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Self-directed adult social care in London

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Executive summary

In recent years measures have been taken to increase the amount of individual involvement in how social care services are delivered, including direct payments and, more recently, individual budgets.

In December 2007, all relevant central government departments, the Local Government Association and a number of other key agencies and associations committed to "Putting People First: A shared vision and commitment to the transformation of adult social care". A key component of this vision is a move to a self-directed adult social care system.

As self-directed social care is fundamental to the goal of helping those with care needs live independently, it directly affects the community care sector – care provided to individuals in their community rather than in care homes.

The community care sector

The general trend since the early 1990s has been the growth of independent provision and self-funding, and of home care (care delivered in individuals' own homes) at the expense of residential care. The move to home care has been driven by a combination of factors including: resource constraints; correction of the traditional bias towards institutional care; central government policy; technological advances; and individuals' preference to stay in their own homes.

Local authorities still provide about three quarters of formal care funding, which amounted to about £2 billion in London in 2005/06. Of this, 39.8 per cent (compared to 43.5 per cent in England as a whole) was spent on care homes, 42.6 per cent on community care (42.6 in England), while 17.8 per cent was on assessment and care management (13.9 per cent in England). Most of the 42.6 per cent allocated to community care in London was directed towards either home or day care, with only 6 per cent going towards direct payments.

The prevalence of different types of community care varies between the different needs groups. Older people and adults between the ages of 18 and 64 with physical disabilities or sensory impairment are more likely to receive home care than day care (care delivered in day care centres). The reverse is the case for adults between the age of 18 and 64 with mental illness or learning difficulties, with significantly more receiving day care services than home care.

The most recent survey of council-funded home care, in September 2006, estimated total provision at around 509,000 hours a week in London, provided to around 49,000 households. Of these, around 426,000 hours, or 84 per cent, were provided by the private or third sector.

The higher cost of living in London raises the cost of home care, particularly in inner London where the average cost is about 10 per cent above England as a whole. The difference is much higher in day care where land and property costs play a bigger role. Council-provided home care in London is roughly twice as costly per hour as home care contracted out.

Home care privately-funded by individuals has been steadily increasing in recent years as direct payments have become more prevalent and constraints on public care funding have become tighter. Privately-funded

home care tends to be provided at a higher intensity, that is with longer duration of visits, than publicly-funded care.

The care workforce is a relatively low-paid one, with high turnover. In 2006 the average wage in the home care sector in London was estimated to be £6.30 per hour in the independent sector and £7.38 per hour for council staff, both considerably below the London average wage. Home care turnover rates have been estimated at 24.9 per cent per year and vacancy rates at 5.9 per cent. The community care workforce is predominately female, and older on average than the workforce as a whole. London's community care workforce is more ethnically diverse than the broader London population, and significantly more diverse than in England as a whole.

In the 2001 Census, 607,000 Londoners stated they provided some amount of informal social care, of whom 20 per cent provided more than 50 hours of care per week. The cost of replacing all informal care in England with formal care has been estimated recently by Laing and Buisson in their *Domiciliary Markets* 2007 at £31 billion per year.

The community care market

Demand is determined by the total of public funds directed towards community care and the funds of self-funders. The supply is the total potential provision of care by either local authority, private or third sector providers. More broadly, supply of social care includes the informal care provided by family and friends.

The home care market is very fragmented, with a few very large providers and many small ones. There are 584 registered providers in London alone, mostly independent providers, who provide around 74 per cent of all home care.

Current contracting arrangements essentially pool together resources to purchase social care collectively, providing local authorities with considerable buying power to keep down costs. Recent trends suggest larger providers are gaining an increasing proportion of local authority contracts, while smaller providers have benefited disproportionately from the growth in privately-funded home care.

The move to self-directed social care has potentially significant implications for the sector's structure and for care outcomes. Traditionally, whether care has been provided by council staff or contracted out, social services departments' decisions on what services to commission essentially established the market. The market for care should become far more fluid with a move to self-directed care.

Policy instruments of self-directed care

A direct payment is provided as a cash payment, commonly around 90 per cent of the cost of the service that would have otherwise been provided by the local authority.

Take up of direct payments has been slow since they were introduced in 1996. Direct payments are highest among younger adults with physical or sensory disabilities (from whom the push for independent living was generated) and lowest for older people.

A key issue with direct payments is the availability of support to set up and manage a self-directed care plan. A recent survey found about 20 per cent of users had to wait to access direct payment support in England, implying a gap between support provided and the number of direct payment recipients.

Individual budgets differ from direct payments in three key ways. First, they aim to coordinate multiple income streams from a number of agencies. Second, they allow for these coordinated income streams to be made as a direct payment but do not exclude more limited mechanisms of individual control. Third, their

cash value is based on the level of need rather than the cost of alternative council services as is the case with direct payments.

The evaluation of the Individual Budgets Pilot Programme is due to be released in the autumn and a decision as to whether to roll out Individual Budgets across the country will then be taken.

Economic implications of self-directed care

The transformation to a self-directed adult social care system is likely to have implications for the quality and efficiency of community care. It is still unclear how far users will gain control of the care provision under a transformation to self-directed care, both in the proportion of users that take up a self-directed care mechanism and the degree of restrictions associated with user control in these mechanisms.

Providing the necessary support is there, the impact on the quality of care and how users value it is likely to be positive with increased user control over their care. As long as the information on available providers is good, and switching relatively easy, a service user would be able to change providers if they were unhappy with the quality or relevance of that service. Self-directed care could further increase the value of publicly-funded care by allowing users to determine exactly how best to meet their needs given the finance available to them, possibly through a completely different mix of goods and services.

Under current arrangements, where the majority of home care is contracted out to the independent sector, there is considerable buying power. A shift to a self-directed care system would reduce this buying power as at the very least councils could no longer guarantee clients to contractors.

For existing social services, centralised direction of social care potentially benefits from improved supply information, including better information on cost structures and range of service possibilities. On the other hand, service users have a better understanding of their needs, how they value different service options and how they could best fit in with their lives.

Whether public administration costs will be greater or less under a self-directed system depends on whether the costs of supporting and monitoring choice exceed the savings in commissioning and administering care provision. This is difficult to forecast, as the degree of support brokerage and monitoring that will exist under the new system is not yet clear. If appropriate support is not provided there is a risk that the administrative costs of managing the care provision could shift to those in receipt of direct payments and/or their carers.

Particularly in the provision of day care, a certain minimum number of users is required to deliver the service at a justifiable level of cost. If a significant number of users opt out of a particular service, then average costs may rise to a level that makes the service unviable, to the detriment of those remaining. As such, those in need could feasibly be adversely affected despite not having opted for an individual budget or a direct payment.

The transformation to a self-directed care sector will have significant impact on employment in the sector. The profile of the workforce, from the direct providers of care to those administering and facilitating it, will be required to change considerably. Emerging roles such as support brokers and personal assistants will become significant components of the social care workforce.

Currently, all home care providers are required to register with the Commission for Social Care Inspection and are subject to periodic inspection and evaluation. Self-directed care poses a considerable regulatory challenge. As empowerment is a product of choice and risk, it is necessary that some risk be born by users.

Policy issues of self-directed care

A successful move to a self-directed adult social care sector is likely to result in a system that better meets the needs of service users. Like any institutional transformation, however, there are a number of important implications and risks that need to be thought through in planning the transition.

Fundamental change will be required in the function of council social services departments, where they move from the role of "gatekeepers" of care access and provision to market-enablers and supporters of user-controlled care. Likewise, there are a number of broader issues in relation to market management and policy friction that require consideration.

There are a number of income streams and support options currently available to carers and people with care needs, provided by a number of agencies. In addition to local authorities, these include Independent Living Funds (financial resources designed to assist people with disabilities to live independently), Primary Care Trusts and social security benefits such as Disability Living Allowance and Attendance Allowance. If introduced properly, independent budgets provide the opportunity to significantly reduce the overlap in assessment processes and case management.

A bank of experience and knowledge in individuals and organisations that is trusted by users is vital to the effectiveness of a self-directed social care system. The absence of this is likely to increase the possibility of individuals purchasing care at a higher price than they would otherwise have, purchasing care packages that fail to meet their needs, or simply opting for the status quo. A strong support network that is well-funded and enabled could provide a mechanism to overcome many of the potential negatives of a self-directed system in relation to information, transaction costs, risk, and buying power.

A key policy problem with decentralising decision-making is the loss of scale economies associated with collecting information on cost, quality and availability of services. Support organisations and networks that collectively collect and pool information along with councils, regulators and other agencies could mitigate much of this potential loss. In a recent survey of direct payments, London boroughs were most likely to cite a lack of available support service as a critical hindrance to the expansion of direct payments.

A move to self-directed social care is likely to have fundamental implications for the profile of the adult social care sector and its workforce. This will create significant challenges of adaptation for social services departments, central policy makers as well as independent providers. Common commitment and collaboration in addressing these challenges, both nationally and locally, is vital to the success of this transformation.

1. Introduction

Over recent decades there has been fundamental change in the way that adult social care is commissioned, funded and delivered. While local authorities still determine the profile and recipients of services, their role has changed from broadly one of service provision to one of service procurement.

As recently as the early 1990s nearly all formal care was provided by council staff. Now the vast majority of publicly-funded care is provided by the independent sector. Another change has been the increasing growth of home care (care delivered in individuals' homes), partly at the expense of residential care (care homes without permanent nursing staff), which has experienced little growth. Self-funded care has become increasingly more prevalent, though it still represents a minority of total funding.

In recent years measures have been taken to increase the amount of individual involvement in how care services are delivered. An example of this is the introduction of direct payments. Direct payments are "cash payments made to individuals who have been assessed as needing services, in lieu of social service provisions"[1]. Introduced in the mid 1990s, take-up of direct payments has been greatest for younger adults with physical disabilities or sensory impairment, but slow amongst other need categories, particularly older people.

Individual budgets are a more recent initiative, aimed at coordinating the various resources available to individuals in need and giving them a greater say in how they are directed. Individual budgets differ from direct payments in three key ways. First, they aim to coordinate multiple income streams from all agencies, giving a fuller understanding of the finance available. Second, they allow for these coordinated income streams to be made as a direct payment but do not exclude other more limited mechanisms of individual control. Third, their cash value is based on the level of need rather than the cost of alternative council services as is the case with direct payments.

In December 2007, all relevant central government departments, the Local Government Association and a number of other key agencies and associations committed to "Putting People First: A shared vision and commitment to the transformation of adult social care". A key component of this vision is a move to a self-directed adult social care system.

The move to a self-directed system is a fundamentally more radical transformation of adult social care delivery than the shift from council-delivered to contracted-out care. In shifting the decision-making power on care delivery from local authorities to individuals, fundamental shifts in the way care is provided and the proper role of local councils and other agencies are inevitable. How this shift is facilitated is vital to the success of this transformation.

This paper explores the issues, implications and risks of the transformation to user-led adult social care. It does this with a focus on community-based care, as this is the area more directly affected by the change, and with a particular focus on London.

The paper is structured as follows. In section 2, the role of government in social care is summarised. In section 3, an outline of the community care sector in London is provided. Section 4 scopes the market for community care in London. In section 5, the key policy instruments that promote self-directed care are looked at. Section 6 looks at the economics of self-directed care. Section 7 discusses the key policy implications and risks to a successful transformation to self-directed social care sector. Finally key conclusions are provided.

2. The role of Government in social care

English social care operates under a needs-based, means-tested system funded from general taxation, where those with the financial means are expected to contribute towards the cost of their own care, or fund it entirely. Alternative models include general taxation-funded universal (no means-testing) systems such as in Scotland, and insurance-based systems where contributions are made compulsorily into a pooled fund from which social care is funded on the basis of need, such as Germany's[2].

The UK Government has recently announced a six-month consultation on the future funding of social care. Its scope is considerably larger than the scope of this paper, which focuses on the move towards self-directed social care.

In England, public expenditure to meet care needs is allocated via social services departments in local authorities. There are a number of other benefits provided through other agencies, which will be summarised in Section 4.

Local authorities and other public agencies play a role in determining what mix of care is provided, who gets access to this care and how the quality and standards of care are maintained. This section summarises the three core functions of commissioning, assessment, and regulation.

2.1. Commissioning

Local authorities can commission social care in three broad ways: direct provision; contracting-out; or via direct payments. From a low base in the early 1990s, contracting-out has grown to dominate the delivery of council-funded home care in London.

Contracting behaviour varies between councils, however each uses some mix of unit-based contracts and block purchasing. Unit-based contracts set a price per unit of service and pay the provider depending on the amount provided. Bulk contracts purchase a certain quantity in advance.

Direct payments were introduced in 1995, providing some social care recipients the option of a cash payment in replacement for the care that would otherwise have been provided. These will be discussed in more detail in Section 4.

2.2. Assessment

Local authorities assess and determine access to publicly-supported social care through a process that determines an individual's needs and then, given this assessment, allocates a certain quantum and mix of care provision.

Assessment occurs at the local authority level, and there is a high degree of difference between them in how they go about setting criteria and how they assess against these criteria. Though they operate within guidance set by the Social Care Institute for Excellence (SCIE) and agreements with central government, differing priorities, resources and demographics lead to a diverse range of resourcing outcomes.

An assessment is first carried out on the needs of the individual and then a financial assessment is carried out determining the individual's means. Individuals are risk-assessed in terms of four levels - critical, substantial, moderate and low. There has been a general trend from local authorities to require a higher level of risk to warrant council-supported residential care, instead providing packages of care into the homes of those who fall below this increasing threshold, if any care is provided at all.

Financial means-testing is based around three tiers of net assets. The upper threshold above which no social care is publicly provided is £21,500. Between £13,500 and £21,500 the user is expected to fund part of their care whereas those with assets below this lower threshold have their care fully funded.

Needs- and means-based assessment also occurs in determining eligibility for various allowances paid via the tax and benefit system.

2.3. Regulation

The Commission for Social Care Inspection (CSCI) is the regulator of social care in England. With a remit to improve the quality and standards of social care in England, the CSCI works with local authorities and inspects and judges providers on seven measures:

- (users) exercising choice and control
- health and emotional well being
- personal dignity and respect
- quality of life
- freedom from discrimination
- (facilitating users) making a positive contribution
- economic well-being

The CSCI has consistently reported annual improvements in the number of providers meeting minimum standards[3].

The CSCI is developing a process that provides information on service quality of relevant providers to local authorities to assist in their commissioning of social care.

There is no specific regulation of day care provision.

3. The community care sector

Adult social care includes all care provided to adults with care needs, including those relating to age, mental illness, learning disabilities or physical or sensory impairment. The sector may be considered along a spectrum that begins with the most basic home care, and ends in nursing home care. In between are degrees of care intensity, including higher levels of home care support, day care centres, temporary care and residential care.

There is a logical division of the adult social care market between individuals in care homes and community care. The former includes both nursing homes and residential homes. The latter includes care provided to people in their homes as well as care provided in day care centres.

The general trend since the early 1990s has been the growth of independent provision and self-funding, and of home care at the expense of residential care. From a UK-wide base of just five per cent in 1993[4], independent provision surpassed council-delivered care for the first time in 1999[5], and by 2006 accounted for about three quarters of the London market[6].

Growth in home care has been driven by a combination of factors including: resource constraints; correction of the traditional bias towards institutional care; central government policy; technological advances; and individuals' preference to stay in their own homes[7]. Home care provision grew by 67 per cent across the UK in the ten years to 2002[8], while residential care places achieved little sustained growth over the same period[9]. In 2002 the Public Service Agreement between Central Government and local authorities was to increase the ratio of home care to residential care, further encouraging this trend.

Slow growth in funding allocated to social care relative to rising need driven by demographic change has led to an increase in the threshold criteria for access to care and a reduction in the amount available to those who qualify. This has contributed to a growth in self-funding, with private contributions to home care estimated at 26 per cent of total funding in London in 2006[10].

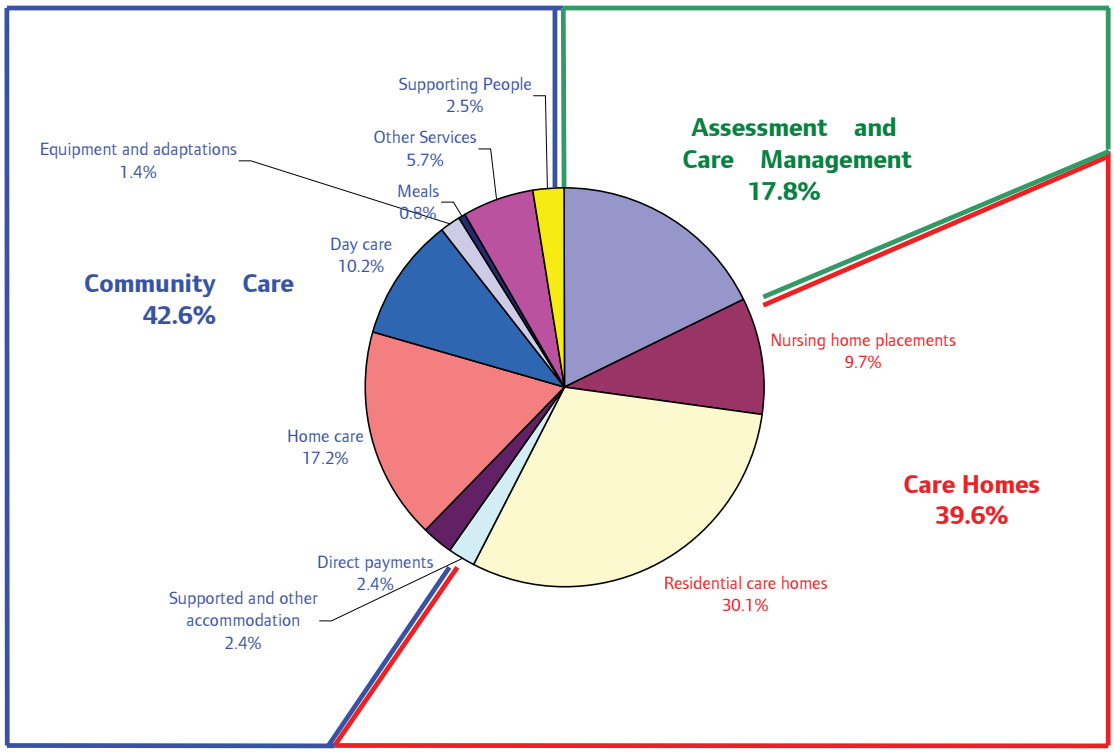
The degree of care that is suitable for an individual depends on a number of factors including: their degree of need; their ability to look after themselves; and the presence or otherwise of informal care (care provided by friends or family). The appropriate degree of care is constrained by the resources available and the cost of the care options.

3.1. Publicly funded community care

Local authorities continue to provide the bulk of the funding for adult social care. The table in Appendix A presents the aggregate council expenditure in England and London in 2005/06. The most significant differences to note are the higher proportion of expenditure in "administration and care management" in London compared to England as a whole and the lower proportion directed to care homes. The charts in Appendix C give the breakdown of expenditure for each London borough.

The distribution of London councils' spending on adult social care is portrayed in Chart 3.1.

Chart 3.1: London council expenditure on adult social care 2005/06



Source: Information Centre Department of Health: Detailed Council Expenditure 2005/06

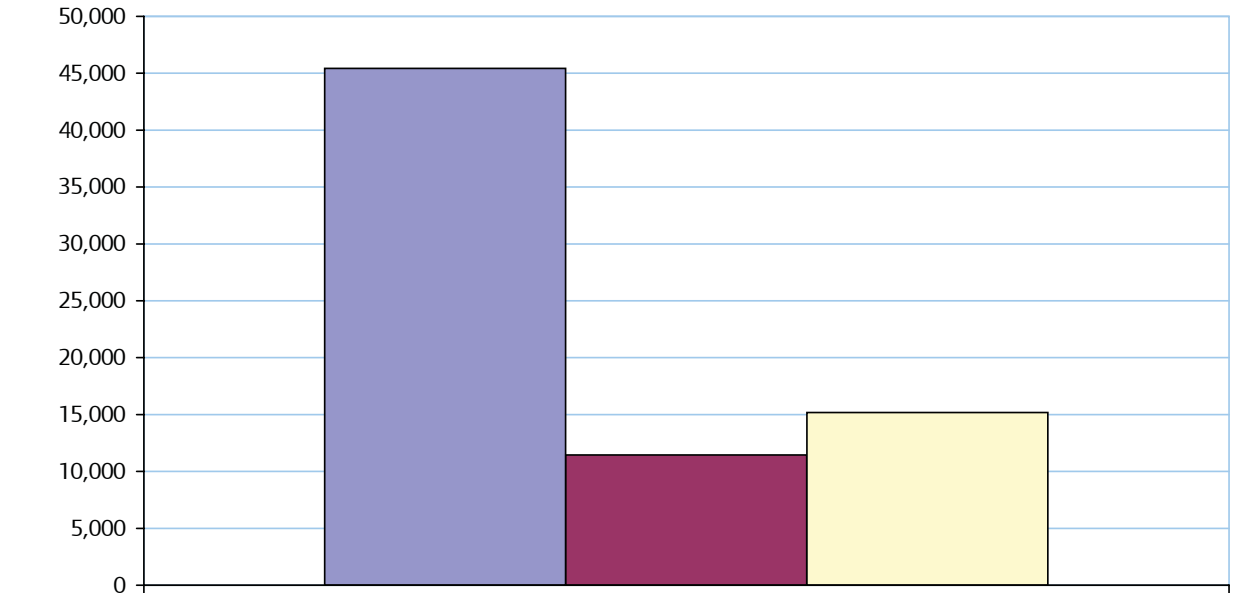
While direct payments had grown to about 2.4 per cent of the adult social care sector in 2005/06, day care and home care consumed almost two thirds of council spending on community care.

Supporting People, which consumes 2.5 per cent of London councils' adult social care budgets, is a broad program that "offers vulnerable people the opportunity to improve their quality of life by providing a stable environment which enables greater independence"[11].

The prevalence of different care types varies by the different needs groups. Charts 2.2 and 2.3 show the numbers of council-funded recipients of community care in London by the major care types, for people 65 and over and adults between the ages of 18 and 64 respectively. It should be noted that care types are not exclusive of each other, as some individuals receive multiple types.

In Chart 3.2 we can see that older people are more likely to receive home care than either day care or meals. The story is similar for adults between the ages of 18 and 64 with physical and sensory disabilities[12].

Chart 3.2: Council funded recipients 2005/06 – Over 65[13]



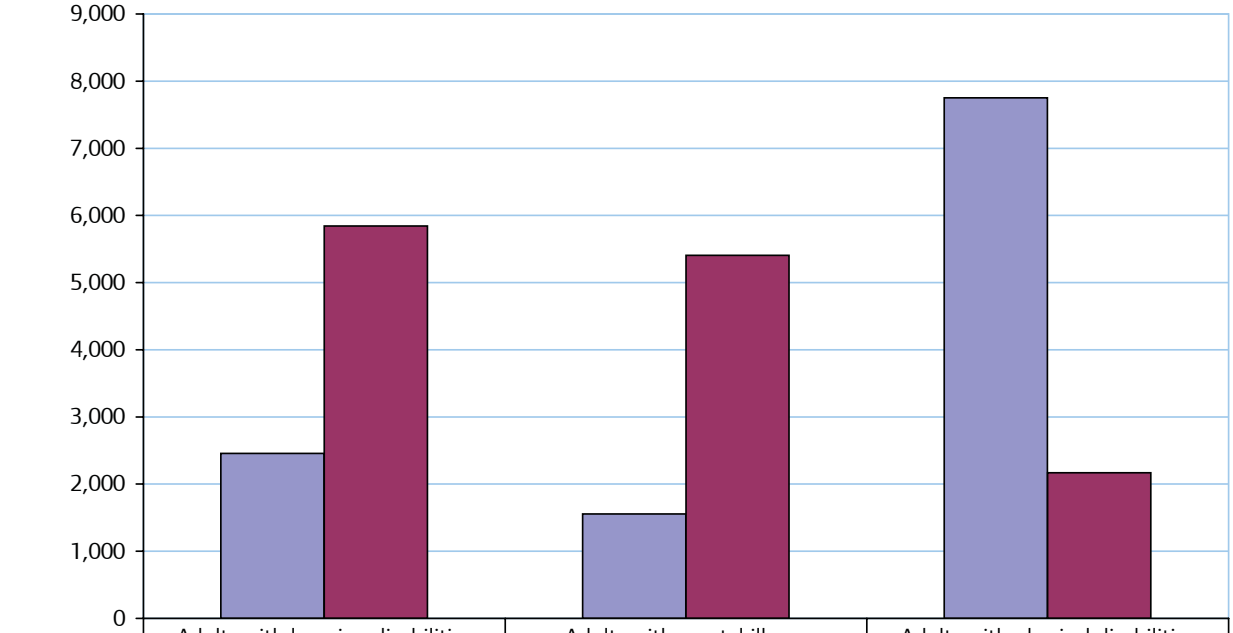
	Older people (65 +)
Home Care	45,432
Day Care	11,452
Meals	15,173

Source: Information Centre Department of Health: Detailed Council Information 2005/06

The reverse is the case for adults between the age of 18 and 64 with mental illness or learning difficulties, with significantly more receiving day care services than home care.

Meals appear to be provided exclusively to those 65 and over.

Chart 3.3: Council funded recipients 2005/06 – 18 to 64



	Adults with learning disabilities	Adults with mental illness	Adults with physical disabilities
Home Care	2,457	1,555	7,753
Day Care	5,844	5,406	2,170

Source: Information Centre Department of Health, Detailed Council Information 2005/06

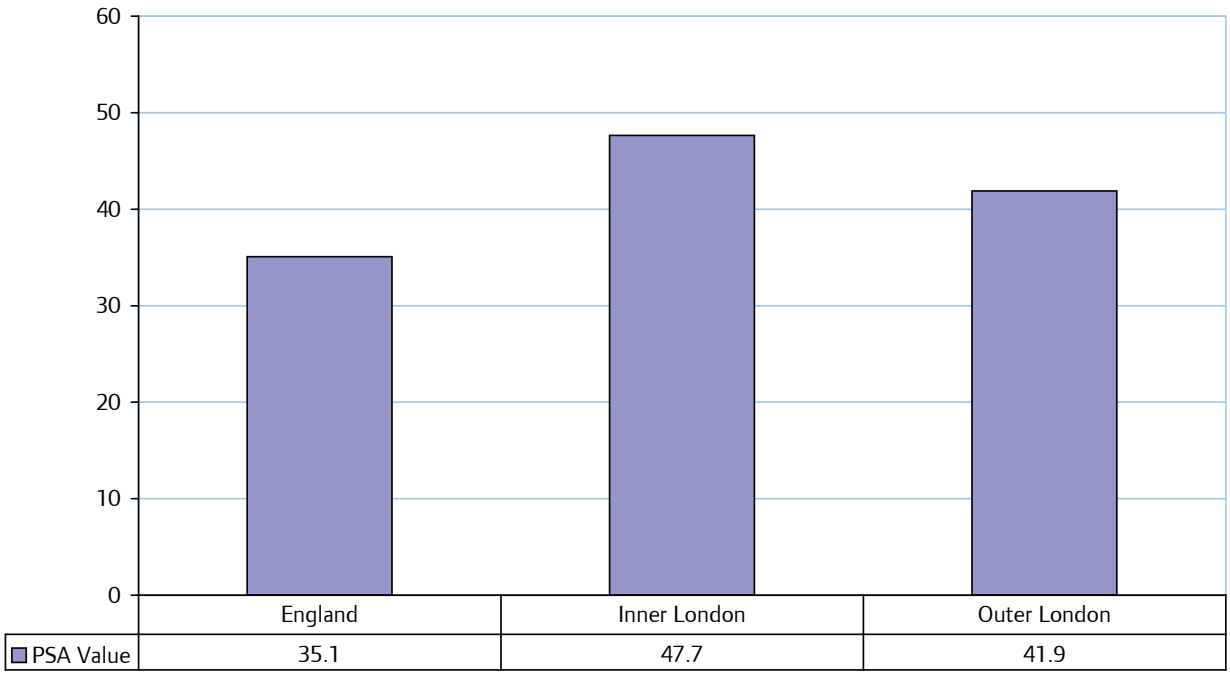
3.2. Provision and unit costs

3.2.1. Home care

Home care output is generally measured by the number of care hours provided. It is difficult to develop a solid estimate of the total market due to limited data on activity not commissioned by local authorities, the significance of informally-provided care and difficulties in market definition. The most recent survey of council-funded home care, in September 2006, estimated total provision at around 509,000 hours a week in London, provided to around 49,000 households (excluding direct payments). Of these around 426,000, or 84 per cent, were provided by the private or third sector[14].

A Public Sector Agreement in 2002 established a target of 30 per cent of residents in a local authority's area to be supported in their homes out of the total either receiving home care or in residential care. This measure is referred to as a PSA value. As shown in Chart 3.4, in 2005/06 the PSA values for inner London, outer London and England were 47.7, 41.9 and 35.1 respectively, indicating a considerably higher proportion of residents cared for in their own homes in London relative to England as a whole (a list of the boroughs in inner and outer London is provided in Appendix B).

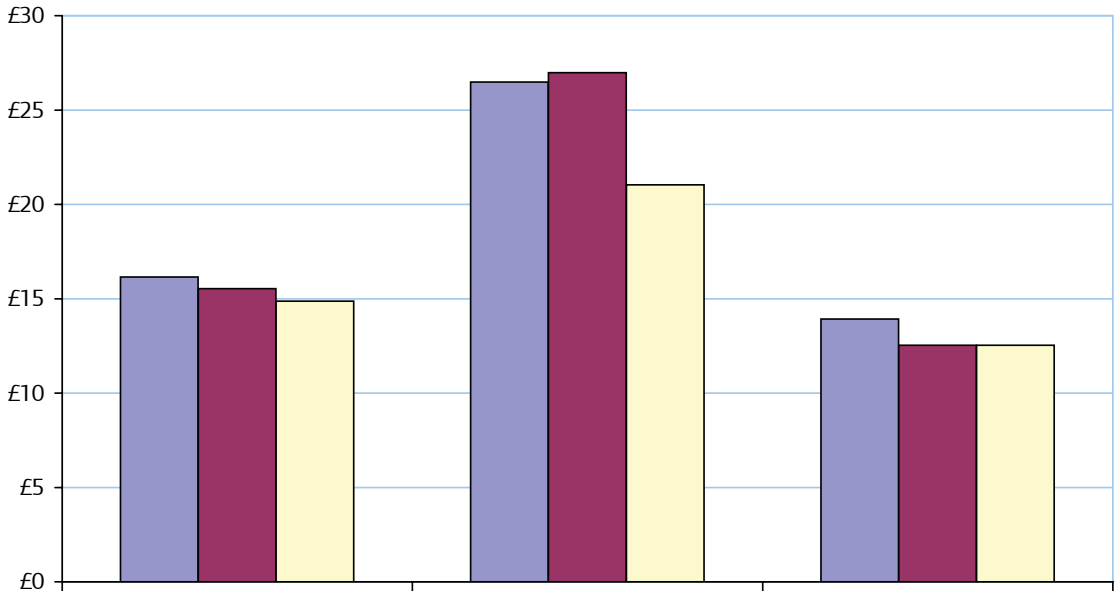
Chart 3.4: PSA values in 2005/06



Source: Information Centre Department of Health, Detailed Council Information

Chart 3.5 compares the average cost per hour of council funded home care in inner London, outer London and England as a whole.

Chart 3.5: Council expenditure per hour of home care 2005/06



	All Home Care	Council Provision	Independent Provision
Inner London	£16.15	£26.48	£13.93
Outer London	£15.53	£26.98	£12.54
England	£14.87	£21.04	£12.53

Source: Information Centre Department of Health, Unit Costs 2005/06

As would be expected, the higher cost of living in London raises the cost of home care considerably above that in the rest of England. Indeed the average cost of an hour of delivered home care to Inner London councils is over 10 per cent above that in the rest of the country.

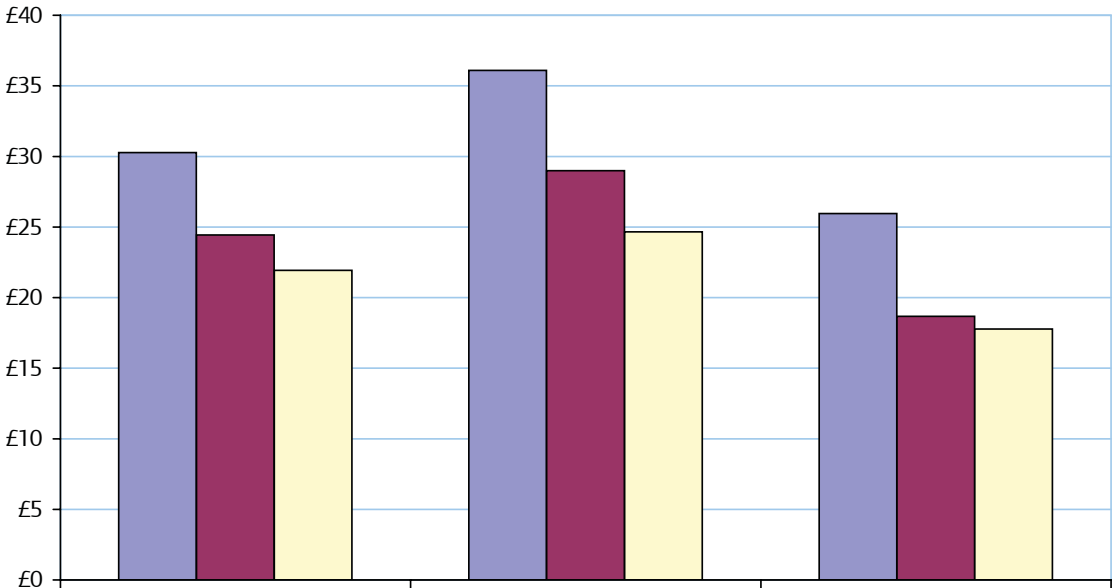
For home care provided by London councils, there is little difference on average between Inner London and Outer London (with unit costs in Outer London being marginally higher). There are higher average unit costs for contracted home care in Inner London than in Outer London and England as a whole.

Council-provided home care in London is roughly twice as costly per hour as home care contracted out. This could be due to a number of factors including better efficiency and lower wages in the independent sector, or the more expensive provision remaining with local authority staff with outside providers perhaps being reluctant or unable to take on individuals with more expensive needs.

3.2.2. Day care

Day care output is measured in sessions. A session is defined as either a morning, an afternoon or an evening at a day care centre per client[15]. Chart 3.6 shows the costs per session of Day Care in 2005/06.

Chart 3.6 Council per session costs of day care 2005/06



	All	Council Provision	Independent Provision
Inner London	£30.28	£36.09	£25.96
Outer London	£24.44	£28.99	£18.67
England	£21.94	£24.66	£17.77

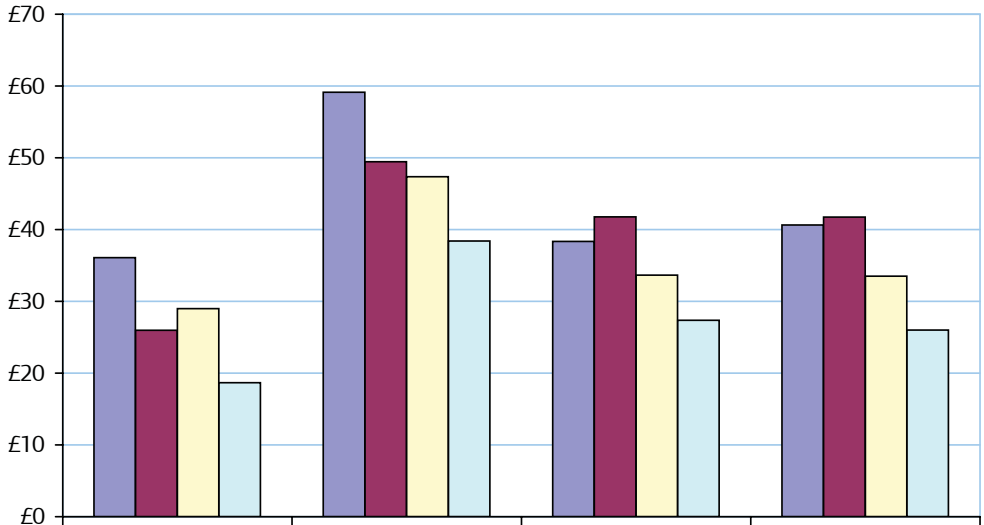
Source: Information Centre Department of Health, Unit Costs 2005/06

Here, we can see a similar story to that in home care, where higher average unit costs are experienced by Inner London councils relative to Outer London councils, and both are significantly greater than in England as a whole (with the exception of younger adults with physical disabilities, where costs are marginally higher in England than in Outer London).

The difference in unit costs between Inner London and the rest of England is considerably greater for adults with mental illnesses, where costs are more than double, than for services for older people, where costs are 38 per cent higher. More generally, the difference between London and England is considerably higher in day care than in home care. The larger discrepancy in costs between Inner London, Outer London and England is mostly due to the higher land and building prices in London[16].

In Chart 3.7 we can see a similar pattern to home care, where contracted out provision costs councils less than own provision. Interestingly, the exception to this is in day care for adults with mental illness and physical disability or sensory impairments, where council provision in Inner London is, on average, less costly.

Chart 3.7: Per session costs by provider type for day care 2005/06



	Older people (65 +)	Adults with learning disabilities	Adults with mental illness	Adults with physical disabilities
Inner London Council	£36.09	£59.13	£38.35	£40.63
Inner London Independent	£25.96	£49.46	£41.78	£41.73
Outer London Council	£28.99	£47.36	£33.64	£33.50
Outer London Independent	£18.67	£38.39	£27.36	£26.00

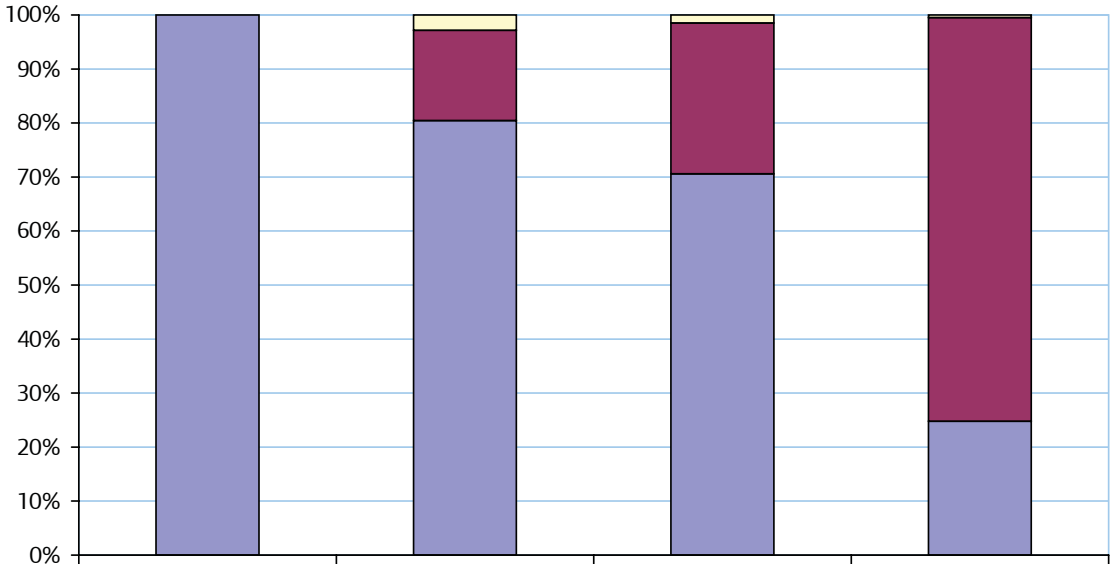
Source: Information Centre Department of Health, Unit Costs 2005/06

3.3. Private funding

Privately-funded home care has been steadily increasing in recent years as direct payments have become more prevalent and constraints on public care funding have become tighter. In addition, rising household incomes may have played a role in increasing demand for home care services. Privately-funded home care covers about 26 per cent of all home care and 33 per cent of all home care provided by the independent sector[17]. The value of privately-funded home care in England was estimated at almost £700 million in 2006[18].

Chart 3.8 presents the breakdown of home care between provision and funding types. Privately-funded home care tends to be provided at a higher intensity, that is with longer duration of visits, than publicly-funded care. While only around 16 per cent of independently provided "hourly paid care" is funded privately, about 28 per cent of "sessional care" (care provided in greater time blocks) and three quarters of live-in care are privately funded.

Chart 3.8: Home care in England 2006 (000s hours per week)



	Council Provided	Independent - Hourly Paid	Independent - Sessional	Independent - Live in
NHS and other		75	5	5
Privately Funded		442	93	776
Council Funded	949	2127	235	257

Source: Laing and Buisson Domiciliary Markets 2007

The relatively longer visits associated with privately-funded home care are likely to reflect both demand- and supply-side factors. Contracted home care can tend towards short, time-constrained visits that are often not preferable to the user and place high cost pressures on the provider. Providers have more power when dealing with individuals than in competing for council contracts and can insist on longer visits as a requirement of service provision.

3.4. Employment

Data collection on employment and skills in the social care sector has traditionally been poor, though recent endeavours of organisations such as Skills for Care and the CSCI, and improved information gathering from councils, is increasingly overcoming this.

Skills for Care recently estimated the number of workers (head count) in home care in the independent sector across England in 2006/07 at 226,000, with a further 77,000 working in other domiciliary care environments (including sheltered housing)[19]. Assuming similar workloads would imply there are about 45,000 domiciliary care jobs in London.

Council domiciliary care staff numbered 47,980 in England in 2006, and about 4,300 in London.

Three quarters of employment in independent domiciliary care is in direct care or support roles, compared to 84 per cent of council domiciliary care employment.

There were an estimated 29,000 people working in adult day care in the independent sector in England in 2006, in addition to the 28,000 council staff providing adult day care. In addition it is believed that day care depends more on voluntary workers than other types of day care[20].

Surveys conducted by Skills for Care of direct payment users and their personal assistants estimate the number of personal assistants per direct payment recipient at between 2.4 and 1.64 respectively[21]. A crude

application of these averages to the number of adult social care direct payment recipients in England in September 2007 (41,000) would suggest the number of these personal assistants is somewhere around 65,000 to 100,000. If behaviour is similar in London then its 6,300 adult social care direct payment recipients would be employing around 10,000 to 15,000 personal assistants. The large and growing number of users funding their own care suggests the number of these personal assistants may be considerably larger.

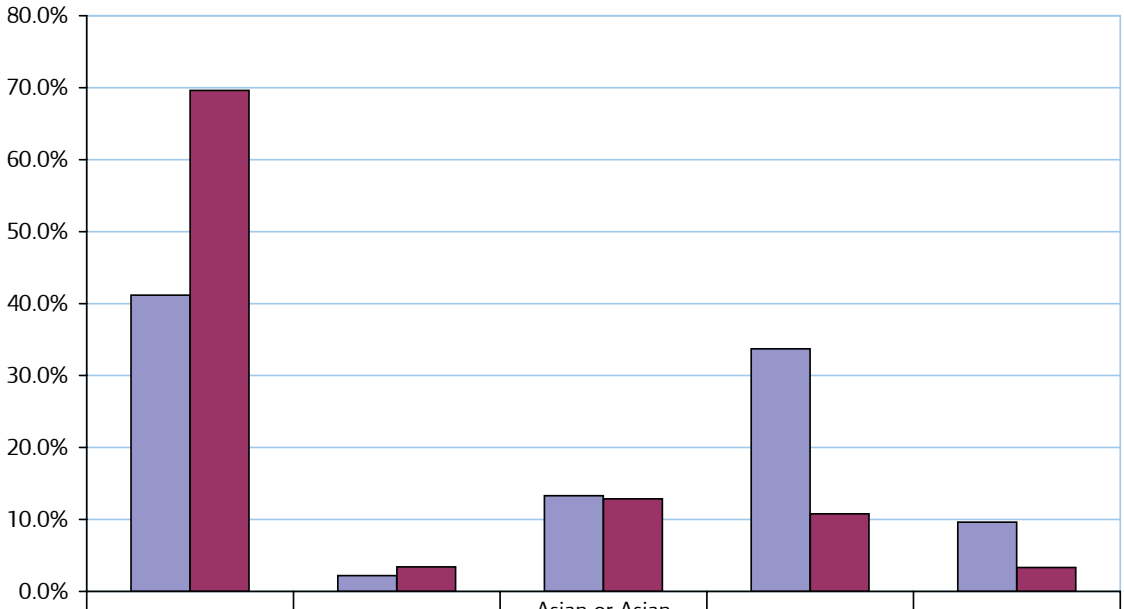
The care workforce is a relatively low-paid one with high vacancy rates and turnover. In 2006 the average wage in the home care sector in London was estimated to be £6.30 per hour in the independent sector and £7.38 per hour for council staff (both considerably below the London average), turnover rates were estimated at 24.9 per cent and vacancy rates at 5.9 per cent[22].

There continues to be a significant gender bias, with females dominating all main roles in every care type. This bias is most prominent in domiciliary care where, in England, 87 per cent of workers are estimated to be female, and lowest in day care where about 76 per cent are[23].

The community care workforce also appears to be older with an estimated 31 per cent of domiciliary care workers and 55 per cent of day care workers being 50 years old or over[24], compared to 28 per cent in the entire labour force[25].

Chart 3.8 compares the ethnic profile of the London adult social care workforce with the profile of the broader London population (this comparison should be made with considerable caution as the National Minimum Data Set (NMDS) is very incomplete). This comparison suggests that the social care workforce is more diverse than the population more generally, with carers identifying themselves as "black or black British" at a proportion three times that in the general population.

Chart 3.9: Ethnic profile of the London adult care workforce



	White	Mixed	Asian or Asian British	Black or Black British	Other groups
Care Work Force	41.2%	2.2%	13.3%	33.7%	9.6%
Population	69.6%	3.4%	12.9%	10.8%	3.3%

Source: NMDS-Skills for Care Data March 2008, ONS Ethnic Group Population Estimates 2005

3.5. Informal care

Informal care makes a fundamental contribution to social care. In the 2001 census, 607,000 Londoners stated they provided some amount of informal social care, of whom 20 per cent provided more than 50 hours of care per week[26]. For every 1000 older people there are 545 informal carers in inner London, 680 in outer London and 626 in England.

In their Domiciliary Care Markets 2007, Laing and Buisson estimated the cost of replacing all informal care at £31 billion across England, including £6 billion for home care, or close to three times the amount of publicly-funded adult social care and home care[27].

As more people live alone in London it is likely the balance may be more tilted to home care in the absence of informal care.

4. The community care market

This section provides an overview of the community care market, with a particular focus on the home care market. It will look at issues related to demand, supply, market structure, barriers to entry and investment as well as the market for care viewed more broadly.

4.1. Demand

As the considerable majority of social care is still publicly-funded, its allocation is central to market demand. Demand is determined by the total of public funds directed towards social care and those of self-funders. Currently, 74 per cent of home care is publicly-funded. Demand for home care has increased in recent times largely due to substitution for residential care.

An alternative definition of demand is the aggregation of all care needs in the community. This approach has more merit when considering adequate public resourcing, though it is next to impossible to quantify.

The growth of private funding for community care occurs in the space where individuals are willing to purchase care they are not eligible for on either needs or financial means grounds or that is not publicly-funded in the desired form by the local authority. Recent growth is likely to be due to local authority funded provision not growing at the rate of community care needs.

A key distinction exists between the nature of demand for home care and for day care. Home care helps people with social care needs to live independently. Day care provides activities and social interaction for users and also offers respite for carers.

4.2. Supply

The supply of home care is the total potential provision of care by local authority, private or third sector providers. More broadly, supply of social care includes the informal care provided by family and friends. Supply is determined by the cost of delivery, including labour and regulatory costs, and the availability of necessary resources, most importantly labour.

Home care providers have generally experienced high turnover and vacancy rates. Poor pay has been identified as a significant barrier to the recruitment and retention of trained staff[28].

Regulation of the home care sector affects supply in a number of ways. Standards and requirements add to the cost of both setting up and operating a home care business. Additionally, requirements for staff qualification can reduce the potential pool of workers able to provide the care (although clearly some form of regulation is necessary for the protection of a group that includes some very vulnerable individuals).

4.3. Market structure

The home care market, under current arrangements, is very fragmented, with a few very large providers and many small ones[29]. Home care does not have the features seen in residential care, such as building and land costs, higher regulatory barriers and more favourable investment conditions that encourage larger corporate entities to enter the market on a significant scale. A considerable proportion of the independent provision of home care is not-for-profit and it has been noted that profit is often not a dominant motivation for many private providers[30].

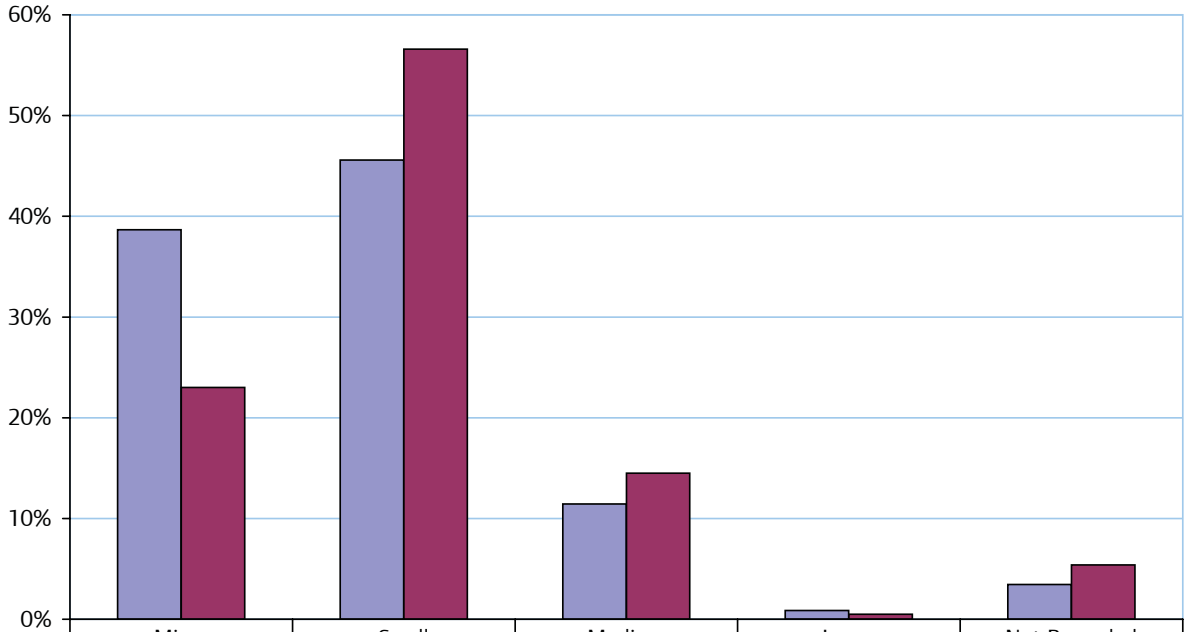
Current contracting arrangements essentially pool together resources to purchase social care collectively, providing local authorities with considerable buying power to keep down costs. There is evidence that providers are operating on relatively low margins of between 5 and 10 per cent[31].

There are 584 registered providers in London alone. These include 446 private sector operators, 90 classified as either voluntary sector or other, and 48 local authority providers[32]. In terms of provision 51 per cent is by private operators and a further 23 per cent from the third sector[33]. The charts in Appendix D show the number of private, volunteer, local authority and "other" providers in each borough (according to their addresses).

Chart 4.1 shows the distribution of providers of all care types by size of establishment in London and England as a whole, according to Skills for Care's National Minimum Data Set (NMDS). Over 84 per cent of providers in London are either micro (up to 9 employees) or small (10 to 49 employees). A further 11.4 per cent are medium-sized enterprises (50 to 249 employees) and fewer than one per cent large ones (250 plus). Of note is the considerably higher proportion of micro establishments in the London care sector (38.7 per cent) than in England as a whole (23 per cent). This may have something to do with the higher proportion of home care in London or perhaps be due to the different methods of collecting data used by the various regional Skills for Care offices.

There has been a recent trend towards consolidation of the home care industry. The factors that have contributed to this consolidation include: local authorities reducing the number of providers they purchase from; the costs of contractual obligations and regulation; the squeezing of margins in contracts; and recruitment difficulties[34].

Chart 4.1: Size of establishment – All care providers



	Micro	Small	Medium	Large	Not Recorded
London	38.7%	45.6%	11.4%	0.9%	3.4%
England	23.0%	56.6%	14.5%	0.5%	5.4%

Source: NMDS-Skills for Care Data March 2008

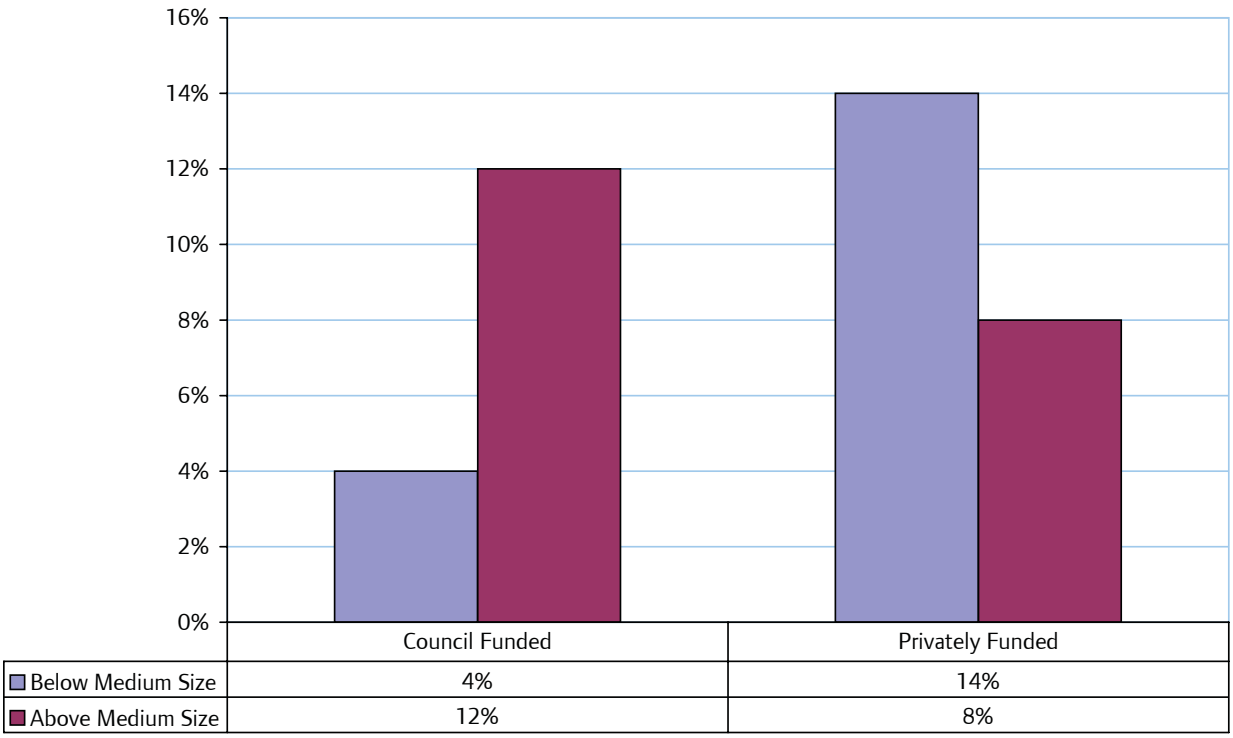
While smaller providers have been losing out generally in gaining local authority contracts, they have benefited from the growth in privately-funded home care. This polarisation is expected to continue as smaller private providers are squeezed out of local authority contracts, but offer a relatively friendlier and

more personalised service than larger agency provision, making them more attractive to individuals purchasing their own care.

These trends have been noted for several years[35]. According to a 2006 Laing and Buisson survey[36] of changes in provision between 2004 and 2006, private care providers below the median (in terms of home care hours provided) experienced a growth of 16 per cent in privately-funded care hours, compared to only 8 per cent for providers above the median size. The same smaller care firms experienced a more moderate growth of 4 per cent in council-funded hours, compared to 12 per cent for larger firms.

The story is similar in the voluntary sector, with the exception being slower growth in privately-funded hours for voluntary sector providers below the median size. The combined totals for the independent sector are presented in Chart 4.2.

Chart 4.2: Independent sector hours growth by funding type 2004-2006



Source: Laing and Buisson: Domiciliary Markets 2007

In 2007, there was strong evidence of larger providers spreading across municipal boundary areas in accessing council contracts. A survey of respondents found that the top ten providers had contracts with 39 per cent or more London councils[37].

Local authorities provide over half of day care directly. Much of the rest tends to be awarded in large block contracts to the voluntary sector.

4.4. Barriers to entry

The cost of entry into the homecare market is relatively low (compared to care homes), as property is not a requirement[38]. Recruitment and winning local authority business have been identified as the main barriers to entry[39]. The latter of these has been made easier by centralised accreditation where providers are no longer required to evidence a three-year track record. Larger contracts, though, favour bigger providers with established reputation, tendering experience and financial security. A move to self-directed care may actually break down this advantage.

There is some synergy between care home providers and home care, which could allow residential care home providers to enter the home care market. In a 1997 survey, 14 per cent of nursing homes and 19 per cent of residential homes provided a homecare service[40]. There are limits to these synergies however, as there are different skills involved and home care generally requires a considerably larger pool of workers than care homes.

4.5. Investment

As investment decisions involve a balancing of risk and expected profit, secure long-term contracts increase the attractiveness of investment. Traditionally, private investment has been considerably higher in residential care than community care. There is anecdotal evidence that investors see home care as higher risk than residential care[41].

4.6. Broader market considerations

The move to user-directed social care has potentially significant implications for the sector's structure and for care outcomes.

Traditionally, where the local authority funded and provided the vast proportion of care, service provision was determined by policy makers' judgements on community need, given resource constraints. This provision essentially established the market.

The move to provision that is predominantly contracted out has encouraged the growth of independent sector providers, though the mix and quantum of care is still determined by councils. While innovative approaches may change the nature of provision, essentially the decision on whether to contract out, and what to contract, is largely driven by the cost of provision.

The move to self-directed service provision makes for a far more complex consideration of the social care market. What goods and services might be considered as being care-related? When should more general household services such as gardening be considered a care need? When could a common household item such as a microwave be considered as a purchase related to a care need? Of those already purchasing private home care, most also purchase other services, such as cleaners and gardeners, from elsewhere[42].

These considerations are both dependent on, and could inform decisions on, how individual budgets might operate. If individual budgets are relatively constrained in the degree of user control, then innovation around the margins of care will be limited. If user control is relatively freer, and take-up widespread, then how the market is considered in relation to adult social care is substantially broadened, as the rigid boundaries traditionally determined by social services departments dissolve into the broader household services sector.

5. Policy instruments of self-directed care

This section looks at mechanisms used to empower users to take control of their own care.

5.1. Direct payments

Direct Payments were introduced in the UK initially under the Community Care Act 1996. Local authorities were then given the power to provide individuals with a cash payment as a substitute for council-provided care. Since April 2003 the power to provide direct payments became a duty to offer them to all eligible individuals. Despite these changes direct payments still make up only about 2 to 3 per cent of all local authority adult care funding.

Essentially, a direct payment is provided as a cash payment, commonly around 90 per cent of the value of the service that would have otherwise been provided by the local authority. The marginally lower amount is in recognition of the administrative costs of direct delivery and an incentive to encourage efficiency gains.

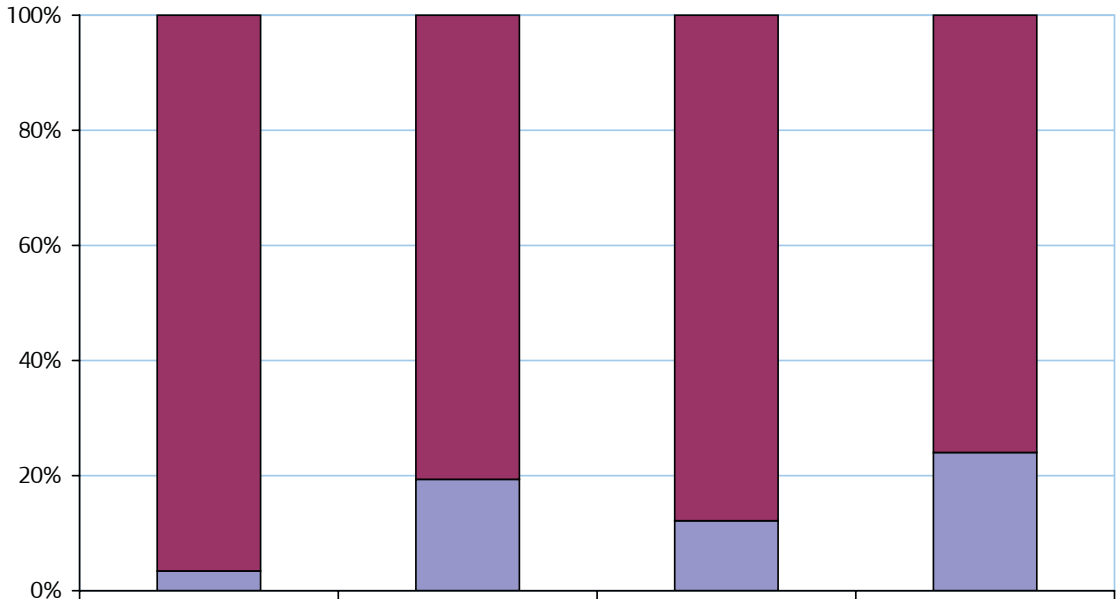
A constraint on the use of a direct payment is that it cannot be used to pay for informal care from a friend or family member living in the same residence as the user. The main justification for this appears to be to avoid the dead weight loss associated with paying for informal care that would have largely been provided anyway.

While councils are obligated to offer direct payments to all eligible service users, it remains an "opt-in" system, with patients retaining traditional services if they wish. Likewise, it is claimed that council staff resistance (including "tying-up" direct payments in red-tape) and a lack of supply of personal assistants have hindered their uptake[43]. Chart 5.1 shows the distribution of home care and direct payment recipients in London in 2005/06.

For Londoners between the ages of 18 and 65 with physical or sensory disabilities, direct payment recipients made up about 24 per cent of the total that received either direct payments or home care. This figure falls to around 19 per cent for those with learning disabilities and 12 per cent for those with mental illness. At a little over 3 per cent, take-up of direct payments by people over 65 has been limited.

It should be noted that direct payments are taken in replacement for all care types, not just home care. As day care is relatively more prevalent than home care among people with learning disabilities and mental illness, the comparison provided in Chart 5.1 may considerably understate the higher take-up amongst the physically disabled.

Chart 5.1: London home care and direct payments recipients 2005/06

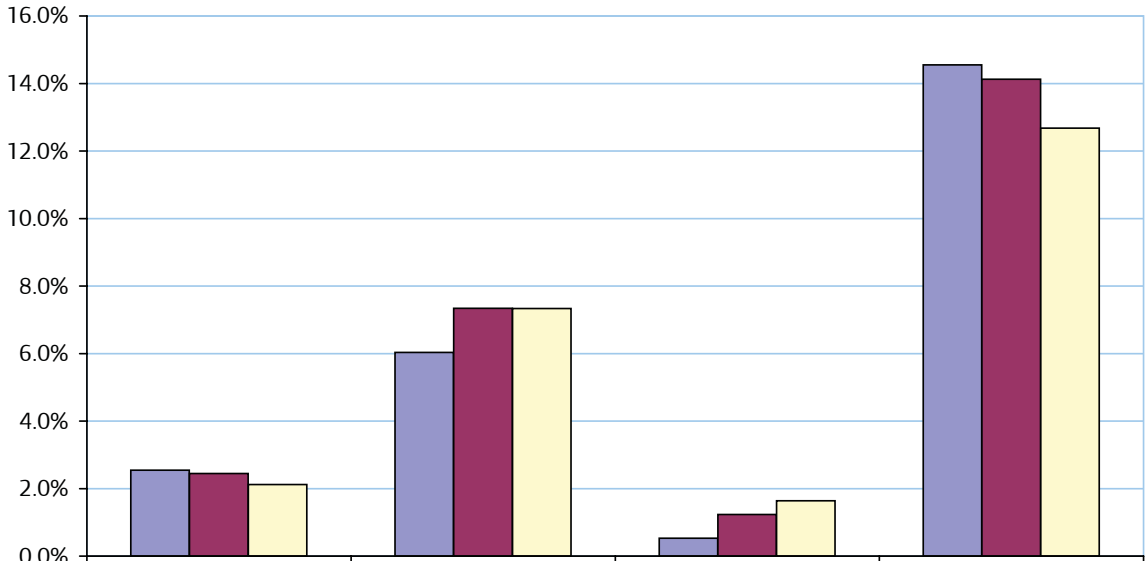


	Older people (65 +)	Adults with learning disabilities	Adults with mental illness	Adults with physical disabilities
Home Care	45,432	2,457	1,555	7,753
Direct Payments	1,604	589	215	2,448

Source: Information Centre Department of Health, Detailed Council Information 2005/06

In Chart 5.2, direct payments recipients are presented as a proportion of total clients (including care homes) for each need group. Again we can see take-up of direct payments is much higher amongst adults with physical disabilities or sensory impairments. Take-up is marginally higher in this category in London than in the rest of England. Appendix E presents charts showing direct payment shares for all clients in each London borough.

Chart 5.2 Direct payments recipients as a share of total clients 2005/06

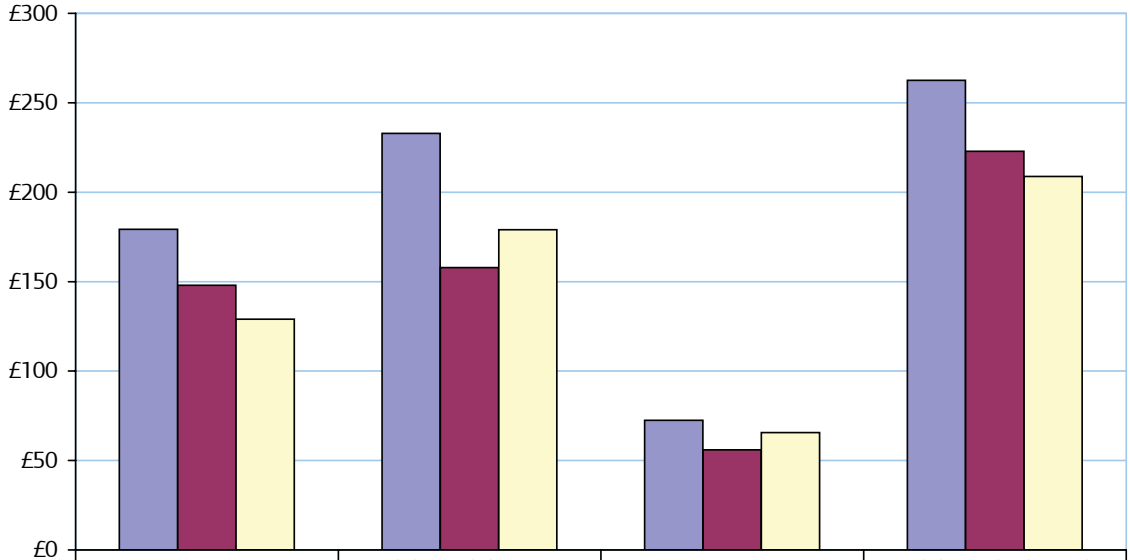


	Older People (65 +)	Adults with Learning Disability	Adults with Mental Illness	Adults with Physical disability
Inner London	2.5%	6.0%	0.5%	14.6%
Outer London	2.4%	7.3%	1.2%	14.1%
England	2.1%	7.3%	1.6%	12.7%

Source: Information Centre Department of Health, RAP 2006/07

In Chart 5.3, the average direct payments made in Inner London, Outer London and England in 2005/06 are shown. Again, the higher Inner London average direct payments can be explained by the higher costs prevalent in London. Intuitively, higher unit costs for services should result in higher direct payments.

Chart 5.3 Average direct payments 2005/06



	Older people (65 +)	Adults with learning disabilities	Adults with mental illness	Adults with physical disabilities
Inner London	£179.27	£232.93	£72.46	£262.55
Outer London	£148.02	£157.87	£55.97	£222.93
England	£128.98	£179.06	£65.64	£208.79

Source: Information Centre Department of Health, Unit Costs 2005/06

Other countries in Europe have had variations of direct payments for some time. Sweden introduced a scheme in the 1980s that provided direct payments as an alternative to direct service provision for people with physical disabilities.

Germany and the Netherlands introduced schemes in the 1990s. These countries' social care systems differ from the UK in that they are funded from a compulsory insurance contribution and are universal. In Germany, when an individual is deemed to be in sufficient need, they can either access council-provided services or take a payment that is dependent on whether their care type is care home, domiciliary or family-based. The most popular is the family-based payment, despite its being considerably less than the in-kind services payment[44]. The take-up in Germany has been considerable, with 75 per cent opting for the direct payments[45]. Germany allows for the direct payment to be used to compensate informal care providers.

A key issue with direct payments is the availability of support to set up and manage a self-directed care plan. This support is provided either by local authorities or by community-based organisations such as Centres for Independent Living; there is no "for profit" provision of support[46]. A recent study found 39 agencies in London providing support schemes for direct payment recipients[47]. Across England, income for these support schemes is almost fully funded from social services, with about a third coming from the Direct Payments Development Fund, a £9 million fund set up to help local authorities work with local voluntary sector organisations to develop support services and promote direct payments[48].

About 20 per cent of users have had to wait to access direct payment support in England. It is not known exactly how many recipients of direct payments did not receive any support, though surveys of providers imply a gap between support provided and the number of direct payment recipients.

5.2. Individual budgets

Individual budgets is an initiative that aims to coordinate the various resources available to individuals in need and give them a greater say in how they are directed. Individual budgets differ from direct payments in three key ways.

First, they aim to coordinate multiple income streams from all agencies, giving a fuller understanding of the finance available. Second, they allow for these coordinated income streams to be made as a direct payment but do not exclude more limited mechanisms of individual control. Third their cash value is based on the level of need rather than the cost of alternative council services as is the case with direct payments.

Individual budgets essentially only affect community care directly, though it is envisaged that users eligible for residential care may redirect their resources to a package of care that will allow them to continue to live in their homes.

An Individual Budgets Pilot Programme has been operating involving thirteen local authority areas including three London boroughs: Barking and Dagenham; Kensington and Chelsea; and Newham. An evaluation of this programme is due to be released in the autumn and a decision as to whether to roll out Individual Budgets across the country will then be taken.

5.3. Other allowances

Allowances based on care needs and independent living provided by other agencies via the tax and benefit system may also be considered a mechanism of self-directed care in that they are provided on the basis of care need. Extending the definition of self-directed care to these allowances is problematic however, as there is no requirement that they are spent on addressing care needs.

Independent Living Funds (ILF) are financial resources designed to assist people with disabilities to live independently rather than in residential care. ILF supports about 21,000 individuals nationally, of whom over 90 per cent are younger than 65[49]. To access ILF requires a need and means eligibility assessment.

Disability Living Allowance (DLA) is a tax-free benefit for children and adults under 65 who need help with personal care or have walking difficulties because they are physically or mentally disabled. Attendance Allowance (AA) is a benefit similar to DLA except that it is specifically for people over 65 with care needs. A carers allowance is paid to eligible carers over 65 who provide over 35 hours of informal care per week.

6. Economics of self-directed care

The transformation to a self-directed adult social care system is likely to have implications for the quality and efficiency of community care. Shifting the decision-making on procurement of adult social care from local authorities to individuals represents a potentially fundamental shift in the functioning of the market.

Economists normally start with an initial presumption in favour of leaving the allocation of resources to market forces. In a competitive market, firms are efficient not because they are convinced of the benefits to society of efficiency, but because it is in their own interests to be efficient. We should distinguish here between three types of efficiency; productive efficiency, allocative efficiency and dynamic efficiency. Firms will seek to minimise their costs of production in order to be able to charge the lowest possible price in order to match or undercut the prices of their rivals. Allocative efficiency, in which the prices of goods and services reflect the cost of the resources used up in their production, is ensured by competition between firms, who will lower their prices until they just cover the costs of production, including a reasonable return to the firm for undertaking this activity. Competition also spurs firms to develop better products and processes that by better meeting consumers needs attract more business to them (dynamic efficiency).

The above argument rests on a number of assumptions. Most notably it requires that the market in question is competitive. In the absence of sufficient competition, firms can charge high prices as consumers cannot switch their business to other companies offering the same good or service. Other requirements include that producers and consumers bear all the costs and appropriate all the benefits of production and consumption of the product; and that individuals are well informed about the cost, quality, fitness for purpose, range and availability of the products or services in question.

In reality, markets that fully meet all these conditions are very rare. When these assumptions are significantly incorrect, a market failure is said to exist. The existence of market failure provides a significant component of the theoretical basis for government intervention[50]. Though it is important to note that associated costs and distortions of government intervention can also lead to government failure, where the cure is more costly than the illness. Hence even in the presence of market failure, policy intervention should only be considered if there are good grounds for believing that it is likely to be effective.

Governments may also intervene where a non-economic social objective exists. Few would argue that people with care needs are not rightfully entitled to a life of safe, dignified and fulfilling existence. As care needs generally also imply an impediment to engaging fully in the economy (if at all), much social care is beyond the means of those in need of care. Where support from family and friends is available, informal care is often at least partly provided at the expense of paid employment elsewhere. For these reasons a significant component of adult social care will always be publicly funded.

This section provides a discussion of the economic implications of the transformation to a self-directed community care sector. It first looks at the impact on the price, quality and efficiency of self-directed community care summarising market characteristics and failures. Then a summary of the broader economic implications is provided.

6.1. Quality and efficiency of self-directed care

It is still unclear how far users will gain control of care provision under a transformation to self-directed care, both in the proportion of users that take up a self-directed care mechanism and the degree of restrictions associated with user control in these mechanisms. As demonstrated in the previous section, direct payments have had relatively high take-up among people with physical disabilities but more limited take-up in other need categories. As individual budgets are only in a pilot stage, the degree and variance of user control are unclear. As such, any analysis of likely impacts on quality and efficiency will necessarily be speculative.

The impact on the quality of care and how users value it is likely to be positive with increased user control over their care. The impact on efficiency is less clear. The unit cost of provision is affected by a number of factors that are not necessarily acting in the same direction. Given no provider subsidy, the price paid for care will ultimately be determined by the cost of care: competition is sufficient to restrict providers raising their prices above costs. The following provides a summary of the key factors influencing quality and value, efficiency and prices paid for self-directed care.

6.1.1. Market power

Under current arrangements, where the majority of home care is contracted out to the independent sector, buyers have considerable power. A shift to a self-directed care system would reduce this buying power as at the very least councils could no longer guarantee clients to contractors.

RSe Consulting recently compiled a report for London Councils on the impact of increased individual control and choice, which predicted a further fragmentation of the LAs' buying power and a potential threat to the stability of existing care providers. The importance of stability of care providers is a contentious one. In the long-term, providers not offering services of value to users should not survive, though in the short to mid-term a sudden collapse of a significant amount of provision before the emergence of adequate alternatives would seriously undermine the success of the transformation to self-directed care.

6.1.2. Information

In addition to increased buying power, centralised direction of social care would potentially benefit from improved supply information, including better information on cost structures and range of service possibilities.

On the other hand, service users have a better understanding of their needs and, importantly, how they value different service options and how they could best fit in with their lives. An increase in control by the service user could be expected to lead to a better match between service and user preference, as long as adequate information on service options is collected and provided when users are deciding how their budget is directed.

The information requirements will potentially broaden immensely depending on the limitations on what can be justified as meeting care needs.

6.1.3. Administration and transaction costs

The associated administration and assessment costs will differ with a self-directed system. How they will differ largely depends on the nature of service use direction, the amount of support (brokerage and advocacy) provided, and the degree of monitoring and constraints on how budgets are spent.

Whether public administration costs will be greater or less under a self-directed system depends on whether the costs of supporting and monitoring choice exceed the savings in commissioning and administering care provision.

In the extreme case of no extra support and negligible monitoring, the associated administrative costs of council-contracted or direct provision would be saved (by the council at least). If appropriate support is not provided there is a risk that the administrative costs of managing the care provision could shift to those in receipt of direct payments and/or their carers.

Moving back from this point, the cost of monitoring and supporting individual choice is based on the policy decisions of local authorities within the broader guidance of individual budgets and direct payments. More intense brokerage and support or more constrained and monitored control will increase the likelihood of the cost of administering care under a self-directed system rising.

Independent Budgets aim to streamline services and benefits from multiple agencies available to recipients. One feature of this is the pooling of information and processes to reduce overlap and streamline the assessment process. To the extent that this successful, there is potential for resources currently required in these assessment processes to be freed up for care delivery. This streamlining is likely to prove difficult though, as differences in eligibility criteria remain.

Moving from a system where the purchasing of community care is through direct provision or contractual arrangements between local authorities and providers received passively by users to one where individuals make their own arrangements will increase the associated transaction costs to users.

This may be true for independent providers as well, though this will depend on whether the administrative costs associated with meeting council contract regulatory obligations are greater than the increased transaction and marketing costs that may occur when providers are dealing with users directly. This equation will be the key determinant of whether overall costs for a comparable service will increase or decrease under a transformation to self-directed care.

As direct payments remain opt-in then the increased transaction costs to the user are less of an issue. In choosing a direct payment or an individual budget (given full information), an individual is essentially revealing a preference for taking full control, given the increase in transaction and service costs.

6.1.4. Rationing efficiency

It is highly possible that the current system leads to inefficient and inequitable rationing of social services budgets. It has been argued that the current role of service "gatekeeper" has encouraged a "squeaky wheel" effect, where applicants that are more assertive are able to gain access to care when others more in need fail to. The current purchasing of bulk contracts for home care and day care services often results in people with very different needs getting the same services[51].

6.1.5. Scale economies and critical mass

Particularly in the provision of day care, a certain minimum number of users is required to deliver the service at a justifiable level of cost. It is possible that a significant number of users could opt out of day care, to the extent that average costs rise to a level that makes the service unviable, to the detriment of those remaining. As such, those in need could feasibly be adversely affected despite not having opted for an individual budget or a direct payment.

In home care, the trend towards larger contracts has increased the benefits of scale. Larger agencies are better able to spread the associated administrative costs and to ensure the supply of workers to carry out the contracted care work. Self-directed care is likely to reduce some of the benefits of scale.

6.1.6. Quality and value

Of parallel importance to the cost efficiency and viability of care provision is the quality and value of the care provided. The quality of service is largely a subjective consideration of the service user. The quality of a

particular service may be viewed as a subset of the value of the best alternative service (or good) in meeting the particular need. For a particular service a user will value that service according to the quality of that service as they perceive it. Alternatively, they may value a completely different servicemix of services (or perhaps goods) higher still.

Self-directed care creates the possibility of improved quality of existing services. As long as the information on available providers is good and switching relatively easy, a service user would be able to change providers if they were unhappy with the quality of that service. Providers wanting to maintain clientele would need to redirect their provision from one based on meeting contractual requirements to one that satisfied the expectations of users.

Further to improving the quality of existing services, self-directed care could increase the value of publicly-funded care by allowing users to determine exactly how best to meet their needs from a given available financial resource. This could involve a radically different mix of goods and services from the original social service, a mix that is valued much more highly.

6.1.7. Quality (value) vs efficiency trade off

A commissioning system that is largely focused on local authorities contracting out of home care, as has been dominant over the last decade, may be best to achieve optimal efficiency in a purely quantitative sense. Local authorities can employ their bargaining power to achieve the maximum quantity of care provision given funds available. Additionally, as it is easier to measure, contracts are likely to be biased towards the quantity of care provided rather than towards considerations of quality and value to users.

On the other hand, a system that gives control of care funding to users will likely result in services of higher quality and value to the users. Given support and good information provision, care users would be able to change care providers if they are not happy with their current provider. Likewise they could seek out services that better suit their wishes and needs. Smaller providers may be more innovative in how they provide care that matches the care users value, if it is these users that determine provision.

Moving to a user-directed system, particularly one where direct payments are prominent, could only reduce buying power. This will be minimised by the extent that the system remains opt-in. That is, users will only have an incentive to opt in to direct payments to the extent that they can achieve a preferred bundle of services by themselves with available support. Intuitively, a system where local authorities contract the bulk of care could be expected to promote a higher degree of concentration than one that is user-driven.

6.2. Broader economic impacts of self-directed care

6.2.1. Employment and skills

The transformation to self-directed social care will have a significant impact on employment in the sector. Social care workers are among the lowest paid professionals, and turnover in the field is high. Self-directed care could increase self-employment opportunities if user preferences as to who provides their care and its nature have greater influence in decision making.

The profile of the workforce, from the direct providers of care to those administering and facilitating it, will be required to change considerably in a successful transformation to self-directed care. Emerging roles such as support brokers and personal assistants will become significant components of the social care workforce.

Skills for Care recently modelled projections of future skill needs in England under three scenarios including a base case of moderate take-up of self-directed care and a scenario called "maximising choice" where take-up is significantly higher[52]. This is the only attempt at a quantified profile of the future social care workforce in the UK, and so cannot be benchmarked against other modelling. The underlying demand

projection used for the model is PSSR's Future Demand for Long Term Care, 2002-2041. This uses the Government Actuary's Department's 2006-based population projections (which predict an increase in the number of people over the age of 65 of around 80 per cent and over the age of 85 of about 220 per cent) and assumes that "proportions of older people receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics"[53].

Each scenario forecasts a significant growth in the required social care workforce. From a base of 1.39 million in 2006, the workforce is projected to grow to 2.26 million in 2026 (63 per cent increase) in the base case and 2.51 million (81 per cent increase) in the "maximising choice" scenario.

The forecast growth in direct payments in both cases leads to large forecast growth in the worker category "personal assistants and similar". This category starts from a low base as it relates to care workers employed by the care user directly. In 2006, an estimated 114,000 workers in England fitted this description, about eight per cent of the total workforce. Even under the base case this is projected to increase to 646,000 in 2026, about 29 per cent of the total workforce. Under the "maximising choice" scenario this estimate is 1,018,000, or 40 per cent of the entire adult social-care work force. This role is expected to grow with the move to self-directed care at the expense of growth in traditional direct-care roles of agency workers. The category "direct care providing" (which includes people hired directly by individuals) is expected to grow by just 24 per cent and 12 per cent in the "base case" and "maximising choice" scenarios respectively, much less than the overall projected growth of the workforce.

Demos, in their recent paper Making it Personal, identified six more creative roles for social workers to play in a self-directed social care system[54]:

- *Advisers*: helping clients to self-assess their needs and plan for their future.
- *Navigators*: helping clients find their way to the services they want
- *Brokers*: helping clients assemble the right ingredients for their care package from a variety of sources
- *Service providers*: deploying their therapeutic and counselling skills directly with clients
- *Risk assessors and auditors*: especially in complex cases and with vulnerable people deemed to be at risk to themselves or other people
- *Designers of the social care system as a whole*: to help draw together formal, informal, voluntary and private sector providers.

6.2.2. Informal care

Direct payments in the UK cannot currently be used to pay family or friends who live with the recipients. Allowing this could have both adverse and positive impacts. If resources currently delivered to users were to pay for relatives to provide care not currently provided, this could potentially relieve pressure on the existing social care workforce. If direct payments were used to pay for existing informal care then the provision of all care (formal and informal) would fall by the amount of formal care that was previously provided.

As well as providing a majority of the overall total of community-based care, carers are affected by how publicly-funded care is structured. Carers are often important beneficiaries of day care, which provides respite where intensive care is required. Carers may potentially carry much of the burden of administering an individual budget and are affected by how formal care aligns with their broader lifestyle and commitments.

6.2.3. Regulation and risk

Currently, all home care providers are required to register with the CSCi and are subject to periodic inspection and evaluation. Self-directed care will raise a number of regulatory issues as to what requires

regulation, how regulatory cost might be affected, and how regulatory information can be used to improve the information feeding into decision making.

In addition to impacts on how adult social care is regulated, and the associated costs of this regulation, the question of what is regulated is important. Currently all registered home care providers are required to register with the CSCi and are subject to periodic inspection, assessment, qualification requirements and other regulatory obligations. It is unclear what kind of regulatory obligations a personal assistant who is hired directly by a care user on an individual budget, for instance, will be subject to.

Empowerment is a product of both choice and risk. That some of the risk should be transferred to the carer is likely be both true in a functional sense and also necessary if the objective is to truly empower those with care needs and their carers.

6.2.4. Investment

Like many other factors in the transformation to self-directed care, the potential impact on investment carries both negative and positive implications. Long-term bulk contracts promote a better environment for larger institutional investors that are perhaps best able to cope with the high turnover and labour scarcities inherent in social care. On the other hand, the traditional commissioning arrangements constrain investment in innovative care provision under a system that is skewed towards provision determined by council social services professionals.

6.2.5. Local authority consistency

Generally, a potential recipient of council-funded social care would need to be assessed anew when moving into a new borough. Differing priorities mean that someone eligible in one borough will not necessarily be able to receive publicly-funded care in another. It is not clear if direct payments and individual budgets will alter this situation; if a user is eligible for support at their new address it may be easier for them to keep the same care arrangements. For London, with its highly mobile population, this is a very significant issue.

6.2.6. Public service interdependencies

There is growing empirical evidence of the link between the provision of social care and the burden on the health budget. For instance following a health problem requiring hospitalisation, well-provided social care can reduce the incidence of recurrence. Community care can often provide some social interaction that can alleviate a sense of loneliness.

It is far beyond the scope of this paper to speculate on the broader implications for other public sector resources, such as NHS, that may occur with a move to a self-directed social care system. It is possible that personal budgets poorly managed could lead to increased pressures on other public resources, though there is anecdotal evidence that the improved flexibility and quality of a well managed personal budget has led to reduced need for other public resources[55].

There is a growing push to expand the move towards self-directed social services into sections of health care, particularly for those health services that relate to chronic and predictable problems where patients have a good understanding of their needs[56]. Many of these patients would currently draw on both health and social care resources, which could provide synergies and economies of scale to more fully achieve the benefits that comprehensive personal budgets might offer.

7. Policy issues of self-directed care

A successful move to a self-directed adult social care sector is likely to result in a system that better meets the needs of service users. Like any institutional transformation, however, there are a number of important implications and risks that need to be thought through in policy planning.

Fundamental change will be required in the function of council social services departments, where they move from the role of "gatekeepers" of care access and provision to market-enablers and supporters of user-controlled care. Likewise, there are a number of broader issues in relation to market management and policy friction that require consideration at a higher level.

This section highlights some policy issues, implications and risks created by the transformation to self-directed care. First, the framework for user-directed care is discussed, focusing on the details of the degree of user-control. Then some broader issues that will determine the success of the transformation are discussed, namely support and brokerage and employment, skills and roles.

7.1. The framework for self-directed care

Individual budgets are still in the pilot stage, and a number of approaches are being trialled for different needs groups. Direct payments have been around for over a decade but are still a relatively minor component of adult social care, and interpretations and approaches vary depending on the council. How this user control policy framework may evolve is important in understanding its broader implications.

7.1.1. Constraints on how the budget is spent

Officially at least, direct payments are meant to allow an eligible care recipient to opt for a cash payment instead of the equivalent council-allocated service provision, though in practice the degree of monitoring and conditions of use vary from council to council. Individual budgets will operate on a spectrum of user control, depending on users' circumstances and council priority.

The optimal level of user control is dependent on a number of factors and is subject to the weightings put on different policy objectives. If user choice were seen as a substantially more important objective than quality monitoring and optimal public efficiency, direct payments with as little control as possible would be optimal. Conversely, if quality monitoring, efficiency and concerns about the proper use of public money were considered relatively more important, then a relatively higher degree of monitoring and constrained control may be preferred.

Increasing the control that individuals have over their care provision is likely to see overall quality improvements in the care provided. Despite this there are potential concerns with regulatory issues and access to information.

The quality of social care is to a degree factored into the tendering process, though there are fears that quality often loses out to cost minimisation. In terms of standards, the CSCI regulates care homes and home care providers by a series of measures. There has been continuous improvement in the numbers of registered care providers meeting national minimum standards since the CSCI was created by the Health and Social Care (Community Health and Standards) Act 2003. The CSCI is introducing a system where information is shared with local authorities on the care standards of the providers they contract to. Mechanisms to disseminate this information to users and brokers, where professionals in social services departments no longer determine the profile and provider of care, will be vital.

7.1.2. Income streams

There are a number of income streams and support options currently available to carers and people with care needs, provided by a number of agencies. In addition to local authorities, these include the ILF, Primary Care Trusts and social security benefits such as Disability Living Allowance and Attendance Allowance. If introduced properly, independent budgets provide the opportunity to significantly reduce the overlap in assessment processes and case management. They also allow for the individual to have a clearer understanding of the totality of the finance that is available to them.

7.2. Support and brokerage

For the transformation to a self-directed social care sector to be successful it is vital that adequate support is available to assist in the setting up, informing and management of individual budgets.

A bank of experience and knowledge in individuals and organisations that is trusted by users would greatly increase the effectiveness of a self-directed social care system. The absence of this is likely to increase the possibility of individuals purchasing care at a higher price than they would otherwise have, purchasing care packages that fail to meet their needs, or simply opting for the status quo. A strong support network that is well-funded and enabled could provide a mechanism to overcome many of the potential negatives of a self-directed system.

A key problem with decentralising decision-making is the loss of scale economies associated with collecting information on cost, quality and availability of services. Support organisations and networks that collectively collect and pool information along with councils, regulators and other agencies could mitigate much of this potential loss.

Support agencies could facilitate and manage the pooling of resources. This could potentially (at least partly) overcome the loss of buying power and the loss of critical mass associated with day care centres for instance.

In a recent survey of direct payments, London boroughs were most likely to cite a lack of available support service as a critical hindrance to the expansion of direct payments[57].

7.3. Employment, skills and roles

As noted in section 5, a move to self-directed social care is likely to have fundamental implications for the profile of the adult social care workforce. This will create significant challenges of adaptation for social services departments, central policy makers as well as independent providers.

The traditional arrangements required the work force of social services departments to provide a gate-keeping and rationing role for the access of care services they commission and administer. These functions are likely to change to a support role in advising and facilitating individuals' personal budgets and a market management role including the collection and provision of information to support this.

Traditionally, providers have had to structure care and respond to the requirements set out in contractual arrangements determined by councils' social services departments. In self-directed care, where the control shifts from the council to the user, providers will need to adapt their provision to the needs and wishes of those receiving care.

Achieving this workforce transformation will require a proactive change in attitude and skills development of social services departments and their staff, as well as providers and their employees, to embrace the roles and functions needed for a successful transformation to a self-directed social care sector.

Conclusion

A transformation to a self-directed social care system has the potential to greatly advance the cause of promoting independent living in users of adult social care, while better meeting their needs and wishes. While this is to be welcomed there are a number of policy challenges that will determine the degree of success or otherwise of this transformation.

It is vital that a strong network of support and brokerage exists to provide complete and quality advice, support and information to users and their carers moving to self-directed care. This network should ideally be independent of those over-seeing the assessment and market management (local authorities) and the providers of care. With a facilitating role from social services departments and other government agencies, this network may be able to ameliorate some of the potential losses associated with self-directed care such as loss of buying power and scale economies, increased transaction costs and the dispersal of risk.

In addition to support and brokerage, transformation of all factors and institutions involved with the supply and management of care is vital. This will include the institutional change of local authority social services departments and the roles of their staff, and the adaptation of current providers. Also how regulation is conducted and how the policy friction between it and independent living is approached will be a major challenge.

The characteristics of London and its care sector create particular challenges and opportunities. London's social care workforce is considerably more ethnically diverse, which has associated challenges in communication, training and retention. Higher costs in London will remain, reflecting the higher cost of living, though the predicted decline of day care potentially frees up relatively more financial resources due to the much higher property costs.

London's high density offers the possibility that adjacent boroughs could work closely in addressing the challenges of self-directed care. Boroughs that have moved more slowly in embracing self-directed care may benefit from the experiences and the development of those that have responded earlier.

As the move to self-directed care involves such a radical shake up of the social care system, and is still in its early stages, accurately predicting its evolution is extremely difficult. The process of addressing policy challenges will be a dynamic one that responds as self-directed care emerges. Common commitment and collaboration in addressing these challenges, both nationally and locally, are vital to the success of this transformation.

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Appendix A: Council expenditure on adult social care 2005/06

£ Millions		England	Share of England's	London	Share of London's	London's Share of England
Assessment and care management		**£1,650**	**13.9%**	**£361**	**17.8%**	**21.9%**
Care Homes	Nursing home placements	£1,285	10.8%	£193	9.5%	15.0%
	Residential care home placements	£3,896	32.7%	£612	30.1%	15.7%
	Total Care Home	**£5,181**	**43.5%**	**£804**	**39.6%**	**15.5%**
Community Care	Supported and other accommodation	£238	2.0%	£48	2.4%	20.3%
	Direct payments	£267	2.2%	£48	2.4%	18.0%
	Home care	£2,240	18.8%	£349	17.2%	15.6%
	Day care	£1,145	9.6%	£207	10.2%	18.1%
	Equipment and adaptations	£182	1.5%	£29	1.4%	16.1%
	Meals	£56	0.5%	£16	0.8%	28.4%
	Other Services	£490	4.1%	£117	5.7%	23.8%
	Supporting People	£455	3.8%	£50	2.5%	11.0%
	Total Community Care	**£5,074**	**42.6%**	**£864**	**42.6%**	**17.0%**
TOTAL ADULT CARE		**£11,905**		**£2,030**		**17.0%**

Source: Information Centre Department of Health Council Expenditure Tables 2005/06

Appendix B: Borough abbreviations

Inner London

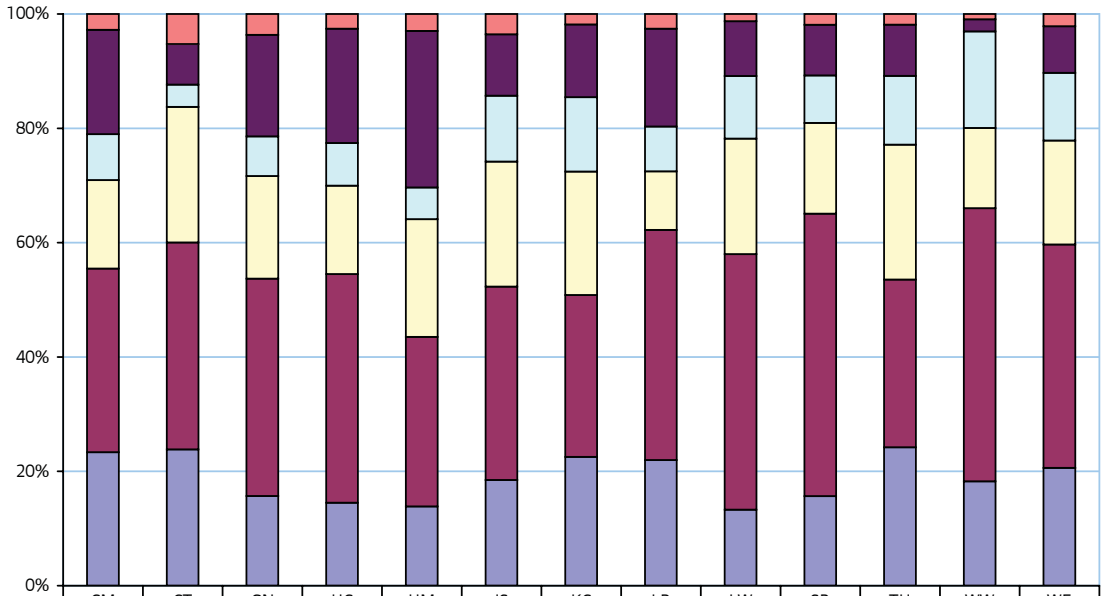
CM	Camden
CT	City of London
GN	Greenwich
HC	Hackney
HM	Hammersmith and Fulham
IS	Islington
KC	Kensington and Chelsea
LB	Lambeth
LW	Lewisham
SR	Southwark
TH	Tower Hamlets
WW	Wandsworth
WE	Westminster

Outer London

BK	Barking and Dagenham
BA	Barnet
BX	Bexley
BN	Brent
BM	Bromley
CR	Croydon
EL	Ealing
EN	Enfield
HG	Haringey
HR	Harrow
HV	Havering
HD	Hillingdon
HO	Hounslow
KT	Kingston upon Thames
MT	Merton
NH	Newham
RE	Redbridge
RT	Richmond upon Thames
SN	Sutton
WF	Waltham Forest

Appendix C: Distribution of social care expenditure

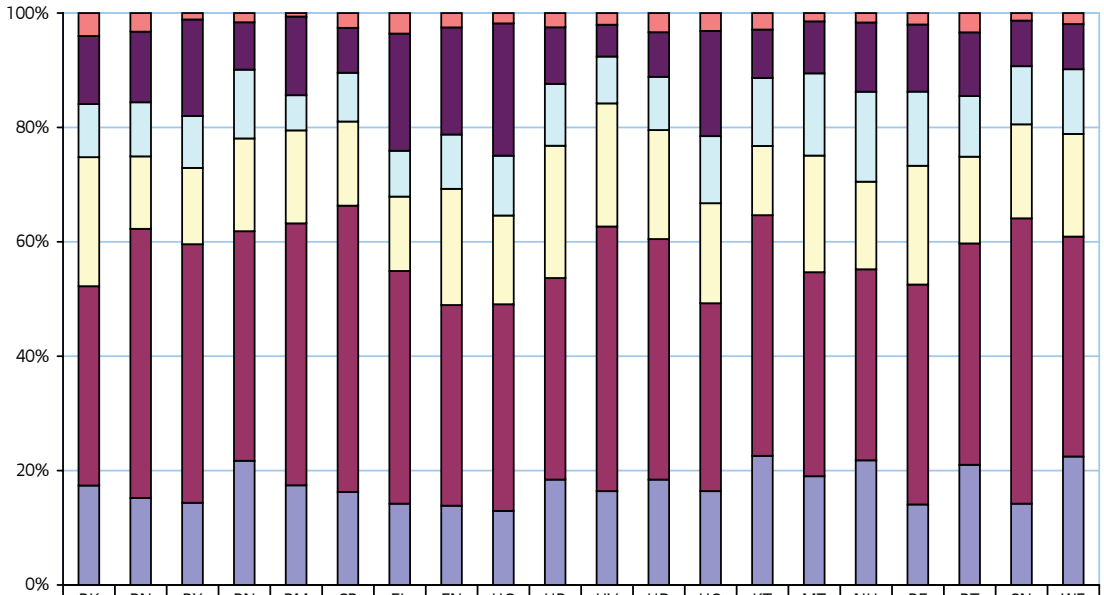
C1 Inner London boroughs (£ millions)



	CM	CT	GN	HC	HM	IS	KC	LB	LW	SR	TH	WW	WE
Direct Payments	2.2	0.2	2.5	1.7	1.6	2.4	0.9	2.5	1.0	1.7	1.4	0.7	1.5
Other Community Care	14.2	0.3	11.9	13.3	14.6	7.2	6.1	16.2	7.3	7.7	6.8	1.6	5.8
Day Care	6.3	0.2	4.7	5.0	2.9	7.7	6.2	7.4	8.4	7.2	9.2	12.8	8.4
Home Care	12.1	1.0	12.1	10.3	11.0	14.6	10.3	9.7	15.4	13.7	18.0	10.6	12.9
Care Homes	25.0	1.6	25.5	26.7	15.8	22.6	13.6	38.2	34.1	42.8	22.4	36.1	27.6
Assessment and Care Management	18.2	1.0	10.5	9.7	7.4	12.3	10.8	20.8	10.1	13.6	18.4	13.8	14.6

Source: Information Centre Department of Health Council Expenditure Tables 2005/06

C2 Outer London boroughs (£ millions)

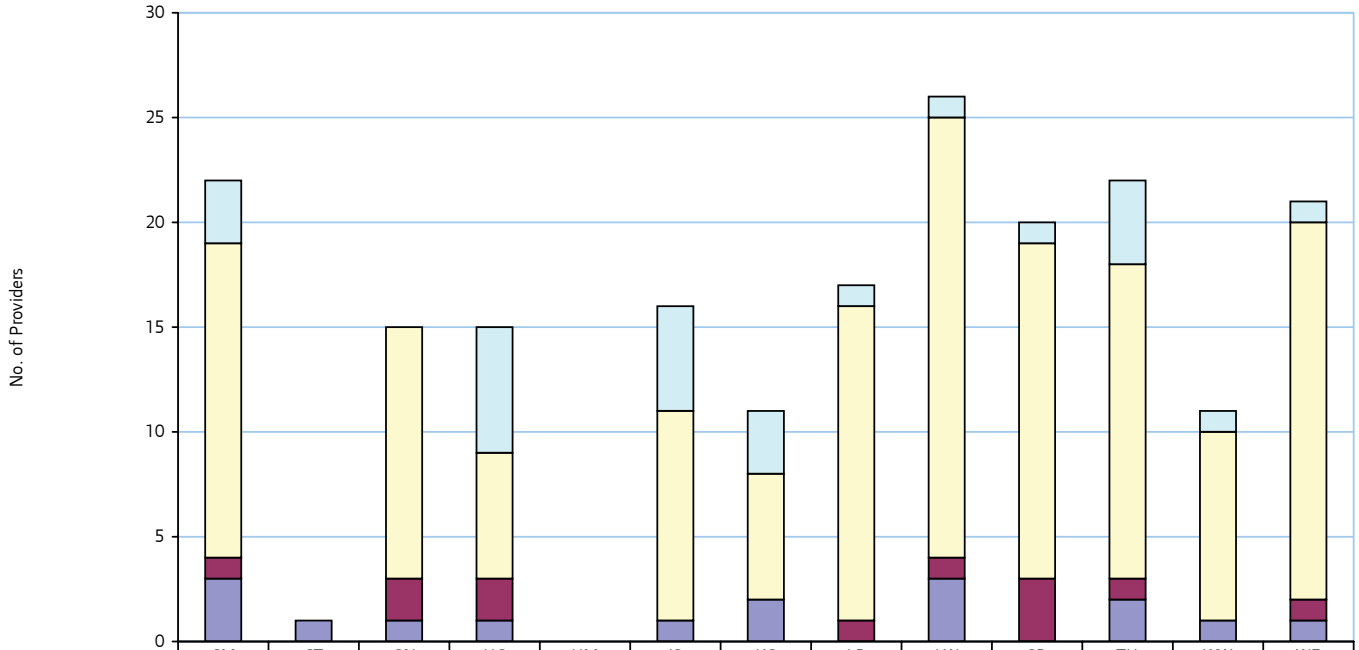


	BK	BN	BX	BN	BM	CR	EL	EN	HG	HR	HV	HD	HO	KT	MT	NH	RE	RT	SN	WF
Direct Payments	1.9	2.9	0.5	1.1	0.4	2.1	2.8	1.8	1.3	1.3	1.0	2.0	1.7	1.1	0.6	1.1	1.1	1.6	0.5	1.0
Other Community Care	5.7	10.8	7.9	5.6	8.8	6.2	16.1	13.0	16.4	5.1	2.6	4.6	10.2	3.1	3.8	7.9	6.5	5.1	3.3	4.2
Day Care	4.5	8.3	4.3	8.2	3.9	6.7	6.3	6.6	7.4	5.6	3.8	5.5	6.5	4.4	6.0	10.2	7.2	4.9	4.2	6.0
Home Care	10.9	11.1	6.3	11.1	10.4	11.6	10.2	14.1	11.0	11.9	10.0	11.3	9.7	4.5	8.5	10.0	11.6	7.0	6.7	9.6
Care Homes	16.8	41.1	21.3	27.4	29.3	39.6	32.0	24.4	25.6	18.2	21.6	24.9	18.1	15.5	14.9	21.7	21.4	17.8	20.4	20.5
Assessment and Care Management	8.4	13.3	6.8	14.8	11.1	12.9	11.2	9.6	9.2	9.5	7.6	10.9	9.0	8.3	7.9	14.2	7.8	9.7	5.8	12.0

Source: Information Centre Department of Health Council Expenditure Tables 2005/06

Appendix D: Numbers of providers by sector

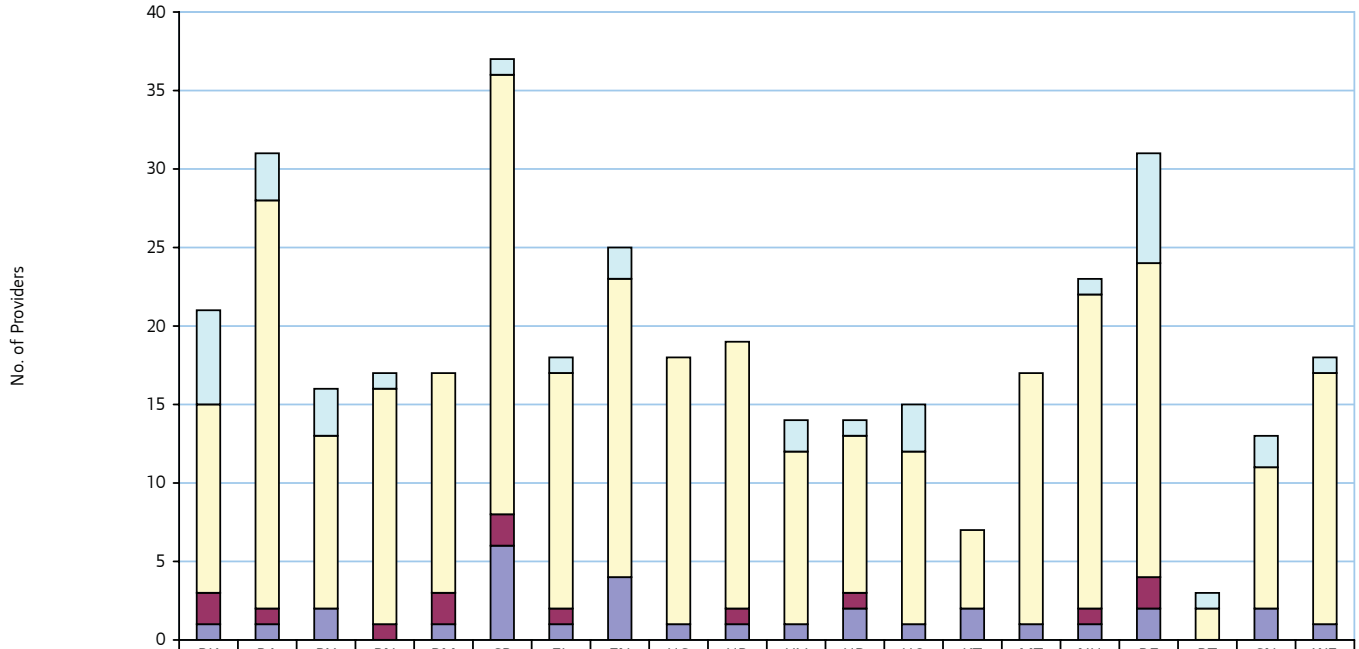
D1 Inner London boroughs



	CM	CT	GN	HC	HM	IS	KC	LB	LW	SR	TH	WW	WE
Voluntary	3	0	0	6	0	5	3	1	1	1	4	1	1
Private	15	0	12	6	0	10	6	15	21	16	15	9	18
Other	1	0	2	2	0	0	0	1	1	3	1	0	1
Local Authority	3	1	1	1	0	1	2	0	3	0	2	1	1

Source: CSCI March 2008

D2 Outer London boroughs

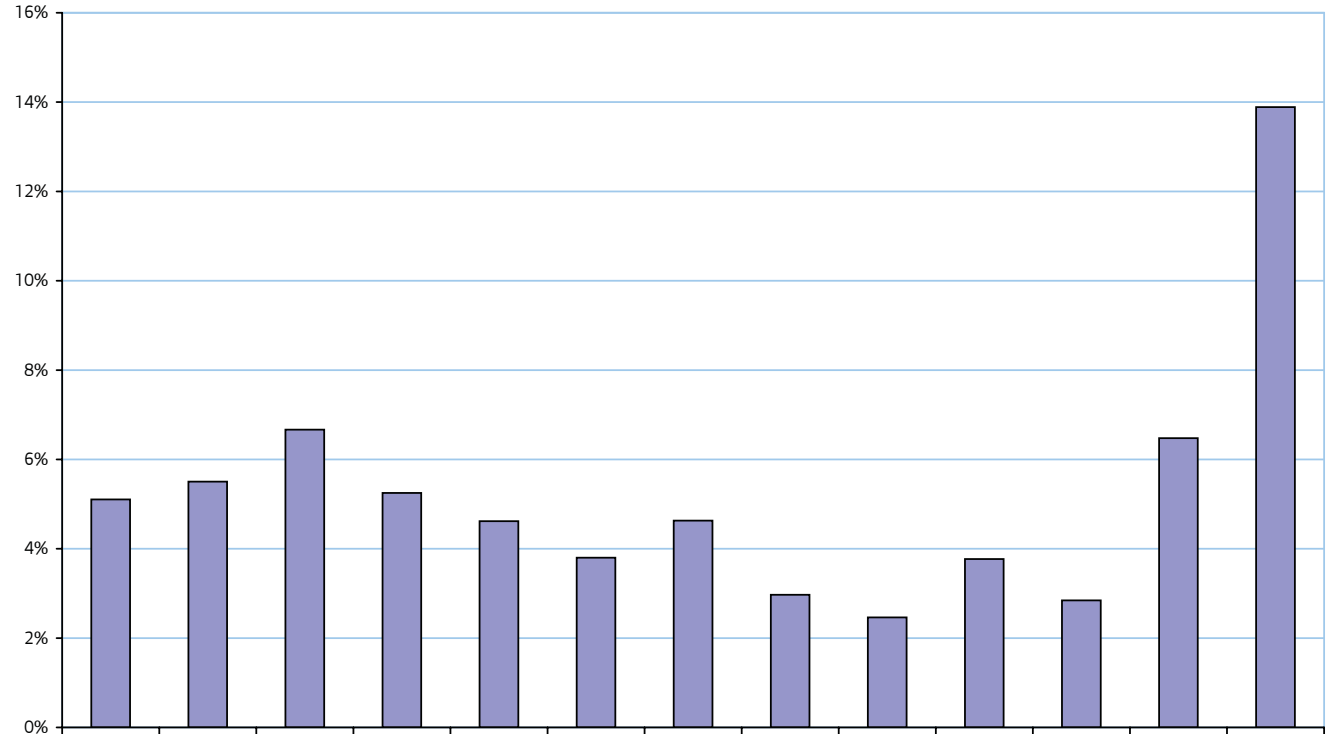


	BK	BA	BX	BN	BM	CR	EL	EN	HG	HR	HV	HD	HO	KT	MT	NH	RE	RT	SN	WF
Voluntary	6	3	3	1	0	1	1	2	0	0	2	1	3	0	0	1	7	1	2	1
Private	12	26	11	15	14	28	15	19	17	17	11	10	11	5	16	20	20	2	9	16
Other	2	1	0	1	2	2	1	0	0	1	0	1	0	0	0	1	2	0	0	0
Local Authority	1	1	2	0	1	6	1	4	1	1	1	2	1	2	1	1	2	0	2	1

Source: CSCI March 2008

Appendix E: Direct payments recipients share of total clients

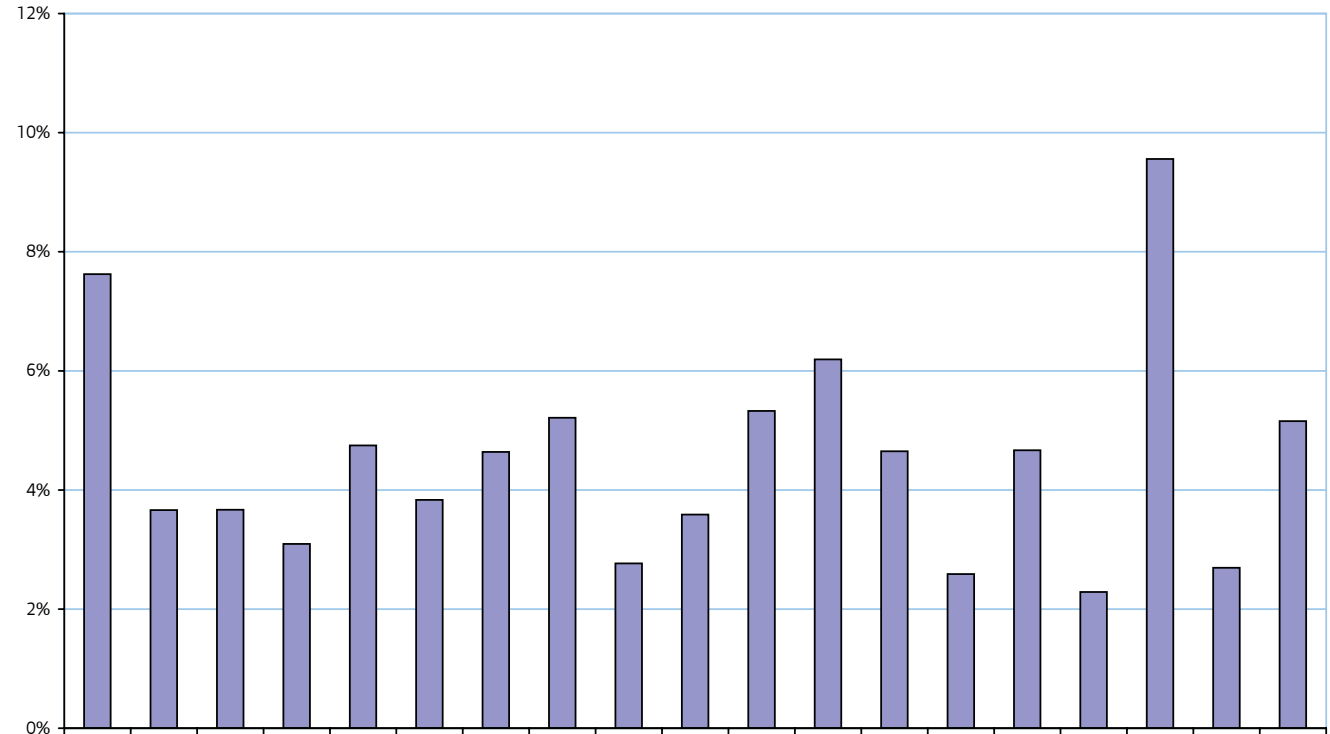
E1 Inner London boroughs



	CM	GN	HC	HM	IS	KC	LB	LW	SR	TH	WW	WE	CT
Shares	5.1%	5.5%	6.7%	5.2%	4.6%	3.8%	4.6%	3.0%	2.5%	3.8%	2.8%	6.5%	13.9%

Source: Information Centre Department of Health, RAP 2006/07

E2 Outer London boroughs



	BK	BA	BX	BN	BM	CR	EL	EN	HG	HR	HV	HD	HO	KT	MT	NH	RE	RT	SN
Shares	7.6%	3.7%	3.7%	3.1%	4.7%	3.8%	4.6%	5.2%	2.8%	3.6%	5.3%	6.2%	4.7%	2.6%	4.7%	2.3%	9.6%	2.7%	5.2%

Source: Information Centre Department of Health, RAP 2006/07

Other formats

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Chinese

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Vietnamese

Nếu bạn muốn có văn bản tài liệu này bằng ngôn ngữ của mình, hãy liên hệ theo số điện thoại hoặc địa chỉ dưới đây.

Greek

Αν θέλετε να αποκτήσετε αντίγραφο του παρόντος εγγράφου στη δική σας γλώσσα, παρακαλείστε να επικοινωνήσετε τηλεφωνικά στον αριθμό αυτό ή ταχυδρομικά στην παρακάτω διεύθυνση.

Turkish

Bu belgenin kendi dilinizde hazırlanmış bir nüshasını edinmek için, lütfen aşağıdaki telefon numarasını arayınız veya adrese başvurunuz.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੀ ਕਾਪੀ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਹੇਠ ਲਿਖੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਹੇਠ ਲਿਖੇ ਪਤੇ 'ਤੇ ਰਾਬਤਾ ਕਰੋ:

Hindi

यदि आप इस दस्तावेज की प्रति अपनी भाषा में चाहते हैं, तो कृपया निम्नलिखित नंबर पर फोन करें अथवा नीचे दिये गये पते पर संपर्क करें

Bengali

আপনি যদি আপনার ভাষায় এই দলিলের প্রতিলিপি (কপি) চান, তা হলে নীচের ফোন্ নম্বরে বা ঠিকানায় অনুগ্রহ করে যোগাযোগ করুন।

Urdu

اگر آپ اِس دستاویز کی نقل اپنی زبان میں چاھتے ھیں، تو براہ کرم نیچے دئے گئے نمبر پر فون کریں یا دیئے گئے پتے پر رابطہ کریں

Arabic

إذا أردت نسخة من هذه الوثيقة بلغتك، يرجى الاتصال برقم الهاتف أو مراسلة العنوان أدناه

Gujarati

જો તમને આ દસ્તાવેજની નકલ તમારી ભાષામાં જોઈતી હોય તો, કૃપા કરી આપેલ નંબર ઉપર ફોન કરો અથવા નીચેના સરનામે સંપર્ક સાધો.

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