment. What is perhaps less widely understood is that the time span for this is between three and seven (and occasionally 10) years, rarely longer. One of the key elements influencing the decision whether or not to invest in a particular care service is the presence of more or less secure income streams. In this context, contracts with local councils, which almost guarantee an income stream, were **a**, if not **the**, significant element in the investment decision. In general, businesses with significant council contracts were seen as lower risk than those without such contracts and which operated wholly within the privately-funded part of the market.

2.2 Perhaps surprisingly it became clear that, from the viewpoint of banks and investment houses, investing in residential care homes was not primarily a property issue, ie the security represented by the asset (land and buildings) did not really drive investment decisions. Property might influence the overall valuation of a company but profitability came from income streams and efficiency. In this context, the demographic pressures represented by an ageing population were key, suggesting rising demand for care. Moreover, by comparison with small providers, much of the profitability of the large providers derived from the efficiency gains secured through their greater purchasing power – in goods and services – as well as through lower unit costs for management and other overheads.

2.3 Moreover, investing in domiciliary care was, as far as investors were concerned, no different from care homes, or any other proposition. It was simply a matter of risk and rate of return. This is considered further below. The issue for investors – and providers – is the relationship of debt to profitability, which in turn relates to income streams and efficiency. So who finances care sector investments?

Financing investment in care

2.4 Those at the London seminar spoke about the amount of private equity available for investment, often through venture capital houses. Venture capital

is used to fund some of the large 'deals' which have recently been seen in the market, perhaps through a greater willingness than mainstream banks to go for higher 'gearing' of debt to operating costs/profits. We were told that some 90 billion Euros were seeking 'safe' investments. When multiplied by the level of debt that an initial actual capital investment, in cash terms, might sustain (debt ratios), this could amount to investments worth some €360 billion [Euros] (around £250 billion at the time of the seminar). In essence this has helped fuel some of the recent increase in deal sizes and transaction multiples. One participant said:

"The prices being paid for healthcare assets [in this context this means care homes] are astronomical. So [those businesses] are very highly geared."

Over recent months the debate about the business model adopted by certain private equity houses has grown. The Financial Services Authority has announced twice-yearly surveys of bank lending to private equity houses, partly as a result of concerns about debt levels.[15] Private equity is already prominent in the financing of social care.

2.5 As well as the relatively ready availability of capital, the increasing property valuation of companies being taken over or merged, whilst (as said earlier) not the critical factor in investment decisions, is contributing to such companies' overall valuation and hence to the scale of these recent deals. Companies with hundreds of care homes clearly have a large property bank, whose value rises in line with commercial or domestic property values, depending on type. New owners, having paid a high price to acquire them, can take on a high ratio of debt to operating costs, assisted by the rising value of property. Hence there is pressure on profit margins to cover the debt. As noted above, profit can only come through a mixture of fees, operating efficiencies and reduced management and other overheads. The advantages of taking over existing care homes are that places are already occupied and funded. New buildings may take some time to fill and generate sufficient income and profit.

2.6 The homeowners at the regional seminar were particularly concerned about the level of fees paid by local councils, arguing that they had tended not to rise in line with inflation. In this situation, smaller providers who are heavily reliant on local council contracts (sometimes with a single council) can

15 Feedback Statement 07/3 *'Private equity – a discussion of risk and regulatory engagement'*, Financial Services Authority, 2007. This statement reports on the main issues arising from FSA Discussion Paper 06/06 of the same title, published in November 2006.

quickly find themselves in financial difficulty, more so if they also have high debt ratios.

"A number of businesses will struggle and find themselves breaking bank covenants with not that much going wrong."

The *"not much going wrong"* may hinge on internal performance or external factors. For example, it could result from holding rooms vacant for longer than anticipated, increases in interest rates or renegotiation of contract values (fees).

2.7 Venture capital was said to be largely absent in the regional market comprising small and medium-sized enterprises. For these providers, the high street banks were said to be the main source of investment funds.

How do banks decide whether to invest?

2.8 Whilst perhaps more risk averse, in many ways banks behave similarly to venture capital houses. They too seek an acceptable return on their capital and are equally cautious in their investment decisions. Homeowners told us that the banks would look for a 'good provider' and one who knows the local market. For example, would there be space in the local marketplace for another nursing home? Banks would rely on the provider to make the business case, which they would assess using any local knowledge and their assessment of the provider.

2.9 We were told that, again, assured income streams were a key part of banks' decision making. They looked almost exclusively at cash flows, expecting the provider to research local markets. In this context council income through contracts was often a crucial factor.

2.10 In residential care mergers and acquisitions, there were apparently opportunities to maximise profits by separating the property portfolio from the operational activities of a care home. Some companies, for example, use a sale-and-leaseback structure which involves the company buying a care home and selling the underlying property to real estate investors. In this way, care home operators are able to acquire new operating businesses with minimal impact on cash flows. The sale of the property portfolio creates the cash for additional acquisitions – presumably as long as property values continue to rise.

2.11 Alternatively, sometimes a holding company will split the operating company from the property portfolio and the care home operation pays some form of rent to the property company. Where people invest in this type of company,

there are two income streams to assess: the operational income from the care home operation and the rental income to the property company. Whilst there may be some large profits to be made by splitting the operational and property businesses – based on the valuation of the properties being acquired – this is a 'one-off'. Future profit levels come from the operation of the care home, the levels of rent that are chargeable, the overall value of the property portfolio and the possibility of realising that value. Once done, the growth potential, in terms of return on investment, is subject to usual risk analyses including the movements in rental valuations and the commercial property market.

2.12 Where the local council pays for relatively few people – for example, West Sussex, where some 80% of the people entering residential care fund themselves – the banks look also at either their own or the provider's analysis of the supply and demand ratio based on occupancy rates.

2.13 At the Birmingham seminar, participants said that there were few parts of the region where self-funders predominated. Hence it was even more understandable that councils dominated the market.

2.14 Overall, it seems that investing in the care industry is therefore no different from other decisions an investor – venture capitalist or banker – might make. Investors want to know:

- the supply and demand relationship
- what might be the likely return on their investment
- the nature of the risks – these largely revolved around
  - reliability of income streams
  - occupancy/vacancy rates locally
  - the debt to operating costs ratio
  - the reliability of the provider.

The influence of councils as purchasers of care

2.15 The Commission's report *Relentless Optimism*[16] identified that the commissioning role of local councils was crucial for the future. Directors of Adult Social Services will need to know the future social care needs of people in their areas, identify how people would prefer those needs to be met and estimate how much of the various 'services' the council might purchase directly. In this way they could signal to investors and others what people in their areas want for the future.

16 *Relentless Optimism: Creative Commissioning for Personalised Care*, CSCI, 2006.

2.16 Participants at both seminars emphasised councils' influence as a result of their purchasing power and hence their importance in investors' analysis of risk. At present it seems that many councils determine their own priorities and hope or assume that the independent sector will supply appropriate services. But councils were not good at signalling their purchasing intentions in the short term, nor did they signal the need for new services. Finally, they did not signal the services that might be needed in the long term, regardless of the numbers of people the council might support financially. In some instances, where councils did have discussions about future intentions, particularly about the development of new services, the private sector was often excluded (or perceived itself to be).

2.17 A particular example given was extra care housing. This required land for building, expertise in managing construction projects and an understanding of the market for extra care housing. Some local private sector care providers said that councils appeared more prepared to work with (not-for-profit) registered social landlords to develop extra care housing facilities than themselves, even though some had 'land banks' and experience of managing construction projects. As one person said:

"Our experience of trying to put innovative proposals to local authorities is that they don't listen."

On the other hand, another participant said:

"Many commissioners complain that they are not getting innovative proposals [from providers]."

2.18 The position of the private sector's relationship to local councils was raised in a variety of ways in the seminars. At some points, the political sensitivities – around not only fee levels and apparent differential fee levels between sectors, but also how far councils actively engaged with the private sector – became clear.

"There's antagonism towards what they see as the private sector... and unfortunately the councillors are the elected councillors; their officials have to take a lead and are influenced by those players."

2.19 There was a further view that councils, by not talking to the private sector, were implicitly pushing the private providers into a more and more specialised market niche.

"We asked at discussion and consultation with regard to what services they [councils] want... We are not getting any direction from the commissioners how we, as a private sector, can further partner them moving forward. I've

also looked at those [home care] services but we aren't given the impetus to want to invest further in this sector, rather we are being pushed towards more specialised ends of the market. Commissioning is where the breakdown comes because of their [councils'] lack of willingness to commit to service development."

2.20 Providers also felt that councils' annual budget setting inhibited the possibility of longer-term signalling. In the absence of both short- and long-term signalling, providers felt they were being implicitly pushed not to diversify or to try to engage and develop partnering relationships with councils. Although the majority view, some thought this was changing.

2.21 For the corporate sector, extra care housing was not necessarily economical as the grants available for building this type of facility were restricted to social landlords. From their perspective there were plenty of things the private sector could do: the key question is "who might buy it?" For example, there are now many assistive technologies available; one involved being able to open and close blinds electronically from a bed. Councils, we were told, were not willing to fund this innovation but people paying privately could see the benefit and were willing to pay for it.

2.22 In general, both small and larger corporate providers took the view that councils were frequently more concerned with costs than with quality or innovation and were often risk averse in case new approaches failed. It was perhaps surprising that larger providers took this view given that, on the surface, they might be assumed to be in a better position than smaller operators to spread the risk of innovations and to sell them to local councils and individuals.

Domiciliary care: whether to invest?

2.23 Investors said that in principle they assessed the domiciliary care market in exactly the same way as the care home market. As far as they were concerned the key elements were rate of return on investment and risk. Although there are some large service organisations whose portfolios include domiciliary care, such care is, as *Time to Care*[17] reiterated, still predominantly delivered by a cottage industry. That report painted a mixed picture of the quality of home care. Many people told us that the services which were provided in their own homes were too rushed; that care workers often had large caseloads inhibiting proper service delivery. The report sparked a debate which has

17 *Time to Care?* An overview of home care services for older people in England, CSCI, 2006.

helped to raise the profile of this issue. How councils respond and change their assessment and purchasing decisions will influence how investors view domiciliary care and, in the end, their understanding of the potential for investment.

2.24 One conclusion drawn by the investors was that, in practice, home care is in many instances a higher risk than residential care. One said:

"We've looked at domiciliary care. It's a very fragmented market... It's very difficult to see how you can deal in the value of a market that is always going to be on the price rather the quality of the service it's offering."

2.25 However, seminar participants also felt there were opportunities for efficiency gains in the home care market – particularly around the recruitment of staff, training and payroll. If operators grew, there could be benefits from economies of scale.

2.26 To date, neither the corporate nor the small and medium-sized care home sector has diversified significantly into the domiciliary care market, although some corporate providers have acquired some home care services as part of an acquisition and retained them because of their high reputation. But in general, corporate care home providers did not envisage getting into this market in a big way.

2.27 However, in speculating about future investment in home care, some at the seminars considered it essential to retain the local nature of home care. They saw this as potentially a unique selling point. If consolidation within home care was to increase, through acquisitions and mergers, then it would be important to try to

retain its current strengths. The advantage of the 'cottage industry' approach is that the organisations often revolve around the owner/managers, who have a considerable knowledge about local people and the services they want.

2.28 Some participants could envisage issuing franchises for home care, rather than investing directly in home care businesses. Alternatively, domiciliary care agencies could club together, locally, to create a separate social enterprise agency to provide back-office functions, such as payroll, recruitment and training. Indeed, this approach could cover small and medium-sized care homes too.

3

Innovation and a 20-year time frame

3.1 So what of the future? Are potential investors receiving signals to encourage longer-term decisions?

3.2 For many homeowners, including the larger corporate groups, councils are the key driver of what is purchased. Not only did investors focus on fairly short time horizons, councils too were seen as not being good at signalling their medium- (the next three to seven years) or long-term (10 to 20 years) intentions. Despite this, council contracts were seen in many areas as a key factor driving investment decisions in services. This may, of course, change as the proportion of those funding their own care rises and the personalisation agenda gathers momentum, an issue discussed further below.

3.3 One banker suggested they do not currently invest for the long term:

"I don't think actually 20 years is a time frame that even banks look to any more when looking at deal sizes or restructuring. From a bank's perspective, banks tend to take a more short-term [view] – seven to 10 years."

Another participant said:

"Bear in mind that a lot of investors are probably only looking to be in there between three and seven years."

3.4 It seemed generally agreed at the seminars that few, if any, investors are positioning themselves for timescales anywhere near 15 or 20 years.

3.5 By contrast, many providers indicated a long-term commitment to the sector. They had studied the population projections and anticipated that, despite the policy emphasis on more older people living in their own homes, demographic pressures meant there would be a continuing, and possibly growing, need for residential care and nursing homes.

3.6 Participants at the regional seminar shared an underlying assumption that, in their fundamentals, residential and nursing homes for older people would continue in much the same way as now. It was, however, widely thought that people in 10 to 20 years' time will demand more and better information and higher standards of care than at present.

3.7 Nor did the investors, for the most part, focus much on likely demand outside

the existing suite of services. Many thought new service developments should come from councils signalling the type of care that people in their areas would wish to use – some of which the council would purchase. However, a 20-year time horizon was simply too long a period in which to speculate. Nevertheless, it can often take at least five years to develop a new buildings-based service from conception, finding the land, through planning permission and construction to being fully operational.

3.8 Moreover, at the corporate end of the care home market, venture capital houses, which want relatively quick returns on their investments, are concentrating on mergers and acquisitions rather than innovations, if only because good returns can be made through tried and tested service models which do not carry equivalent risks. One suggestion was that if the stock market rather than equity houses funded some of the companies, there might be longer-term investments and hence a greater interest in developing long-term innovations. Others thought this somewhat paradoxical given the pressure on quoted companies to perform in the short term.

Future models of care

3.9 Those at the seminars agreed that the present models of care were essentially inherited from a welfare state model in which the state, central or local, provided or paid for most services, including social care. Hence one participant asked:

"The challenge we've got, and why this is such an important [discussion] is, what is the 21st century model... for old age?"

3.10 But despite all the current analysis of social care, most of the information collected is predicated on the council providing – or at least commissioning – the service. So, for instance, home care statistics do not accurately reflect the number of people who pay for their own home care:

"What is visible statistically [in home care] is getting an increasingly smaller

proportion of the reality of the range of things being looked at. You've got this huge number of private purchasers... which is not clearly documented."

3.11 In addition, there are two social forces generating pressure on social services – on both councils and providers. First there is a set of people entering old age (ie 75+) who have social care needs but do not qualify for financial support from the council. Some of these people will have a modest retirement income and may have some housing equity but not enough to pay for all their care needs

3.12 Secondly, part of the generation now entering old age and the subsequent generation who are now 50+ will, it was felt, be richer than their parents and probably richer than their children. As one person said:

"When I get to that age, I'll go there with equity from a good occupational pension and through equity from having owned a property in the southeast for 10 years. And with all the impediments around inheritance tax, for better or worse, it's going to be locked in with me... The innovation question is 'Are there going to be new products that are going to go for that?"

3.13 So the issue became:

"There's a real question here which is: 'How sustainable is the system we're in?'... Some of this will be about funding and some will be about the models."

The Wanless report also cast doubt on the sustainability of the current system, not least because of the rising number of people likely to need care services in the next 20 years.

3.14 Paul Birley of Barclays Bank has said of the future of long term care:

"We will see a combination of the following:

- *more community and family care*
- *more domiciliary care*
- *more care villages (including sheltered or extra care housing)*
- *more care homes."* [18]

3.15 Likewise, investors and providers at the seminars all thought there would be increased demand as the structure of the population changes. In 2007, for the first time, the numbers of people of state pension age outnumber the number of children under 16 – by 2031 the former is projected to exceed the latter by almost four million. There was a high degree of consensus that there will continue to be a demand for long-term care – in dedicated care and nursing

18 Paul Birley, Head of Healthcare Business Banking, Barclays Bank plc, quoted in *Healthcare Bi-Weekly*, February 2007.

homes – but the market would become more specialised with, for example, more providers concentrating on working with people with dementia.

3.16 Yet the development of direct payments and the broader and more radical individual budgets, which give people real purchasing power and control, have the potential to change the dynamics of the care market. Coupled with growing cohorts of self-payers, investors may find fewer secure or block council contracts in place and so riskier income streams. Some of the old certainties about cash flow might need to be reassessed. For commissioners, providers and investors the challenge will be to deal with a market moving closer to a genuine retail sector:

"Once people have experienced managing and controlling their own services they are not going to accept a return to a traditional menu of prescribed options that they have previously experienced." [19]

Information and advice

3.17 What sort of infrastructure will be needed to support this type of development? People will need advice as well as information. The Commission has supported the drive for better information on residential and home care services by improving the accessibility of its inspection reports (resulting in some 1.5 million reports being downloaded annually) and, next year, will introduce quality ratings. This will be vital information for prospective customers of these services. This type of information is likely to be very important to investors also. They will be able to use it in assessing a provider's ability to provide services of sufficient quality. Providers will be able to use the information not only in their marketing but also in discussions with potential investors. CSCI is establishing a Market Review Group to seek to assess the impact of quality ratings on the care market.

3.18 What sort of advice or counsel will be available for the many people who do not use or are ineligible for council support or who do not want traditional services? Last year CSCI published a discussion paper *Support Brokerage*[20], in which it floated the idea that support brokers could empower people who fund their own care to make their own choices and plan the package of care best suited to them, rather than simply to go for a care home or domiciliary care. Such brokers would know local services and have local information on which people could base their purchasing decisions.

19 Paul Snell, CSCI Chief Inspector, speech to the 'Direct Payments' conference, 21 May 2007.
20 *Support Brokerage*, CSCI, 2006.

3

Role of the Director of Adult Social Services

3.19 The future will be a very different world from the current one of limited options of (mainly) domiciliary care and care homes. How will councils, in their strategic commissioning work, "aggregate infinity" – the sum of everyone's choices and preferences, to quote one person from *Relentless Optimism?*[21]. However, this 'infinity' may not all be small providers but larger ones with extensive capacity to offer a very wide variety of services – tailored to individual choices, even – with a clear tariff of costs and charges.

3.20 Crucial to this will be the role of the Director of Adult Social Services. Each council will need to develop strategic commissioning for the whole community, working with local communities to identify what people want from social care services and ensuring there is sufficient supply of those services – care, support and infrastructure – to meet local needs. The choice agenda also has other implications:

"The public sector needed to improve its commissioning skills and 'has to come to terms with the implications of choice'. One aspect of that 'which is essential is that you actually have to have spare capacity' to allow choice to happen. That view cut across the traditional public sector concerns about removing spare capacity in the name of efficiency."[22]

3.21 Directors of adult social services will also need to ask what the nature and variety of supply means for the type of place the local council represents. The 'place-shaping' agenda described by Sir Michael Lyons[23], ie the role that councils have in shaping the local environment, implies the need to ask such questions as "what sort of area is this in which to grow old? To live as a person with disabilities? Can a person meet their expectations in this local council area? Is it a place with many options and opportunities?"

3.22 In this context, this means councils will need to engage in long-term relationships with a wide variety of providers. In future, banks and other investors will need to include the strength of this relationship as well as the performance rating of both the council and the providers in their assessment of risk.

21 *Relentless Optimism*, CSCI, 2006.
22 *The Financial Times*, 17 May 2007, quoting Sir Gus O'Donnell, Cabinet Secretary.
23 Lyons, Sir Michael, "*Place-shaping: a shared ambition for the future of local government*". Lyons Inquiry Into Local Government – Final Report, 2007.

4

Conclusions

4.1 The quality of social care services is influenced by a number of factors:

- the extent to which people who use services are listened to when describing their experiences
- the quality of providers
- the effectiveness of councils' commissioning strategies
- the operation of the market
- the effectiveness of regulation.

4.2 This paper has sought to explore some of the issues in the operation of the social care market – the relationship between councils, providers and investors. Despite some recent consolidation, a majority of care home and domiciliary care providers remain small operators. In this part of the market, banks are the key investors.

4.3 At the corporate end of the market, there has been increasing consolidation amongst the large corporate providers of care homes, with deals getting ever larger. Venture capital is heavily involved in many corporate acquisitions and mergers.

4.4 Overall, there is a relatively cautious and conservative view from investors about the services they want to invest in and over what timescale. Investors look for a return within a fairly short, usually three to seven year, time frame and look to projected income streams to sustain profit levels. However, if the wealth of older people grows faster than increases in the means test, more people will have to pay for their own care. Investors may have to look at other criteria – for example the availability of private income and capital to pay for care and the regulator's quality ratings – for indicators of sustainability. How far this will lead to a two-tier system with lower costs and lower-quality care for those supported by councils and higher costs, higher-quality care for those who come above the threshold for council support is unknown.

4.5 There have been considerable efficiency gains in the care home sector over the past 20 years but many feel the scope for such gains has now largely been exhausted. There is thought to be some scope for efficiency gains in the domiciliary care sector, from merged back-office functions like payroll, recruitment and training.

4.6 The 'paradigm shift' in the models of care being suggested here will need to take into account both an increasing number of older old people and decreasing care from family members with the pressure on people to work longer. It is possible that many older people will live in their own homes or in assisted living facilities longer before possibly moving into a care home. Hence, older people in care homes are likely on entry to be more mentally and physically frail than the current cohorts of residents. There will be implications for the nature of the care workforce as well as for financial product development.

4.7 There appears to be relatively little private sector investment in innovative care models, with some notable exceptions like care villages and some extra care housing, though much of the latter is provided by social landlords using public financing.

4.8 A key question is how councils, providers across all sectors and investors can work together to increase the supply of innovative services, including those using new and assistive technologies. Future generations of older people will want a wider range of services to suit their individual circumstances. Unless there is investment in these services, it is difficult to see how care can be truly personalised. At present there is a gap between the policy intentions and people's experience. Councils will not deliver the personalisation agenda if they carry on as they are. They need to find ways of signalling **early** future requirements so that suppliers of care are encouraged, and have the time, to develop and provide new services.[24] Strategic commissioning for the vast variety of needs and ways of meeting them may result in more specialised organisations, but this is not inevitable. So it is possible to imagine organisations that can offer a wide range of services which are personalised at the point of delivery. For instance, home care organisations could, in theory, develop horizontally to supply (or arrange to supply) several services. So, people may choose to have a meals-on-wheels service from a care organisation which offers to arrange delivery of meals from local restaurants or pubs. Indeed, some care delivery organisations may develop a 'broker' service, which offers information and advice but can only offer support from their own suite of services; for example, trips out to go shopping, arrangeing holidays or chiropody. Independent brokers may be free to select from a variety of suppliers.

4.9 The public service reform agenda is likely to continue to promote a mixed

24 *The state of social care 2005-06,* CSCI, 2006 – see chapter 6.

economy in social care – mixed in terms of both service models and their funding. Other countries in Europe, as well as further afield, for example, some states in the USA, have models of care from which we might learn. For example, we heard that in Cleveland, Ohio, there were (social) care managers in some law practices who were in essence 'brokers'. Where people had dementia, legal arrangements were sometimes made to enable the 'broker' also to act as the person's advocate in order to manage their affairs and protect their human rights.

4.10 In the end, those at the London seminar concluded that, whatever care services were available in future, what often mattered most to people was social interaction and personal contact with relatives and friends. This improved the quality of their lives, so vital to maintaining real well-being and encouraging respect for them as individuals with wishes as well as needs. So increased quality of care includes promoting and enhancing the well-being of people.

4.11 The current incentives seem to encourage councils, investors and providers to do more of the same. Yet it seems clear that 'more of the same' will not deliver the range of services people want nor the personalised agenda set out in the Department of Health's White Paper *Our health, our care, our say*[25]. Councils would appear to be best placed through the role of the Director of Adult Social Services to break out of this apparent vicious circle. Indeed the financial pressures on councils and the higher expectations of the coming generations of older people mean that there is little choice but for councils to grasp the opportunities now being offered to develop the right care for older people, at the right time, in the right place.

4.12 The key will be personalised services, wherever a person lives and whatever their circumstances.

"Personalisation... in social care... means there has to be a change of emphasis – from welfare to well-being; from passive clients to active citizens; from services which potentially create dependence to services that support independence; from a state which donates services to a state where people are in control of their own services; to a system where pluralism of providers creates choice for individuals." [26]

25 *Our health, our care, our say*, Department of Health, 2005.
26 Dame Denise Platt, CSCI Chair, June 2006.

5

A way forward

5.1 If personalisation is the vision for social care and yet the seminars accurately reflect investors' and commissioners' relative lack of appetite for developing innovative models of care, what needs to happen to bridge the gap between the policy aspirations and present reality?

5.2 This paper seeks to encourage debate by policy makers, council members, Directors of Adult Social Services, investors, providers and others about possible ways of reconciling this gap.

5.3 It is essential that councils – and particularly Directors of Adult Social Services – engage with providers and investors to signal what people need and expect from social care services. Councils need to signal how they will deliver their part of the social care 'deal' such as a universal right to an assessment of need and access to information and advice about available care services. They also need to signal what people in their area want; what they as councils are prepared to purchase; and how, using the information from the regulator, they will work with providers on improving some services.

How can councils provide what should be universal in social care?

5.4 It is possible to conceive of models of social care whereby, for instance, some independent care managers or social work agencies, commissioned by the council, would deal with all people considering the need for social care. They could provide the information, the assessment, to which everyone is already entitled, and the advice as to what would best suit a person's circumstances. This could leave council staff to assess both the eligibility for council support and the financial contribution, if any. Another idea would be for the council to assess a person's care needs and then for that person to be able, in effect, to take that assessment to a range of agencies, such as social enterprises, independent sector agencies or Centres for Independent Living, to obtain appropriate services.

Is there a role for care brokers?

5.5 Some of these independent care manager or social work agencies might have a variety of services on offer but as with financial services, in terms of developing a care plan, might be limited to recommending only their own services. This reflects part of the discussion in the Commission's report on brokerage[27] and in some ways the idea of independent social work agencies in the White Paper on children in care[28] which the Government has decided to pilot.[29] In responding to the previous Green Paper the Commission commented that independent social work agencies might be more appropriate in adult social care than in children's services.

How to encourage better strategic commissioning and a wider range of services

5.6 Another issue for debate is how to encourage and incentivise councils to become better strategic commissioners, so that their short- and longer-term intentions in relation to specific care services and outcomes are clearly signalled to providers.

5.7 In future, potential consumers of social care services are unlikely to be satisfied with standardised services or placements – yet much current commissioning assumes that such services can be purchased as standard commodities for 'standard' people. In response to rising consumer expectation, commissioners, providers and investors may need to take somewhat higher risks. With income streams from councils becoming less 'secure' in terms of volume, will financial houses support innovative care models which better reflect what people want or will they continue to back the existing, limited, suite of services for as long as possible?

What about services for people supported by councils?

5.8 Direct payments and individual budgets represent good opportunities for services to develop in response to people's individual wishes. As yet there are still too few direct payments – and individual budgets are still in the pilot stage – to be sure that existing services will respond, and in a way that levers in change for all.

5.9 It is equally unclear how personalisation will be implemented in current mainstream services where councils with their purchasing power could have considerable influence.

27 *Support Brokerage*, CSCI, 2006.
28 *Care Matters: transforming the lives of children and young people in care*, Green Paper, DfES, 2006.
29 *Care Matters: Time for Change*, White Paper, DFES, 2007.

5

Finally

5.10 In developing a model for the 21st century, councils will need to get better and more confident at strategic commissioning, tracking individuals' preferences and working with partners in housing and health services to signal people's future requirements to investors and providers. And in seeking to develop their areas as good places in which to grow old, councils should guard against the emergence of a widespread two-tier market, where those with resources buy "good" and "excellent" services, whilst those paid for by councils have to make do with lower-quality services.

5.11 People tell us that they want services that are personal to them. If councils, providers and investors are to deliver this personalisation they need to break out of the inertia in the current arrangements. Councils have a major opportunity to lead in meeting this challenge.

Annex A

List of seminar participants

London

Paul Snell, Chief Inspector, CSCI
David Behan, Director-General for Social Care, Department of Health
Tim Street, Chief Operating Officer, Four Seasons Healthcare
William Laing, Laing and Buisson health and care analysts
Bill McClimont, independent consultant
Marguerite Mulvey, Head of Healthcare, Allied Irish Bank
Mike Reid, Chair, Care and Health
David Whileman, 3i – global venture capital and private equity firm
Lucianne Sawyer, President, UK Home Care Association
Lesley Rimmer, Chief Executive, UKHCA
David Walden, Strategy Director, CSCI
Sarah Norman, Regional Director for West Midlands, CSCI
David Crosbie, Chair's Office, CSCI

Birmingham

Representatives of the West Midlands Care Association:

Tony Billingham (chair)
Shindar Chall
Roger Ephraims
Daniel Johnson
Jag Khatkar
Mervyn Ricketts
Ray Rimmel
Symmr Sandhu
Beryl Seaman, Commissioner, CSCI
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