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Fractured and forgotten?

The social care provider market in England

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About the report

Social care providers in England have been thrown into the spotlight over the last year as they were hit by Covid-19. But providers of these vital care services are still too often ignored in the increasingly intense discussion around reforming our failing system. This report lays out 10 systemic problems with the way our market for social care operates, and argues that unless they are resolved, funding reforms alone will fail to deliver sustainable change.

This is the first of two reports by the Nuffield Trust looking at the provider market for social care. The second will consider the possible solutions and options for reform that can be learned from international settings.

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Key points

Covid-19 has thrown the social care system's myriad deficiencies into sharp relief, and prompted renewed calls for long-promised reform. While there has been no shortage of proposals for reform over the last two decades, the singular focus on funding has ignored the fact that the provider market is not functioning. Comprehensive reform to the entire system is needed.

Downward pressure on fees paid by councils creates uncertainty and variation

The lack of a long-term funding solution coupled with downward pressure on the fees paid by councils to providers over the last decade of austerity has created uncertainty and instability. Low fees have created inequity as providers charge more to self-funders than those funded by their council in order to remain viable. Regional variation in availability of care has widened as greater onus is put on councils to raise revenue from local sources.

Lack of effective 'market shaping' limits innovation and drives short-termism

Councils' efforts at shaping and developing the provider market to suit the needs of the local population are hampered by a lack of a reliable data about providers and the people who use care services. A focus on balancing the annual budget, coupled with losses of experienced staff, has driven a short-termist approach to purchasing individual care packages. This manifests in highly transactional relationships between providers and their commissioners and a lack of focus on innovation.

There are few proactive drivers of improvement or market management in the system

Quality of providers is generally high, but there has been little improvement among low performers over time. Commissioning is heavily transactional and the forces of choice and competition are limited by an asymmetry of information and a reluctance among people to switch provider, so there are few incentives or rewards for proactive service improvement.

The CQC's role in monitoring the financial health of the market is restricted to only the largest, 'hard to replace' providers. The CQC lacks the powers to take an improvement-focused role or to intervene to prevent financial collapse.

The ownership structure of many provider organisations creates instability in residential care

Opaque ownership and complex underlying business models of many large providers creates instability and uncertainty. The potential for making money through refinancing make it an attractive market for hedge funds, property investors and private equity funds. But these heavily debt-laden companies are highly sensitive to changes in the external environment and can quickly become unviable. In the event of a financial collapse, the provider bears no responsibility for care continuity – thus, there is no penalty for risky financial behaviour. Uncertainty over supply and continuity also arises from the business models of many of the smaller care home providers, which are often part of an owner's pension pot and frequently sold to developers on retirement.

Social care has suffered from a lack of prioritisation within government

The Covid-19 crisis has highlighted the consequences of a sustained lack of prioritisation of social care, and a limited knowledge of the provider market, at the heart of government. Without a dedicated Director General between 2016 and 2020 and with a team of just 40, the Department of Health and Social Care's lack of capacity to deal with a crisis on the scale of Covid-19 was plain. With accountability split between national and local government, a lack of good data upon which to base the response, and few established communication channels with providers, there was confusion about where responsibility lay or about the scale or type of need.

While the points we have identified are not exhaustive, they aim to provide a starting point for discussions about solutions. What is now needed from the current government is a vision for the whole system, and a strategy for achieving that. Only by taking a comprehensive approach that avoids the trap of focusing solely on funding will we be able to build a system that is stable, sustainable and resilient in the face of future pressures.

1 Introduction

There is now a political, and growing public, consensus that the social care system is in urgent need of reform. Over the past 20 years, there have been frequent and ever-more urgent calls for reform, yet debate has quickly become politically toxic and progress has stalled. The most recent pledge for reform has come directly from the Prime Minister, Boris Johnson, in his promise in summer 2019 to 'fix the crisis in social care once and for all' (Johnson, 2019), yet at the time of writing (spring 2021), still no firm proposals have been published. The publication of the government's *Integration and Innovation* White Paper for health and social care in February 2021 is yet another missed opportunity to set out the government's social care plans (Department of Health and Social Care, 2021) and the Budget announced on 3 March 2021 contained no reference to social care. With the Covid-19 pandemic highlighting and exacerbating fundamental flaws in the system, there is now more than ever a need to enact change.

One of the features of failed proposals for reform in the past has been the singular focus on funding and financing. While indisputably crucial, it has become increasingly obvious that addressing only the funding and financing issues will not fix the deep structural problems in the social care sector. Rather, comprehensive and wide-ranging reform to the entire system is required to ensure a sustainable footing for the long term.

Too frequently forgotten in discussions of reform is the social care provider market. Although widely acknowledged to be fragile, there is limited understanding of the root causes of its instability and scant discussion of what is needed to make it more functional or, indeed, what the market is intended to deliver. Too often, narratives narrowly focus on a simplistic and partial explanation around the downward pressure on council fees, the solution to which is to put more money into the system. While that is certainly one important factor, there is a range of underlying complex and interlinked factors that are creating instability in the market. To even talk about a single market of care is a gross simplification of the reality of multiple, different, overlapping markets, each with their own dynamics, features and problems.

With the Covid-19 pandemic having brought the social care system's problems into sharp focus, public and political support for reform is high and this opportunity to build a sustainable system must be grasped. However, attempts to reform social care will fail if insufficient attention is paid to the provider market. A fundamental cog in the wider delivery of services, a failure to put right the structural issues inherent within it will see reforms grind to a halt. To move to a more sustainable model of care in the long term, there needs to be a better understanding of how the market(s) work and an acknowledgement that any reform to funding needs also to address the structural faults within the market(s).

Covid-19 has put enormous pressure on providers of social care, but the underlying problems that rendered the system ill-prepared to weather the pandemic storm pre-dated 2020 and so, while this analysis is inevitably set against a backdrop of the pandemic, it does not seek to explicitly focus on its impact. What the pandemic has demonstrated is that it is now more important than ever to pay attention to the market for social care to ensure that the vital services it delivers can be continued, strengthened and developed.

In this report, we seek to set out what is not working in the care provider market(s) in England in order to identify key priorities for policy-makers as they address this complex issue. This analysis will form the basis of a second phase of work that will focus on potential solutions for provider market reform, drawing on the experiences of Germany, Japan and the other nations of the UK.

Our approach

This work is based on a rapid literature review, supplemented by a series of interviews with a range of stakeholders. These stakeholders included providers of residential and home care, representatives from the Association of Directors of Adult Social Services, the Care Quality Commission (CQC), the Local Government Association, Skills for Care and the National Audit Office, a number of academics in the field, a geriatrician and other commentators on the sector. The literature enabled us to develop a thematic analysis framework, which we used to analyse the interview transcripts. We developed and adapted the framework iteratively as we identified new issues or dimensions.

While we have sought to gather diverse views on the workings of the social care provider market, the sheer diversity and scale of the market mean we are not able to represent an exhaustive range of perspectives, but we have tried to be sensitive to the nuances and complexities inherent in the market. We have focused primarily (although not exclusively) on the market for older people's long-term care, which represents 39.9% (£7.9 million) of public expenditure for long-term care, and 65.4% of users (NHS Digital, 2020a). While many of the issues will be in common, it is important to acknowledge that we have not sought to explore the specific dynamics of the market for working-age adult care or children's care. Also, we have concentrated on the council-funded and self-payer areas of the older people's long-term care market and not looked specifically at the part of the market that the National Health Service (NHS) funds.

2 How does the social care provider market operate?

Talking about one market for adult social care provision is perhaps misleading. In reality, there is not one single market, but a number of different intersecting markets, each with different mechanics, features and ambitions and providing services to a huge number of people with a wide range of needs.

In understanding this sprawling and complex 'market', it is important to recognise that the dynamics may vary according to a number of different factors such as:

- whether the service user is a working-age adult (34.6% of publicly funded long-term care users) or an older person (65.4% of long-term care users) (NHS Digital, 2020a)
- whether they fund their own care, or their care is funded by their council or the NHS, or they have a blend of such funds
- whether the care is residential, home-based or community-based
- whether the service user holds a personal budget (including 'direct payments') or not.

Within these overlapping markets, care is provided by a vast and diverse set of providers. Furthermore, there is substantial regional variation in the structure, size and features of the provider market.

Below we present a brief, simplified description of the social care provider sector in order to provide context for further discussion.

Who provides care?

Adult social care in England is provided by more than 14,000 different provider organisations, most commonly through care homes and nursing homes, and domiciliary care agencies. Table 1 shows the breakdown of providers registered with the Care Quality Commission (CQC) by type, across the whole market. However, this does not reflect the entire scope of care provided – the CQC does not regulate all types of social care activities and so there are many care providers about which little is known. For example, Skills for Care (2020a) estimates that around 70,000 direct payment recipients directly employ around 135,000 personal assistants – the CQC does not regulate the care they provide (Skills for Care, 2020b). The numbers presented in the table include services for both working-age and older adults, although the types of services that service users prefer vary according to age and need.

Table 1: Social care-providing organisations registered with the CQC

March 2021	Number of locations registered with the CQC	Number of provider organisations registered with the CQC
Community care, including:	**11,021**	**7,861**
• domiciliary care services	10,014	
• supported living services	2,103	
• extra care housing	540	
• Shared Lives Plus services	130	
Residential care, including:	**15,407**	**7,461**
• care homes	11,233	
• nursing homes	4,366	

Notes: One single organisation can operate across multiple locations. One single organisation or location can provide multiple service types, so the number of services counted does not add up to the number of locations recorded.

Source: Nuffield Trust analysis of CQC directory data, March 2021 (Care Quality Commission, 2021b).

Within the broad categories of providers shown in Table 1, the types of services offered are very diverse. Beyond residential, nursing and domiciliary care, people are increasingly turning to personal assistants, supported living and new models of care such as Shared Lives schemes and extra care housing. The number of people supported by these services is growing rapidly – for example, there are now 12,800 people in Shared Lives schemes, which represents an increase of 4% between 2019 and 2020 – and there is evidence that these new models of care deliver services of a very high quality (Care Quality Commission, 2019; Shared Lives Plus, 2020). The growing preference among commissioners and care users for these new models of care will undoubtedly shape the future landscape of the social care market.

There is also a plethora of wellbeing and support services that are essential to many people in achieving their outcomes, which may not be counted officially as 'social care' services. Additionally, it should be recognised that housing services are intricately bound up in social care provision – those services are beyond the scope of this study.

Providers come in many shapes and sizes – from small family-owned businesses to large-scale, often private equity-backed, companies that own and manage multiple sites. However, small- to medium-sized enterprises largely dominate the market. In 2016, there were 30 providers that owned more than 25 care homes, providing over 130,000 beds. But there were more than 4,300 single-location care homes, which, in total, provided a similar share of beds (over 131,000; Competition and Markets Authority, 2017b). More recent data suggest that single-location care homes make up around 75% of all providers registered with the CQC (Naylor and Magnusson, 2019). While the overall number of care home beds is falling, a shift towards larger care homes has been observed (Naylor and Magnusson, 2019). There is limited knowledge of the features of the other types of providers (such as domiciliary care agencies). The National Audit Office (2021) recently reported that the 10 largest domiciliary care providers have a market share of only 16%, and 90% operate from a single location.

As well as variation in size, care providers also vary in their ownership type: public, private not-for-profit and private-for-profit. Private for-profit providers make up the largest share of the market; 69% of care homes, which equates to 77% of beds, are privately owned, and there is an indication

that this proportion is increasing (Naylor and Magnusson, 2019). Around 20% of the care home market is owned by large for-profit providers that are private-equity owned or backed (Centre for Health and the Public Interest, 2016). There is limited publicly available information on the ownership of domiciliary care providers, although the National Audit Office's (2021) recent report on the adult social care market sets out financial information for 64 of the largest domiciliary care providers, which are both for-profit (38) and not-for-profit (26).

Which national bodies oversee and fund the social care sector?

The complexity inherent in the social care sector cascades from the very top. A number of actors at national, local and service user levels influence, administer, regulate and shape the markets to varying extents. At the national level, one key department, the Department of Health and Social Care, holds overall responsibility and accountability around policy development and implementation. Funding, however, flows via the Ministry of Housing, Communities and Local Government to local councils. The CQC has responsibility for oversight and regulation of the sector (discussed further below). It should also be noted that a third governmental department also has an important role to play in social care – the Department for Work and Pensions, from which disability and carer benefits are generated (this is out of scope for this project).

How does funding reach providers?

Public funding for social care has three main sources:

- the national grant that flows from the Ministry of Housing, Communities and Local Government to local authorities
- the revenue that local authorities raise themselves from sources such as Council Tax, the precept and business rates

- the NHS, through funds such as the Better Care Fund and NHS Continuing Care.

The central government grant is not ring-fenced for social care and local authorities have discretion over how much of it they allocate to such care. Local authorities also have some flexibility over how much they raise from the ring-fenced precept, up to a maximum of 3%.[1] In the past decade, local authority net spending has fallen in real terms, from £17.2 billion in 2010/11 to £16.5 billion in 2019/20, although in 2019/20 it was at its highest level since 2012/13, notwithstanding increases in need and demand (National Audit Office, 2021). Government funding to local authorities has seen a 55% drop between 2010/11 and 2019/20, resulting in a real-terms reduction of 29% in local authority spending power (National Audit Office, 2021). There is an ongoing policy ambition to further reduce local authority reliance on central funding and instead to allow local authorities to retain a higher proportion of their business rates.[2]

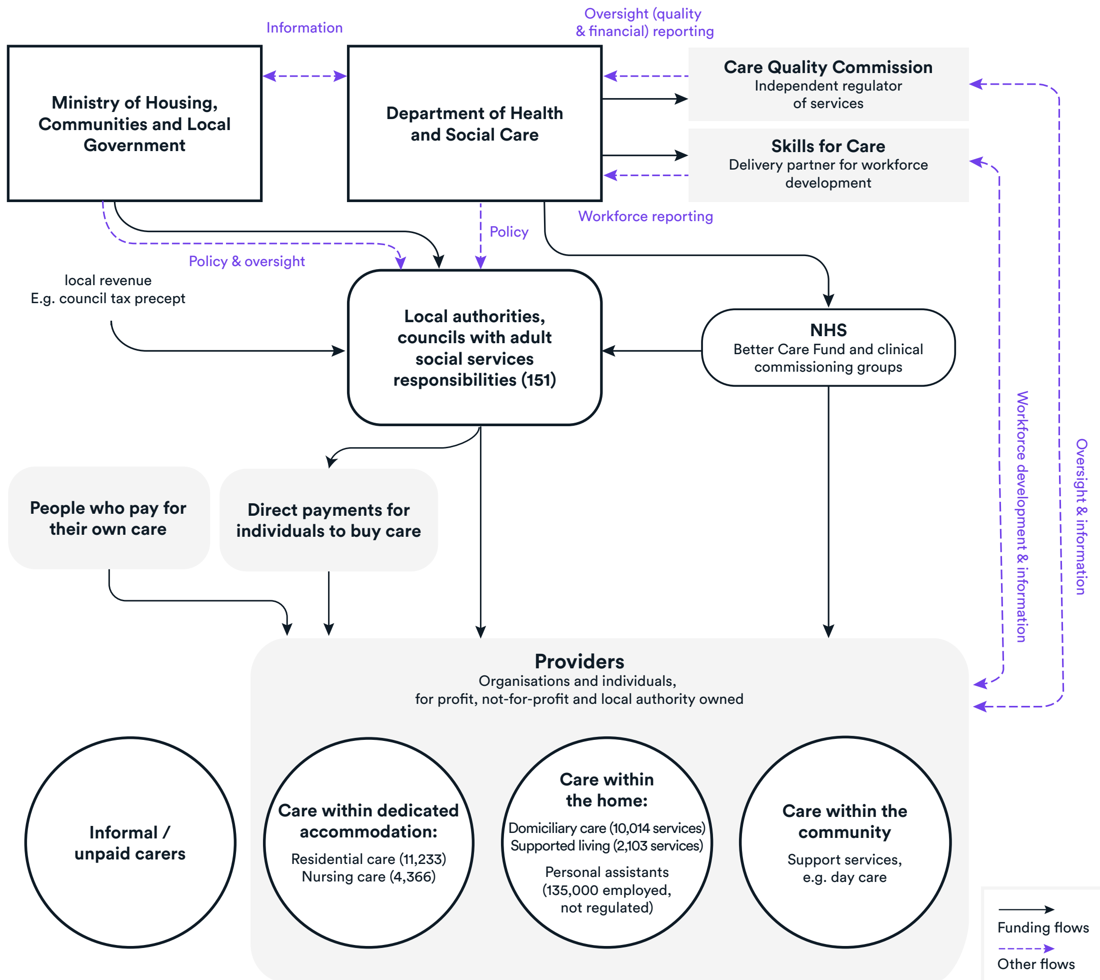
However, as a service that is not free at the point of use, individuals privately fund a large proportion of social care. Many service users do not meet the means-test of £23,250 (that is, they have savings, income or assets over this amount) and are thus left to fund their own care entirely. There is a lack of data on how many self-funders there are and how much they spend on care, but the National Audit Office (2021) has previously reported that private individuals spend around £8.3 billion on care. Some estimates suggest that in England, 30–46% of residential care users, and 20–30% of domiciliary care users, fund their care privately (Baxter and Glendinning, 2015; Skills for Care and Development, quoted in Oung and others, 2020). Current estimates suggest that the number of people self-funding in residential care has increased over the past 10 years (National Audit Office, 2021).

1 This increased from 2% in the November 2020 Spending Review.

2 Introduction of the Business Rates Retention Scheme has been delayed until 2021/22. See Peters D and Ford M (2019) 'Fair funding review and 75% retention delayed', *The MJ*, 4 September. www.themj.co.uk/Fair-funding-review-and-75-retention-delayed/214519#. Accessed 1 April 2021.

Figure 1 illustrates the complexity of the social care system and the actors involved at different levels.

Figure 1: Funding and other flows in the social care system



Notes: The Department for Work and Pensions also has a role in administering benefits, such as Carers' Allowance and Personal Independence Payment. This is out of the scope of this project and is not represented on this Figure.

Sources: Care Quality Commission data directory (Care Quality Commission, 2021b); Skills for Care estimates of workers employed through direct payments, October 2020 (Skills for Care, 2020a).

Marketisation of provision: how is the market intended to work?

The current social care market has developed as both a planned and unplanned consequence of NHS and community care restructuring in the 1980s. The New Public Management movement of the 1980s sought to shift the responsibility for provision from the state to the private and voluntary sectors and frame care users as consumers (Bode and others, 2011). This was achieved, among other things, through the introduction of social security payments to individuals with very little assessment of needs, and available to all, whether in public, voluntary or private residential care homes (Ham, 2009, p. 39). This led to a rapid and uncontrolled expansion of the private market, while NHS provision of nursing care was reduced (Lister, 2020). The National Health Service and Community Care Act 1990 (HM Government, 1990) introduced a framework for a 'mixed economy' of care, partly as a response to the growing dominance of private providers in community care, and the changes were introduced with little controversy or scrutiny of the possible impacts (Ham, 2009, p. 40). It placed local authorities as the lead purchaser of community care and required them to buy at least 85% of services from a range of independent providers (Ham, 2009, p. 39; Baxter, 2018). As such, the dominance of private- and voluntary-owned care homes (and other providers) developed in a rather unregulated and unplanned way, with little consideration of the implications this may have for the delivery of care.

The current model for the market is that the state (that is, local authorities) commissions care to suit the needs of local populations. Providers compete for business from local authorities and private individuals, under the assumption that increased competition can improve efficiency and quality, reduce bureaucracy, drive innovation and increase service user choice (Needham and others, 2018). Local authorities do continue to provide some care directly, but this amounts to a small proportion of overall provision (10% of care homes are run by a local authority or the NHS; National Audit Office, 2021).

The social care market has been described as a 'quasi-market', where the majority of providers are privately owned but the state is both the regulator of services and a monopsony purchaser of care (Bode and others, 2011). However, as the means-test thresholds have been held steady and eligibility

thresholds have been raised, resulting in more self-funders, it is likely that the extent to which local authorities hold complete monopsony over purchasing care has diminished in recent years and at different paces across regions. Indeed, research by Bottery and others (2019) has shown that funding pressures and an unchanged means-test have resulted in lower access to state-funded care among older people, with significant regional variation, and led to a growth in self-funders, many of whom purchase their care directly from providers. In addition, uptake of direct payments is also growing as a result of the drive to personalise care (NHS Digital, 2020b). These, in principle, afford service users greater control over the care they choose to fund (Age UK, 2020).

Changes introduced in the Care Act 2014

In recognition of its shortcomings, significant changes to the way the market operates were made as part of the Care Act 2014. Without changing the basic tenets of a market-based approach, the Act sought to rectify some key elements that were deemed to be deficient (such as unclear accountabilities for care failures and a lack of business regulation) and that had allowed the high-profile failure of a large care home provider, Southern Cross, in 2011.[3] The Care Act sought to strengthen the market in three main ways:

- **Regulation**. The CQC was given new duties to oversee the financial health of the largest providers in addition to their existing duty to assess the quality of all registered providers.
- **Choice**. In recognition that the market is complex to navigate, local authorities were given new duties to support choice by providing an information, advice and advocacy service.
- **Market shaping/removing barriers to entry**. Local authorities were given an explicit duty to shape the local provider market (including the self-funded sector). The Care Act requires local authorities to engage with their local markets to develop a market position statement, which should address, among other things, local barriers to entry for new providers.

3 Southern Cross went into administration in 2011. See the section on ownership in Chapter 3 for more on this.

What does the Care Act mean for local authorities?

Within their 'market-shaping' role, local authorities are intended to play an active part in developing and stimulating the market of provision. The Care Act 2014 placed a duty on local authorities to 'promote diversity and quality in provision of services… and… the efficient and effective operation of a market in services for meeting care and support needs' (HM Government, 2014). The intention was to ensure care provision is sufficient, appropriate and high quality. Importantly, local authorities have a duty to shape the entire local market, including providers who cater only to private self-funders, not just the providers they purchase care directly from.

What is the role of the regulator under the Care Act?

The CQC regulates social care providers. It acts as an independent non-departmental public body to ensure the delivery of safe and quality care services. It assesses the quality of social care provision through registration, monitoring, inspection of providers, and safeguarding against unsafe services. The CQC uses five key dimensions as part of its inspection regime to describe the quality of a care service, from 'outstanding' to 'inadequate'. In addition, under the Market Oversight Regulations introduced in the Care Act 2014, the CQC has a duty to monitor the financial performance of the largest providers and raise significant concerns around financial viability with local authorities and the Treasury.

The CQC does not inspect or regulate the local authority commissioning function – this function is not currently subject to scrutiny by any national body. In February 2021, the Department of Health and Social Care (2021) published its *Integration and Innovation* White Paper about the future of integrated care systems. The paper puts forward proposals to create a new duty for the CQC to assess the performance of local authorities in achieving their duties as set out under the Care Act.

3 What's not working in the market?

Our interviews and literature review found that the social care provider sector is under considerable strain. It was striking that, despite speaking to people with a range of different perspectives, not a single interviewee felt that the market is functional as it is currently structured. These conversations revealed that, although funding and fees are a major issue, the root causes of the dysfunction extend to deeper structural problems that span the demand and supply sides as well as policy and regulation. There was a consensus that simply pouring more money into the market will not fix these structural faults and that more extensive reform is required. In this chapter, we seek to summarise the main issues that have emerged during this research. While we have focused mainly on older people's care, we have tried to reflect where the issues might be different in the market for working-age adult care, and we have attempted to draw insight across both residential and home care. This market is vast and the dynamics are complex so we do not claim this to be a comprehensive overview of every issue. But we hope that it illuminates some of the root causes of the market's instability that will underpin further debate in this space.

Funding: low provider fees create uncertainty, variation and instability

With year-on-year cuts to local authority budgets between 2010/11 and 2019/20, resulting in a 29% real-terms drop in local authority spending power, local authorities have been under pressure to reduce expenditure on social care (National Audit Office, 2021). At the same time, overall demand for care has been rising, particularly among working-age adults, and complexity of need increasing (Bottery and Babalola, 2020; Care Quality Commission, 2017). There were 1.9 million new requests for support in 2020/21 (NHS Digital, 2020a). Although spending on care in 2019/20 reached its highest levels since

2012/13, it still sat at 4% below 2010/11 levels in real terms (National Audit Office, 2021). As well as tightening eligibility criteria for care, local authorities have sought to balance their books by putting downward pressure on the fees they pay to providers for publicly funded service users. This has had a number of consequences.

The National Audit Office report that the Department of Health and Social Care recognises that the majority of local authorities pay providers below a sustainable rate (National Audit Office, 2021). In interviews, providers reported that the fees paid for local authority-funded individuals are either lower than the cost of delivery, or so close to cost, that margins are too tight to offer stability, to mitigate external cost pressures (such as changes to the national minimum wage), or to enable investment or innovation. They talked about needing to make difficult decisions between investing in training or information technology (IT) or staff pay. Of course, as set out earlier, it should be noted that the provider market is diverse and margins will vary by provider type and size, but there is widespread concern about provider closures. As surveys by the Association of Directors of Adult Social Services (ADASS) have documented, recent years have seen an increase in the number of provider organisations closing or handing back contracts. ADASS (2019) estimates that, from 2016 to 2018, 1,211 residential care homes stopped delivering services, while only 580 new ones opened. Naylor and Magnusson (2019) have found that the number of care home beds decreased from 462,650 in 2015 to 456,545 in 2019. It is, however, worth noting that the overall number of domiciliary care services has increased over time, although there is some turnover, with high levels of both exit from and entry to the market (Hall and others, 2017).

The Competition and Markets Authority (2017a) has noted that while fees may enable providers to stay in business in the short term, providers are unable to maintain or improve facilities and may end up closing or moving away from local authority-funded care. Its analysis of profitability found that homes with the highest proportions of local authority-funded residents adequately covered their operating costs but were unable to provide a sustainable return to investors in order to raise capital for modernisation or investment (Competition and Markets Authority, 2017a). In contrast, those with high proportions of self-funders were able to generate such returns (Competition and Markets Authority, 2017a). As a result, providers increasingly rely on charging higher rates to self-funders to cover fixed costs (Competition and

Markets Authority, 2017a). In residential care, self-funders pay as much as 42–44% higher fees on average than councils pay for their residents (LaingBuisson, quoted in Competition and Markets Authority, 2017a). Stakeholders reported that most providers have some level of mixed income – local authorities provide a regular stream of business and, even where a provider has moved away from providing for state-funded service users, once self-funders have spent down their assets, they may become eligible for state-funded care.

Although clearly a critical issue for residential care providers, which need to maintain costly estates, the National Audit Office (2021) also found that most local authorities are paying home care providers fees that are below sustainable levels. An ADASS (2019) survey found worrying numbers of home care providers also handing back contracts or closing down.

The often short-term nature of social care funding further exacerbates instability. Rather than being offered a long-term settlement that recognises cost pressures, the sector has been subject to a piecemeal approach to funding, characterised by sporadic injections of cash to help it through winter or to prop it up temporarily. Such an approach means that councils and providers have little long-term certainty or flexibility to drive investment and innovation. This may partly explain the limited spread of technology adoption and innovation relative to the health sector (Sherlaw-Johnson and others, 2021: forthcoming).

Downward pressure on budgets does not affect all regions, service users or providers equally and one of the consequences is marked variation across a number of dimensions. With the means-test threshold beyond which an individual must pay for their own care set at a blanket £23,250, the relative wealth of an area (and, crucially, levels of home ownership) determines the ratio of self-funders to state-funded service users. There is limited knowledge about the size of the self-funder market, particularly in home care, as data about self-funders are not routinely collected. But estimates suggest that people spend around £8.3 billion on their own care (LaingBuisson, quoted in National Audit Office, 2021). Some estimates suggest that 30% of domiciliary care service users pay for their care themselves, rising up to 45% in residential care, but this varies hugely across the country (Oung and others, 2020). It should also be noted that the status of an individual can change over time as

they spend down their assets and may switch from self-funding to partial or total local authority funding.

Regional wealth has a significant impact on the amount and mix of care available, and, in turn, choice and fairness. In less wealthy areas, the amount of money a council can raise via the precept and business rates is more limited than in more affluent areas. Furthermore, the ratio of self-funders relative to local authority-funded service users varies according to local wealth: in less wealthy areas, there are fewer self-funders and thus less scope for cross-subsidisation, which can make the provision of residential care unsustainable (Incisive Health, 2019). Where there is a majority of local authority-funded users, councils act as a monopsony purchaser, which can add to downward pressures on fees and render some providers unviable. Conversely, in areas where there is a shortage of provision, councils will be under pressure to pay higher fees, especially for more specialist nursing and dementia care (Competition and Markets Authority, 2017a). A further dynamic at play in a local market, which is out of the scope of this project, is the role of the NHS, which commissions some care and can have a bearing on commissioning practices and fees paid (Humphries and others, 2016).

Analysis has found that closures of residential care homes have been concentrated in the local authority-funded homes and new entrants have focused on the self-pay market (Grant Thornton, 2018). There is also evidence that closures are not uniform across the country and that some regions suffer from so-called 'care deserts', where providers have withdrawn from the market because provision is either financially unsustainable or the workforce is unavailable (Incisive Health, 2019). Rurality is an additional factor, particularly in the home care market where the distance between service users in receipt of domiciliary care means that costs of delivery are high, and low fees that councils pay can render care provision unsustainable (Bottery and others, 2018; Local Government Association, 2017). With councils increasingly reliant on local sources of revenue (Harris and others, 2019), existing regional differences in the health of the provider market are likely to widen (Care Quality Commission, 2019).

Local authorities struggle to do market shaping consistently

The Care Act 2014 bestowed on local authorities an explicit duty to undertake market shaping – a responsibility that encompasses the entire market, not just the parts that they fund. The Care Act described the act of market shaping as 'the authority collaborating closely with other relevant partners, including people with care and support needs, carers and families, to facilitate the whole market in its area for care, support and related services' (HM Government, 2014).

Interviews with stakeholders suggested that, although there are examples of good practice and much variation in performance, there are a number of common structural factors that stand in the way of councils being able to shape the market.

Contextual factors, such as the relative wealth of an area, have a bearing on how a council will go about its market-shaping role (Needham and others, 2020). In an area with a high proportion of self-funders, the council may be a relatively small purchaser of care and so have little direct knowledge of and influence over many of the providers operating in the area. In an area with a small proportion of self-funders, the council may be the majority purchaser with a more direct relationship with providers. With no mandatory dataset for social care, it is up to individual councils to undertake market mapping and gather intelligence on the local market beyond their direct commissioning relationships (see data section for more on this).

The capacity and capability of councils to fulfil their market-shaping role have been reduced in recent years as budget cuts have seen the loss of skilled and knowledgeable staff. It is estimated that a quarter of local authority jobs have been lost since 2010 (Eichler, 2019) and the remaining resource has necessarily been focused on the purchasing of care packages for those in need rather than taking a broader strategic look at the market. With continued pressure to find savings, and a legal duty to balance budgets annually, it is little surprise that a more strategic long-term approach to market shaping is not more commonplace.

However, a further factor determining the effectiveness of a council's market shaping that stakeholders mentioned is the attitude the council has towards its market-shaping duty. Councils are expected to work with local stakeholders (including those using care services and providers) to co-produce market position statements – a key building block of market shaping – but the extent to which this process is effective is variable. The National Audit Office (2021) recently found that less than half the local authorities it had reviewed had updated their market position statements since 2016, indicative of their limited and varying use. Stakeholders suggested that some local authorities see market shaping as more of a priority than others and that can be dependent on individual leaders. Such issues of the quality of leadership and the culture of an organisation may explain some of the variation in practices within councils (Humphries and Timmins, 2021). Relationships between councils and providers are also key (further explored in the next section).

Transactional contracting drives short-termism and not innovation

Although some local authorities directly provide care, this only accounts for around 4% of the care home market (Competition and Markets Authority, 2017a) and a similar proportion in domiciliary care (Skills for Care, quoted in UK Homecare Association, 2019). Local authorities are therefore reliant on their ability to commission care from a range of different providers in order to meet the needs of their local population. Related to the market-shaping challenges described in the previous section, there are some widespread issues in terms of commissioning processes and practices that do not create the environment in which a sustainable market can develop.

Although local authorities make use of a variety of commissioning practices to shape different parts of the market, and make use of different approaches for specific user groups (Needham and others, 2020), relationships between providers and local authorities are often described as transactional. Despite a greater focus on outcomes-based commissioning in recent years, budgetary pressures do not always facilitate a collaborative partnership between providers and councils and can restrict the potential for conversations to move onto innovative or new models of provision. In turn, this further

cements historic patterns of provision, with little regard to changes in need, demography or demand/expectations. In the absence of a shared and unifying vision of the future, stakeholders told us that relationships between council and provider can be antagonistic and overly focused on the micro-management of contracts. However, they also pointed to examples where the conversation had successfully moved beyond the narrow focus on price, attributing this to visionary leadership or a willingness to take risks and invest reserves. Some reflected to us that the Covid-19 pandemic has had a positive impact on relationships, as providers and commissioners have had to come together and work as one in the face of the crisis. It will be interesting to see if those positives changes are retained in a post-Covid world.

Transactional approaches, focused on price, can drive short-termism and fail to consistently drive quality. Commissioning too often perpetuates the status quo, with commissioners buying care from a narrow menu of what is already there rather than taking a more assets-based approach, considering need, and then drawing in appropriate services. This can be of particular concern to individuals with highly specialised needs that existing provision may not be able to meet easily. Although some councils have made efforts to shift to outcomes-based commissioning, a duty set out in the Care Act 2014, often many resort to spot purchasing – essentially buying care hours for individual placements (Bottery and others, 2018). Spot purchasing does not facilitate collaboration between local authorities and their providers and can lead to reduced choice for individuals (Bottery and others, 2018; Competition and Markets Authority, 2017a; Needham and others, 2020).

Care choices are often based on this year's budgetary pressures rather than the most cost-effective options in the long term or on the individual's preference. Particularly in local authority-funded home care, the consequences are a market that is centred on minutes of care for the cheapest price – so-called 'time and task' provision (Bottery and others, 2018). Providers have little room for innovation and councils have little headspace, resources or incentive to take a long-term, strategic approach.

The added complexity of a lack of integration between health and social care organisations in a local area can further stymy ambitions to shift the focus of care towards prevention. Policies, such as the Better Care Fund, have sought to incentivise investment in prevention and smoother discharge out

of hospital but evidence suggests that they have had limited success (Forder and others, 2018). The recent legislative proposals set out an ambition for greater integration across health and social care via integrated care systems (Department of Health and Social Care, 2021), but whether these will provide an effective vehicle for shifting resources to preventive care services is yet to be proven.

A lack of data and market intelligence limits sector development

A lack of data and intelligence about the social care provider market acts as a barrier to reform and development at both national and local levels. While there are some data on the number of state-funded individuals, the proportion of self-funders in any council is largely unknown. At a national level, the absence of any standard minimum dataset for social care means there is little scope for the CQC to identify issues or problems in advance of a provider getting into difficulty and little scope for getting an overall picture of trends in the market. At a policy level, a lack of grasp on the complexity and diversity of the market, exacerbated by a lack of a ready source of information, presents a real and significant barrier to developing coherent proposals for reform. A limited local and national picture of the market further makes it difficult to produce conclusive evidence of the impact of policies and/or innovation on outcomes for service users.

At a local level, a lack of data and intelligence about the market and, in particular the self-funder market, is an impediment to councils' ability to fulfil their wider market-shaping duties and be accountable for services that are responsive to the needs of service users. Councils do not routinely collect information on personal assistants or other forms of provision not registered with the CQC, making it difficult to assess the quality of care that individuals employing personal assistants receive. The lack of knowledge about self-funders, and the extent to which they are shaping supply in the market (see section on information asymmetry), poses a number of issues:

- The number of self-funders has implications for the availability of services for state-funded individuals and the cost at which they can be purchased (for example, due to high occupancy rates).

- Without good data on self-funders, a local authority lacks an overall picture of need and cannot predict the likely impact on future demand (when self-funders exhaust their funds, for example).

- There is limited understanding of the interaction between self-funders and wider public services, such as health care (very little is known about health outcomes for self-funders against which the success of integration policies can be measured; Sherlaw-Johnson and others, 2021: forthcoming).

- There is a lack of knowledge about the experiences of self-funders in their receipt of care (Baxter and others, 2020).

This lack of information limits the extent to which a council can develop a long-term view or effectively drive change in provision. It can also become a safeguarding issue in the event of provider failure where the council is largely reliant on the willingness of providers to share data about self-funders, for whom the council has responsibility to guarantee continuity of care.

Some stakeholders postured that councils should be putting more effort into understanding their markets. Lack of resources to do this was cited as a barrier. As businesses (for profit or not for profit), providers generally have a reasonable oversight over the market in which they are operating or entering – one former provider commented that they would find out who their competitors were in the local market, what they were charging, occupancy rates, their staff ratios, their mix of residents and the services provided and felt that councils could and should also be doing this more proactively. However, the extent to which providers are willing to be transparent about certain aspects of their business depends on what they perceive their competitive advantage to be (Laing, 2020). Stakeholders also reflected that the willingness of a provider to share information with a council also depends on the relationship they have – where relationships are well established and collaborative, there tends to be a better flow of data.

During the Covid-19 pandemic, efforts have been made to collect standard data via a capacity tracker tool, but this relies on providers self-reporting data on, for example, beds available and staff vaccinated. Stakeholders told us that completion rates and data quality vary and that many small providers find the process onerous. Others reflected that the pandemic had shifted attitudes

towards the importance of data both nationally and locally. Proposals in the recent White Paper on integration and innovation to improve the 'quality, timeliness and accessibility' of social care data perhaps reflect this shift (Department of Health and Social Care, 2021, p. 57).

Information asymmetry limits choice

For the care provider market to operate as intended, individuals – directly as self-funders or via councils acting on their behalf – exercise preferences by choosing providers who compete on quality and price for their business. Theoretically, providers respond by providing the type of services preferred at a high quality and at a competitive price. However, both local authorities and individual service users struggle with asymmetry of information: it is difficult to get a clear picture of the breadth of services, the level of demand and pricing, all of which can affect decision-making and limit choice (Needham and others, 2018). Service users, whether funding their own care or being supported by the state, find the system confusing and complex to navigate, and many are left to make crucial decisions entirely on their own (Bottery and others, 2018). In addition, people in need of care are often under pressure to select a service quickly, and with often little preparation or knowledge of the sector. This is termed a 'distress purchase' or 'crisis purchase' (Centre for Health and the Public Interest, 2016; Needham and others, 2018).

Although the CQC's assessments of quality across five dimensions are designed to be easily understandable to service users, and charities (for example, Age UK, CareChoices and Citizens Advice) provide signposting and support, information asymmetry remains a problem. The Care Act 2014 recognised this and placed a duty on local authorities to provide information, advocacy and advice services to all individuals with a need for care, whether state- or self-funded (Needham and others, 2018). However, these services have often been reported to be insufficient or inadequate for all types of service users (Baxter and others, 2020; Independent Age, 2016). It is also worth noting that many older service users, have limited interest in having vast amounts of choice or control in the organisation of their care, especially where this is needed following a stressful experience, such as leaving hospital (Baxter and others, 2020).

The Care Act 2014 also set out an ambition for individuals to receive more personalised care aligned with their needs and wellbeing outcomes, and requires councils to offer personal budgets to all who are eligible (HM Government, 2014). The use of personal budgets – either as managed budgets or direct payments – is intended to give state-supported individuals the same strength in purchasing power as that held by self-funders (Baxter and others, 2020) and to ensure social care users enter the market as 'empowered consumers' with a choice of services that meet their needs (Slasberg and others, 2012, p. 161). Uptake and use of personal budgets and direct payments vary, particularly between different user groups. For example, the use of direct payments is around 17% among older people and 40% among younger adults (NHS Digital, 2020b).

As explored earlier in this report, the extent to which councils effectively develop a market for care services that reflects service user needs and preferences is variable. The Competition and Markets Authority (2017a) found, for example, that the lack of vacancies in care homes limits choice, a particular problem for local authorities where providers increasingly favour self-funder placements. Among direct payment holders, downward pressures on budgets, and rules imposed on how direct payments can be used, further reduce the scope of providers from which individuals can choose services (Baxter and others, 2020). Evaluations have also found mixed evidence as to their outcomes (Needham and others, 2018). In sum, the supply of care available to state-supported individuals (including direct payment holders) does not enable them to fully exercise choice in decisions around their care (Rabiee and Glendinning, 2014).

The incentives for providers to improve quality and innovate are consequently relatively weak. Although the willingness of an individual to change their care provider may vary between older and working-age adults, research has found that once someone has made a choice about their care and services are in place, it is unusual for them to shift to another competing service (Barron and West, 2017). This is perhaps most significant in the residential care market – rather than in home care – where the upheaval of changing to a new care home may discourage movement between providers, even if an individual is dissatisfied with the standard of care they receive. In effect, the current system for purchasing care creates an uncomfortable trade-off between ensuring stability, through a guaranteed minimum of provision, at the expense of

quality and individual choice, especially for those whose care is supported by the state (Needham and others, 2020).

Ownership structure and complex business models breed instability in residential care

Although the majority of provision is delivered by small and medium-sized enterprises, around 30% of care is provided by large companies, which frequently have opaque ownership and complex underlying business models. Three of the big five providers are funded through private equity (Blakeley and Quilter-Pinner, 2019). As has been seen with the high-profile collapse of care home providers Southern Cross in 2011 and Four Seasons in 2019, these arrangements can drive instability in the market, pose a significant risk to local authorities and cause anxiety over possible displacement or discontinuity of care for service users. This is of particular concern in areas where such providers account for a large proportion of (usually residential and nursing home) provision.

The provisions around regulation included in the Care Act 2014 were intended to prevent the disruption to the market that could arise from the failure of a large provider, such as Southern Cross. That company, acquired by a private equity group in 2004 and heavily debt-laden, ran 750 homes for 31,000 people at the time of its collapse (Scourfield, 2011). It had had a succession of owners and was run via a so-called sale-and-leaseback business model, where property assets and operations are separated, and property is sold on and then leased back to the operating arm, with annual rent increases. Such a model is viable when property prices are buoyant, borrowing is cheap and occupancy rates are high, but the property crash of 2008/09 followed by a freeze on local authority fees, alongside rising rents and costs of care, meant the company could no longer service the debts it had accrued and the business became unviable.

Commentators have raised concern about the motivations of entrants into the market (see, for example, Birrell, 2020; Centre for Health and the Public Interest, 2019; Davies, 2018 Wachman, 2011). Owners are often attracted to the market by the potential for making short-term profit arising from real estate

and are not necessarily driven by an interest in the care provision or business development (Horton, 2017). Such distant ownership can feel very removed from the priorities of the local authorities and local communities to which they are providing care and may make it more difficult for local authorities to establish an effective relationship with them. There is also growing concern that, within such operating models, there is a limit to the extent to which available profits are reinvested (Kotecha 2019; Burns and others, 2016; Davies, 2018; Horton, 2017).

The Care Act 2014 put in place two provisions intended to prevent future crises similar to Southern Cross. First, that large care home providers should be subject to the CQC market oversight regime, requiring them to submit regular financial information to enable the CQC to monitor their financial health. However, as explored in the section looking at the regulator's lack of capacity and powers, the CQC has no levers to *prevent* financial collapse, nor does it have powers to require the owners of the providers to stabilise or improve their financial position (Centre for Health and the Public Interest, 2016). Complex ownership arrangements and a lack of transparency over the financial position of many companies in this sector can also make identifying likely failure difficult (Centre for Health and the Public Interest, 2019; Horton, 2017; Institute of Public Care, 2014). Companies registered overseas are not subject to the same requirements as England-registered organisations and this can limit the amount of information available in the public domain (Institute of Public Care, 2014). As the National Audit Office (2021, p. 30) has recently found, accessing the accounts of private equity-backed entities can be problematic. Opinion is divided over the extent to which private equity can be beneficial for care provision. While it brings in expertise and attracts new entrants (especially in care homes), these are usually short-term investments to increase the value of the business and property, which are then sold on (Horton, 2017; Institute of Public Care, 2014).

Second, the Act requires local authorities to ensure continuity of care in the event of a failure. This means that the local authority has to take responsibility for the care of all service users (whether publicly funded or not) and the provider bears none of the responsibility. In this arrangement, there is no penalty for risky financial behaviour. Although profit margins in the sector are narrow, the potential for making money through refinancing make it an attractive prospect for hedge funds, property investors and private equity

funds (see, for example, Centre for Health and the Public Interest, 2016; Horton, 2017).

The inadequacies of these regulatory arrangements were laid bare in April 2019 when another large provider, Four Seasons, suffered a similar fate. Again, the company, which had been refinanced a number of times and taken on substantial debt, became unviable (House of Commons Library, 2019). The operating models that these types of companies opt for are highly sensitive to slight changes in the property market, in interest rates, in local authority fees, in occupancy rates and in other contextual factors such as changes in the national minimum wage (Institute of Public Care, 2016). Before the collapse of Four Seasons, CQC data revealed that quality had declined, which suggests that poor financial management and quality are related. While the CQC regime meant that the regulator could identify indicators of financial troubles (such as a decline in quality), it did not enable it to take any preventative action (Institute of Public Care, 2016).

In the cases of both Southern Cross and Four Seasons, few homes were actually closed as the companies were broken and sold on to new buyers, but the instability created significant anxiety among local authorities and residents of the care homes and their families. The operating model that underpins these large debt-laden companies is felt to be unsustainable and extremely vulnerable to minor shocks in the market (Whitfield, 2012). However, another example of provider failure suggests that it is not only poor financial management that can be at fault but also a focus on financial health at the expense of quality of care – the collapse of Castlebeck (a provider of care to people with learning disabilities) in 2013 was principally due to care failings, not financial management (Institute of Public Care, 2014).

While much attention has been paid to the instability of large debt-laden entities, there are also risks associated with the opposite end of the spectrum – the very small, often family-run care homes. The issue has not been well explored in England but, in Wales, it has been observed that many small care home owners sell their properties to developers upon reaching retirement. More often than not, they are not replaced by similar providers (Public Policy Institute for Wales, 2015). Given that the majority of care home provision is via small and medium-sized businesses, there is a real risk of considerable disruption if the value of the property outstrips the value of the business. The

Competition and Markets Authority (2017a) has noted that providers that are part of chains, which may have reserves, or may have the ability to cross-subsidise between sites, may be more robust than small, single-site providers ('microbusinesses').

Workforce pressures contribute to provider instability

Pressures in the workforce are a major problem for providers and play a key role in the instability of the market. The social care sector experiences a high staff turnover rate and there are an estimated 112,000 vacancies at any one time (Skills for Care, 2020a). Among other things, this is due to unacceptably low pay rates, status and working conditions (Hemmings, 2020), as well as limited opportunities for training and career progression (Oung, 2020), and a lack of unified worker representation (Horton, 2017). Beyond this, the lack of autonomy afforded to carers due to the time-and-task commissioning of services has resulted in low job satisfaction and a reduction of care to the 'functional' rather than the person-centred care the Care Act 2014 strives for (Bottery and others, 2018).

The undersupply of the social care workforce means that providers need to continually hire new staff, frequently rely on expensive agency staff, and have little incentive to invest in training (Bode and others, 2011; Centre for Health and the Public Interest, 2019; Henderson and others, 2018). Providers face the risk of understaffing, with implications for safety and quality (although, as there is no strict staff:service user ratio set in England, it is difficult to assess the full extent of this). Of particular concern is the undersupply of specialised professionals, such as associate, learning disability or care home nurses, essential to delivering specialised care (Centre for Health and the Public Interest, 2016; National Audit Office, 2018).

The lack of significant pay differential between frontline workers and managerial roles is becoming an increasing problem – many senior staff are paid only 12 pence an hour more than relative newcomers but carry greater responsibility. This is resulting in a shortage of more experienced staff, in particular registered managers – the presence of whom is known to be a key

factor in determining quality (Skills for Care, 2020a). There is evidence that this issue is growing: the most recent Skills for Care workforce report finds that the turnover rate of registered managers is increasing (albeit at a slower rate than previous years). Stakeholders worried that managerial roles in social care are not sufficiently attractive, resulting in high vacancy rates (12% for registered managers). Increasingly fewer senior managers have long-term experience of work in the social care sector, with implications for quality (Skills for Care, 2020a).

Low council fee rates and narrow margins in some sections of the market (for more on this, see the section on funding) mean that small shifts in the market in terms of staff have big implications for providers. It is important to note that margins are highly varied in this diverse market but the National Audit Office (2021) reports that, before the Covid-19 pandemic, 55% of large care home providers and 39% of domiciliary care providers made a return on investment of under 5%. There is also wide variation in the proportion of spend on personnel costs between different providers and, as a people-intensive sector, small changes in the workforce can have major implications. For example, the introduction of the National Living Wage without adequate funding increases made care delivery unsustainable for providers who were already operating at tight margins – especially in more deprived areas; see, for example, Centre for Health and the Public Interest, 2016; Hall and others, 2017; UK Homecare Association, 2018. Similarly, stakeholders reflected to us that changes to local employment structures, such as a growth in similarly paid hospitality roles, can also have a significant impact on the ability of providers to recruit and retain staff. The National Audit Office (2021) found that local authorities are generally reluctant to challenge providers on their workforce practices and plans because they recognise that lower fees are a 'trade-off'.

Some stakeholders referred to different types of provider and how this affected workforce support. Some suggested that not-for-profits may reinvest more of their returns into pay (see, for example, Centre for Health and the Public Interest, 2016; 2019; Naylor and Magnusson, 2019), but stressed that regardless of ownership, the higher the reinvestment into the workforce, the more positive the impacts on turnover and business returns. Providers with higher CQC ratings experience lower turnover, and those with the most training and development opportunities have the best retention of staff (Skills for Care, 2020a). Other stakeholders we spoke to noted that small and medium-sized

companies often put great care and effort into supporting workers to stay within their organisation – but feel the impact of large-scale national policies more greatly.

The Covid-19 crisis has underlined how crucial social care staff are and exposed the consequences of the fragility of the workforce – care workers working across multiple locations were identified as a key source of infection spread; and low wages and zero-hours contracts meant many could not afford to self-isolate (Comas-Herrera and others, 2020). This has led to calls for parity of pay with health (House of Commons Health Select Committee, 2020). While the moral case for better pay is indisputable, careful thought needs to be given to how this can be implemented in a way that does not further destabilise providers. Consideration will also need to be given to the mechanisms to make pay increases a reality. As the majority of providers are in the independent sector, the structured pay scales and negotiations that exist in the NHS are lacking. Calls to introduce registration and regulation of the workforce, as already being rolled out in Wales, Scotland and Northern Ireland, are also gathering pace in the wake of the pandemic. However, experience from the other UK countries shows the importance of considering the potential unintended consequences of compulsory registration on workforce retention – it cannot alone improve conditions and pay, and needs to be considered alongside a more comprehensive reform plan for the workforce (Oung, 2020).

The system has few proactive drivers of improvement

There are a number of features that are known to influence the quality of a provider's service. These include the presence of a registered and experienced manager, the balance of self-funded and council-funded service users, size (particularly in the care home sector) and ownership.

High quality has been linked with high rates of self-funding individuals, while providers with a majority of state-funded service users, especially where fees paid by the local authority are low, are more likely to receive poorer-quality ratings (Horton, 2017; Hall and others, 2017). Furthermore, there is some evidence that not-for-profit services tend to have higher quality ratings than

their for-profit counterparts (Barron and West, 2017; Centre for Health and the Public Interest, 2016; Horton, 2017; Naylor and Magnusson, 2019).

Analysis also suggests that providers over a certain size (for example, care homes with more than 100 beds) struggle to maintain high-quality services (Naylor and Magnusson, 2019). Over the past decade, there has been a growth in large (over 45 beds) care homes and a drop in smaller homes (Naylor and Magnusson, 2019). Analysis of CQC data indicates that of the 2,444 care homes that closed between 2010 and 2015, 59% were small (Roberts and Bernard, 2017). While large chains might benefit from economies of scale and therefore be more stable, this advantage can be diminished by the requirement to adapt to the different contractual arrangements in each of the various councils they work with, with limited reinvestment into local service delivery and workforce development (for example, Centre for Health and the Public Interest, 2019; Horton, 2017).

The features described here are reasonably well evidenced and can help account for variations in quality across providers. However, incentives and rewards for active quality improvement are few. While the regulator, the CQC, holds a central role in assessing quality of service, communicating this information and highlighting good practice, it is notable that there has been little improvement among low performers over time. The most recent *State of Health Care and Adult Social Care in England* report – covering 2019/20 – finds limited change year on year in quality ratings, especially among areas of concern: 3% of care homes and 3% of community settings have only ever received a rating of 'requires improvement' (Care Quality Commission, 2020a). The report also highlights that in these settings positive change is often not sustained, with a further 8% of care homes and 5% of community care settings falling back to 'inadequate' or 'requires improvement' categories after achieving a 'good' or 'outstanding' rating. One stakeholder commented that the regulatory regime "looks only at symptoms, not the causes", with a key query around what to do next for "the tail of providers who required improvements and bumble along in that category for a number of years". With the regulatory regime largely focused on a snapshot in time, commissioning practices heavily transactional and the market forces of choice and competition relatively weak in a lot of the market, quality improvement relies largely on the motivation of front-line staff and providers, and their financial and organisational capacity. There was a high level of consensus among

stakeholders that there could be value in the CQC having a greater role in proactive service improvement, alongside its role in regulation.

Stakeholders commented that inspections have improved in the past 20 years through a transition towards a more collaborative and co-produced model. However, some felt that inspections were sometimes limited by the lack of good-quality data around provider capacity, and failures of access. Others also highlighted the administrative burden of 'post hoc' quality inspections on small and medium-sized providers, with their limited ability or capacity to collect evidence of good practice in their service. Stakeholders were hopeful that the CQC's new 2021 Strategy (the results of the consultation on this are awaited at the time of writing) could go some way to addressing these issues.

It should also be noted that, at present, while providers are subject to a regulatory regime, there is no equivalent assurance framework for commissioners of care. This is in contrast to other nations of the UK where the local authority commissioning function is also inspected according to the wellbeing principles of their legislation (Oung and others, 2020). New proposals for the CQC to extend its remit to local authority assurance are discussed in the section on 'a lack of prioritisation for social care at the centre of government' in this chapter.

The regulator lacks capacity and powers for proactive market management

The Care Act 2014 introduced new duties for the CQC to monitor the financial health of large providers. This market oversight scheme is intended only to oversee and monitor the financial health of so-called 'difficult to replace' providers and to give local authorities advance warning of likely failure so that they can ensure continuity of care (Care Quality Commission, 2020b). The scheme is not intended to intervene or to prevent that failure, although proposals featured in the original consultation designated more interventionist powers for the regulator (Horton, 2017). The National Audit Office (2021) states that local authorities do not benefit from the CQC's monitoring until they are notified that a provider is likely to fail, to enable them, as noted above, to put in place contingency plans to ensure continuity

of care. The Health Select Committee questioned at the time whether it was appropriate to hand the financial oversight regime to the CQC (the quality regulator) as opposed to Monitor (the financial regulator, now disbanded). The CQC's then chair and chief executive, however, emphasised the close correlation between poor quality and poor financial performance (House of Commons Health Committee 2014).

While having a single regulator of health and social care provision may have benefits, the limited powers afforded to the regulator with regard to social care providers' financial health led many stakeholders to describe the CQC as a "spectator at the site of a car crash": identifying providers at risk of failure but without the ability to take any decisive action to support them or remove them from the market (see the ownership section for more on provider failure). Commentators flagged this risk ahead of the introduction of the new financial oversight regime in 2014: 'government and regulation tend to deal with the crisis that has passed rather than the crisis to come' (Institute of Public Care, 2014).

Resourcing is also an issue. Complex ownership structures among some large providers can mean that their financial position is not always easy to discern (Centre for Health and the Public Interest, 2019; Horton, 2017; Institute of Public Care, 2014) and so to do so requires substantial resources. The National Audit Office (2021) notes that five of the large equity-backed providers had to be excluded from its analysis because their accounts could not be accessed. Around 65 of the largest providers, accounting for approximately 30% of all provision, fall into the category of 'difficult to replace', which means that the financial health of the majority of providers is not monitored. A report by the Institute of Public Care (2014), commissioned by the CQC to consider the new financial oversight regime in 2014, emphasised the need for the CQC to maintain an overview of shifts and trends in the sector (that is, to keep track of the wider market beyond just the large providers) in order to consider the implications for any provider failing. It remarked that formal published financial metrics would need to be supplemented with wider market intelligence. However, as it stands currently, the CQC lacks the capacity to extend its financial oversight regime to a wider pool of providers and, without a ready source of data, to do so would be a significant undertaking.

The government's recent White Paper on integrated services (Department of Health and Social Care, 2021) proposes new duties for the CQC to oversee local authority commissioning but does not seek to extend or develop its powers of oversight over the financial health of providers. The CQC is also currently reviewing its strategy from 2021, which proposes a more local- rather than service-focused approach to inspection and a 'smarter' approach to regulation (Care Quality Commission, 2021a).

Social care has suffered from a lack of prioritisation at the centre of government

The Covid-19 crisis has highlighted the consequences of a sustained lack of prioritisation of social care, and limited knowledge of the provider market in particular, within the Department of Health and Social Care and across government. The invisibility of social care in the initial response to the crisis, in contrast to the NHS response, was notable. The small social care team of around 40, led by a director, lacked the capacity to deal with the scale of the crisis. There had been no director general with sole responsibility for social care since 2016 and one was not appointed until June 2020. There was no social care voice at the table when some key decisions were being made about the response to the pandemic – this was evident, for example, in the very hospital-centric response, which paid little heed to the ability of the social care provider market to cope with the policy of the rapid discharge of patients from hospital.

Although capacity at the centre of government was boosted as the pandemic progressed, the staff that were drawn in from across the civil service inevitably lacked detailed operational knowledge of the complex social care sector. A chief nurse for social care was appointed but not until December 2020 and only on a six-month interim basis (Department of Health and Social Care, 2020). Providers reported that they struggled to interpret some of the guidance in the early months of the pandemic. The approach to personal protective equipment (PPE) and testing was framed around an understanding of the NHS, its structures and language, which meant little in a social care context. Stakeholders mentioned examples including the term 'sessions' with regard to PPE, and guidance for staff testing, which failed to understand how the sector

operated. Many people we spoke to saw the creation of the social care sector covid-19 support taskforce and closer working with those in the provider sector during the summer and autumn of 2020 as a positive development.

Another issue that the Covid-19 pandemic has made clear, which has implications for the provider market, is the complex accountability within the sector. While accountability for social care ultimately rests with the secretary of state for health and social care, local government is responsible for commissioning and organising care delivery via upwards of 14,000 different and varied organisations. Money flows through the Ministry of Housing, Communities and Local Government and providers are regulated by the CQC. Stakeholders reflected that the split of accountability between local and national government, without clarity as to where responsibility lay, slowed down the response to the pandemic. The paucity of reliable data in this area, as discussed earlier, became a severe impediment at both local and national levels in coordinating the response.

Legislative proposals in the government's recent White Paper (Department of Health and Social Care, 2021) seek to establish greater central powers and oversight but have been met with a mixed reaction. If passed, the plans would see a new duty for the CQC to assess local authorities' delivery of duties as set out in the Care Act 2014, with the secretary of state for health and social care holding powers of intervention should a local authority be deemed to be failing to meet its duties. Concern has been raised that the new regime risks punishing local authorities for failing to meet duties they lack the resources to fully fulfil. The Local Government Association (2021) has called on the government to ensure that any assessment of a council's performance should be 'contextualised in terms of available resources' and has also urged any new assurance process to build on existing mechanisms of democratic accountability. Similarly, responses to proposals to establish greater central powers for giving direct payments to providers in the event of an emergency have been mixed. Concern has been raised that, if used routinely, such a mechanism could undermine local government and its efforts to shape the market. Perhaps options for clearer accountability, which recognise the important role of localities and the existing mechanisms of democratic accountability, rather than more centralised accountability, should be explored.

4 Ten priorities for reform

Social care in England is in urgent need of fundamental reform. The past decade of austerity, coupled with rising demand for care, has seen an already struggling system further destabilised. Social care is a system that has come to rely on one-off ad-hoc injections of money to prop it up for short periods of time. Unlike its sister service, the NHS, there is no long-term plan for social care or its workforce and no certainty for those who rely on it, organise or provide services, or work in the sector. The Covid-19 crisis has highlighted not just how fragile the sector is but also how crucial it is within the wider network of public services. In this report, while we have not been able to explore all the complex interfaces between social care and the NHS, housing services, other wider communities and benefits policies, what the Covid-19 pandemic has made clear is that the failure to reform the unstable social care system continues to have far-reaching consequences across public services and society.

As the country begins to emerge from the pandemic, there is an opportunity to build on the high levels of public and political support for change and to put the social care system on a sustainable footing for the future. Crucially, plans for reform must go beyond funding and also seek to address the myriad issues that plague the delivery of, and access to, services. The care provider market is one of the pieces of this puzzle that warrants particular attention. It is clear that the English care provider market suffers from some deep structural issues, the complexity of which should not be underestimated. This report has touched on many areas but there are many more that require further exploration. What was most striking about undertaking this work was that, although we spoke to a wide range of stakeholders, no one felt that the market was operating effectively at present. And there was broad consensus that addressing the funding challenge is important but not the sole solution to the range of problems within the market.

Reform to the market(s) will need to tackle a number of different complex, and interrelated, domains. These domains stretch across the system, from commissioner to provider and from local to national government. The vastness

of the provider landscape requires a highly nuanced understanding of its diversity as it is unlikely that a blanket approach to all parts of the market will suffice. A solution to the issue of high-risk behaviours among private equity-backed care home providers, for instance, is likely to look quite different from a solution to the issue of high rates of retirement among owners of small and medium-sized care homes. Likewise, an approach that works in stabilising the residential care market for older people is unlikely to be the same as that for working-age adults or domiciliary care.

But perhaps the starting point in all these discussions needs to be: What is the social care market for and what is it trying to achieve? Do we, as a society, want a social care system that delivers a safety net of life-and-limb care, or do we want to strive for a broader vision that is framed around promoting independence and prevention? The Care Act 2014 set out a vision more akin to the latter and support for such a vision has since been reiterated and developed among people who draw on care services (Social Care Future, 2020). This will inevitably prompt further questions about whether the market, as has (largely by accident) emerged, can be 'fixed' and sufficiently developed, or whether a fundamentally different approach is needed.

An important consideration in all of this will be how the Covid-19 pandemic has impacted not only on the resilience of the provider sector but also on attitudes to care. Concern has been raised that many providers have survived the crisis due to the extra government support provided and that, once that is withdrawn, widespread provider closures will be witnessed. Many providers have faced great pressures from the increased costs of PPE, staff isolating and extra cleaning, at the same time as (in the residential sector) reduced occupancy (Social Care Institute for Excellence, 2021). It is also likely that the pandemic will have hastened trends that were already emerging around changing demand and preferences. In pre-Covid times, there were some indications that demand for residential care was falling as people opted for more home care that enabled them to retain more independence. Fears over infection spread and restrictions on visiting, as witnessed during the pandemic, may hasten that shift away from congregate settings as the dominant model of provision (Carter 2020). While other models of innovative provision have emerged over the years (for example, Shared Lives Plus), their scale and spread have been slow. Part of the thinking about the future of the social care sector should be how new and innovative approaches to care that

better meet people's changing expectations and preferences can be supported to grow. The role of technology in how services are delivered will also need to be factored in.

The answer to questions of vision and demand will help to guide the development of solutions to the more structural and mechanistic issues in the social care sector. As plans are put in place for greater integration between health and social care through integrated care systems, and the NHS moves more sharply away from its own internal market structures, discussions about social care and how its provider market will operate within this new context need to take place with some urgency. If the Covid-19 pandemic has demonstrated anything, it is how interdependent health and social care are and that true integration will depend on both systems being on a firm footing.

Key questions for policy

Based on the research we have set out in this report, we now outline 10 priorities for policy-makers to consider as they develop the social care proposals that have been promised 'this year' (Department of Health and Social Care 2021 p7) (see Box 1). Of course, choices around some of these domains will be contingent upon decisions made in other parts of the system and, indeed, upon some of the broader questions we raise above. Choices around funding, for instance, will have implications for how (and how much) money flows through the system, how it is raised and the balance of responsibility between the state, local and national government and individuals. Similarly, the approach to eligibility and the allocation of funding to individuals will necessarily affect how providers are paid and which bodies are involved in negotiating or setting payment levels. This underlines the importance of having a comprehensive strategy for social care that ensures alignment across the entire system.

Box 1 is intended as a series of prompts to generate further exploration and consideration of what we consider to be essential issues that will need to be addressed if the provider market is to be put on a firm and sustainable footing.

Box 1: Key policy domains and questions

1. **Choice and voice**. What measures can be taken to strengthen the voice of service users and to support them in making choices, underpinned by transparent and widely available information?
2. **Driving innovation**. How can innovative care models be supported to develop and spread to more effectively meet the needs and preferences of current and future care users? How can they be embedded within a wider context of integrated care systems and with other areas of policy (such as housing, benefits and communities)?
3. **Quality and standards**. How can stronger mechanisms be built into the system for driving quality improvement?
4. **Regulation and improvement**. Can the regulatory regime be reoriented to ensure it is improvement-led and better able to respond pre-emptively when a provider is showing signs of financial vulnerability or a deterioration in service quality?
5. **Funding and provider payment**. What approach to funding, pricing and provider payment would offer stability and certainty to providers while also delivering fairness, efficiency, innovation and local flexibility?
6. **Market shaping and effective commissioning**. How can the market-shaping role of local authorities be bolstered? What support can be built into the system to help promote effective and consistent commissioning processes?
7. **Market rules**. Could and should there be stricter rules about entry into, and behaviour within, the market to limit exposure to risk?
8. **Information and data**. How can better and more frequent data for use by local authorities, national bodies and providers themselves be collected to help better understand and shape the market without overburdening providers?
9. **Workforce**. What steps need to be taken to ensure the long-term stability of the care workforce?
10. **Accountability and prioritisation**. How can greater clarity of accountability be defined between providers, local authorities and the different branches of central government and national arm's-length bodies to better ensure the smooth running of the sector through challenging times? What further steps need to be taken to ensure that social care is given adequate weight and resources in national policy-making?

What next?

Having identified, at a high level, the problems within the market, the next phase of this work will seek to explore potential solutions within the 10 priority areas listed in Box 1 – how they might work in an English context and at what level (central, regional or local) they are best implemented. In order to do so, we will be identifying ideas and learning from home and abroad – drawing on innovative approaches within England and seeking new thinking and different ideas from the four countries of the UK and beyond. Our approach will involve engaging with the people who use, deliver, organise and commission care services in order to test out a range of solutions and how they might apply to England.

In our previous work on care reform in Germany and Japan (Curry and others, 2018; 2019), it is notable that developing and extending the provider market was a central element of planning in these countries. On embarking on their reforms, both countries sought to establish and develop mixed markets of provision, which offer choice to individuals and stability to providers. While they have experienced challenges and there have been unintended consequences, both have largely succeeded in creating buoyant and competitive markets with stable providers and adequate supply. Similarly, our work comparing the care systems of the four UK countries and their plans for the future has revealed some interesting differences in the structure and rules around the care provider markets that could offer England ideas and learning (Oung and others 2020).

For too long, social care reform has been put in the 'too difficult' box, repeatedly kicked into the long grass or ignored entirely. The Covid-19 pandemic has demonstrated the consequences of that deferral and shone a light on just how far the issues extend. It is imperative that the current government takes urgent action and is careful not to make the mistakes of previous administrations by focusing solely on funding. We need a vision for the whole system and a strategy for achieving that. Only by taking a comprehensive approach will we be able to build a system that is stable, sustainable and resilient in the face of future pressures.

References

Age UK (2020) *Factsheet 24: Personal budgets and direct payments in social care*. Age UK. www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs24_personal_budgets_and_direct_payments_in_social_care_fcs.pdf.

Association of Directors of Adult Social Services (2019) *Responsive and Sustainable Markets in Adult Social Care: The role of the commissioner*. ADASS. www.adass.org.uk/media/7286/2019-06-18-overview-of-the-social-care-market-briefing.pdf.

Barron D and West E (2017) 'The quasi-market for adult residential care in the UK: do for-profit, not-for-profit or public sector residential care and nursing homes provide better quality care?', *Social Science & Medicine* 179, 137–46.

Baxter K 'The personalisation and marketisation of home care services for older people in England' in Christensen K and Pilling D (2018) *The Routledge Handbook of Social Care Around the World*. Routledge.

Baxter K and Glendinning C (2015) *People who Fund their Own Social Care*. Scoping Review. NIHR School for Social Care Research.

Baxter K, Heavey E and Birks Y (2020) 'Choice and control in social care: experiences of older self-funders in England', *Social Policy & Administration* 54, 460–74.

Birrell I (2020) *Old Money*. Tortoise.

Blakeley G and Quilter-Pinner H (2019) *Who Cares? The financialisation of adult social care*. Institute for Public Policy Research. www.ippr.org/files/2019-09/who-cares-financialisation-in-social-care-2-.pdf.

Bode I, Gardin L and Nyssens M (2011) 'Quasi-marketisation in domiciliary care: varied patterns, similar problems?', *International Journal of Sociology and Policy* 31(3/4), 222–35.

Bottery S and Babalola G (2020) *Social Care 360*. The King's Fund. www.kingsfund.org.uk/publications/social-care-360. Accessed 31 March 2021.

Bottery S, Ward D, Fenney D (2019). Social care 360. The King's Fund. www.kingsfund.org.uk/sites/default/files/2019-05/social-care-360-pdf.pdf?utm_source=website&utm_medium=social&utm_term=thekingsfund&utm_content=pdfreport&utm_campaign=socialcare360

Bottery S, Jefferson L, Bennett L, Hall P, Cream J, Dale V, Honeyman M, Birks Y, Bloor K and Murray R (2018) *Home Care in England: Views from commissioners and providers*. The King's Fund. www.kingsfund.org.uk/sites/default/files/2018-12/Home-care-in-England-report.pdf.

Burns D, Cowie L, Earle J, Folkman P, Froud J, Hyde P, Johal S, Jones IR, Killet A and Williams K (2016) *Where Does the Money Go? Financialised chains and the crisis in residential care*. Centre for Research on Socio-Cultural Change. https://hummedia.manchester.ac.uk/institutes/cresc/research/WDTMG%20FINAL%20-01-3-2016.pdf.

Care Quality Commission (2017) *The State of Health Care and Adult Social Care in England 2017/18*. Care Quality Commission. www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf.

Care Quality Commission (2019) *The State of Health Care and Adult Social Care in England 2018/19*. Care Quality Commission. www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf.

Care Quality Commission (2020a) *The State of Health Care and Adult Social Care in England 2019/20*. Care Quality Commission. www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf.

Care Quality Commission (2020b) *Draft: Market oversight of 'difficult to replace' providers of adult social care: Guidance for providers*. Care Quality Commission. www.cqc.org.uk/sites/default/files/20200820_Draft_Market_Oversight_Guidance_for_providers_0.pdf.

Care Quality Commission (2021a). The world of health and social care is changing. So are we. Consultation on CQC's new strategy. www.cqc.org.uk/get-involved/consultations/world-health-social-care-changing-so-are-we. Accessed 7 April 2021.

Care Quality Commission (2021b). 'Using CQC data': care directory with filters (01 March 2021). www.cqc.org.uk/about-us/transparency/using-cqc-data#directory. Accessed 30 March 2021. Data archive available https://drive.google.com/drive/folders/1Y6V6r-q2l4lJYKuZL0DXw25VDUTH6L4N. Accessed 07 April 2021.

Carter C (2020) Extra £1.7 billion for social care needed this winter to tackle shift away from care homes, warns ADASS www.communitycare.co.uk/2020/11/09/extra-1-7bn-social-care-needed-winter-d-tackle-shift-away-care-homes-warns-adass. Accessed 07 April 2021.

Centre for Health and the Public Interest (2016) *The Failure of Privatised Adult Social Care in England: What is to be done?* Centre for Health and the Public Interest. https://chpi.org.uk/wp-content/uploads/2016/11/CHPI-SocialCare-Oct16-Proof01a.pdf.

Centre for Health and the Public Interest (2019) *Plugging the Leaks in the UK Care Home Industry: Strategies for resolving the care home crisis in the residential and nursing care home sector*. Centre for Health and the Public Interest. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf.

Comas-Herrera A, Glanz A, Curry N, Deeny S, Hatton C, Hemmings N, Humphries R, Lorenz-Dant K, Oung C, Rajan S and Suarez-Gonzalez A (2020) *The COVID-19 Long-Term Care Situation in England*. International Long-Term Care Policy Network. https://ltccovid.org/wp-content/uploads/2020/11/COVID-19-Long-Term-Care-situation-in-England-19-November-2.pdf.

Competition and Markets Authority (2017a) *Care Homes Market Study: Final report*. Competition and Markets Authority. https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf.

Competition and Markets Authority (2017b) *Care Homes Market Study: Final report: Appendices and glossary*. Competition and Markets Authority. https://assets.publishing.service.gov.uk/media/5a32947be5274a1fee16bb9b/appendices-and-glossary-care-homes-market-study-final-report.pdf.

Curry N, Castle-Clarke S and Hemmings N (2018) *What Can We Learn from the Long-Term Care System in Japan?* Nuffield Trust. www.nuffieldtrust.org.uk/files/2018-06/learning-from-japan-final.pdf.

Curry N, Schlepper N and Hemmings N (2019) *What Can We Learn from the Long-Term Care System in Germany?* Nuffield Trust. www.nuffieldtrust.org.uk/files/2019-12/ltci-germany-br1924-6-web.pdf.

Davies R (2018) 'Profit-hungry firms are gambling on social care. Are the stakes too high?', *The Guardian*, 28 February. www.theguardian.com/society/2018/feb/28/profit-hungry-firms-gambling-care-homes-stakes-too-high. Accessed 31 March 2021.

Department of Health and Social Care (2020) 'Chief nurse for adult social care to provide clinical leadership during winter', press release, 7 December. www.gov.uk/government/news/chief-nurse-for-adult-social-care-to-provide-clinical-leadership-during-winter. Accessed 30 March 2021.

Department of Health and Social Care (2021) *Integration and Innovation: Working together to improve health and social care for all*. The Stationery Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf.

Eichler W (2019) 'Around 25% of local government jobs "slashed" due to austerity', LocalGov, 21 June. www.localgov.co.uk/Around-25-of-local-government-jobs-slashed-due-to-austerity/47647#:~:text=New%20data%20from%20Unison%20has,This%20is%20a%2025%25%20drop. Accessed 30 March 2021.

Forder J, Caiels J, Harlock J, Wistow G, Malisauskaite F, Peters M, Marczal J, D'Amico F, Fernandex JL, Fitzpatrick R and Jones K (2018) *A System-Level Evaluation of the Better Care Fund: Final report*. Quality and Outcomes of Person-Centred Care Policy Research Unit. www.pssru.ac.uk/pub/5424.pdf.

Grant Thornton (2018) *Care Homes for the Elderly: Where are we now?* Grant Thornton. www.grantthornton.co.uk/globalassets/1.-member-firms/united-kingdom/pdf/documents/care-homes-for-the-elderly-where-are-we-now.pdf.

Hall P, Jefferson L, Dale V, Bennett L, Birks Y, Bloor K and Murray R (2017) *Understanding Domiciliary Care in England*. The King's Fund and University of York. www.york.ac.uk/media/healthsciences/images/research/prepare/UnderstandingDomiciliaryCareInEngland.pdf.

Ham, C (2009). 'Health Policy under Thatcher and Major', in *Health Policy in Britain*. London: palgrave macmillan (6th ed), 31-49.

Harris T, Hodge L, Phillips D (2019). English local government funding: trends and challenges in 2019 and beyond. Institute for Fiscal Studies. www.ifs.org.uk/uploads/English-local-government-funding-trends-and-challenges-in-2019-and-beyond-IFS-Report-166.pdf.

Hemmings N (2020) 'A public policy blind spot? The possible futures of the social care workforce', Nuffield Trust blog, 4 February. www.nuffieldtrust.org.uk/news-item/a-public-policy-blind-spot-the-possible-futures-of-the-social-care-workforce#a-sector-specific-scheme. Accessed 30 March 2021.

Henderson F, Reilly C, Moyes D and Whittam G (2018) 'From charity to social enterprise: the marketization of social care', *International Journal of Entrepreneurial Behavior and Research* 24(3), 651–66.

HM Government (1990) *National Health Service and Community Care Act 1990*. HM Government. www.legislation.gov.uk/ukpga/1990/19/contents. Accessed 31 March 2021.

HM Government (2014) *Care Act 2014*. HM Government. www.legislation.gov.uk/ukpga/2014/23/contents/enacted. Accessed 31 March 2021.

Horton A (2017) 'Financialisation of care: investment and organising in the UK and US'. PhD thesis. Queen Mary University of London. https://qmro.qmul.ac.uk/xmlui/bitstream/handle/123456789/31797/HORTON_Amy_PhD_Final_281117.pdf?sequence=1. Accessed 30 March 2021.

Horton A (2020) Liquid home? Financialisation of the built environment in the UK's "hotel-style" care homes. Transactions of the Institute of British Geographers, vol 46(1), pp179-192 https://rgs-ibg.onlinelibrary.wiley.com/doi/10.1111/tran.12410, Accessed 7 April 2021.

House of Commons Health and Social Care Committee (2020) *Social Care: Funding and workforce*. House of Commons. https://committees.parliament.uk/publications/3120/documents/29193/default. Accessed 31 March 2021.

House of Commons Health Committee (2014) 2013 accountability hearing with the Care Quality Commission. Sixth Report of Session 2013-14. https://publications.parliament.uk/pa/cm201314/cmselect/cmhealth/761/761.pdf. Accessed on 7 April 2021.

House of Commons Library (2019) Four Seasons Health Care Group – financial difficulties and safeguards for clients. https://commonslibrary.parliament.uk/research-briefings/cbp-8004. Accessed 7 April 2021.

Humphries R, Thorlby R, Holder H, Hall P and Charles A (2016) *Social Care for Older People: Home truths*. The King's Fund and Nuffield Trust. www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf.

Humphries R and Timmins N (2021) *Stories from Social Care Leadership: Progress amid pestilence and penury*. The King's Fund. www.kingsfund.org.uk/publications/social-care-leadership. Accessed 31 March 2021.

Incisive Health (2019) *Care Deserts: The impact of a dysfunctional market in adult social care provision*. Incisive Health. www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/care-deserts---age-uk-report.pdf.

Independent Age (2016) *Information and Advice since the Care Act – How are Councils Performing?* Independent Age. https://independent-age-assets.s3.eu-west-1.amazonaws.com/s3fs-public/2016-05/Care%20Act%20Information%20and%20Advice%20Research%20Report.pdf.

Institute of Public Care (2014) *Care Quality Commission: The stability of the care market and market oversight in England*. Institute of Public Care. www.cqc.org.uk/sites/default/files/201402-market-stability-report.pdf.

Institute of Public Care (2016) *Market Shaping Review: Place-based market shaping: Co-ordinating health and social care*. Institute of Public Care. https://ipc.brookes.ac.uk/docs/market-shaping/Place-based%20Market%20Shaping%20-%20co-ordinating%20health%20and%20social%20care.pdf.

Johnson B (2019) 'Boris Johnson's first speech as Prime Minister: 24 July 2019'. www.gov.uk/government/speeches/boris-johnsons-first-speech-as-prime-minister-24-july-2019. Accessed 31 March 2021.

Kotecha V (2019) Plugging the leaks in the UK care home industry: strategies for resolving the financial crisis in the residential and nursing home sector. Centre for Health and the Public Interest. https://chpi.org.uk/wp-content/uploads/2019/11/CHPI-PluggingTheLeaks-Nov19-FINAL.pdf. Accessed 7 April 2021.

Laing W (2020) '32,000 older care home residents in England have died from Covid-19 and collateral damage by June 2020 – cutting occupancy by 13%'. www.laingbuisson.com/wp-content/uploads/2020/07/Covid-story_v5.pdf.

Lister J (2020) 'The History of Privatisation – the second in a series by John Lister', The Lowdown, 16 March. https://lowdownnhs.info/analysis/long-read/the-history-of-privatisation-second-in-a-series-by-john-lister. Accessed 7 April 2021.

Local Government Association (2017) *Health and Wellbeing in Rural Areas*. Local Government Association. www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf.

Local Government Association (2021) LGA briefing: Health and Social Care Bill White Paper. www.local.gov.uk/parliament/briefings-and-responses/lga-briefing-health-and-social-care-bill-white-paper. Accessed 7 April 2021.

National Audit Office (2018) *Adult Social Care at a Glance*, London: National Audit Office. www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf.

National Audit Office (2021) *The Adult Social Care Market in England*. National Audit Office. www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf.

Naylor AM and Magnusson J (2019) *Data that Cares*. Future Care Capital. https://futurecarecapital.org.uk/research/data-that-cares. Accessed 31 March 2021.

Needham C, Allen K, Burn E, Hall K, Mangan C, Al-Janabi H, Tahir W, Carr S, Glasby J, Henwood M, McKay S and Brant I (2020) *Shifting Shapes: How can local care markets support personalised outcomes?* Health Services Management Centre, University of Birmingham. www.birmingham.ac.uk/documents/college-social-sciences/social-policy/publications/shifting-shapes.pdf.

Needham C, Hall K, Allen K, Burn E, Mangan C and Henwood M (2018) *Market-Shaping and Personalisation: A realist review of the literature*. Health Services Management Centre, University of Birmingham. www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/research/market-shaping-and-personalisation-social-care.pdf.

NHS Digital (2020a) *Adult Social Care Activity and Finance Report, England 2019-20*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20/2.-requests-for-support. Accessed 31 March 2021.

NHS Digital (2020b) *Measures from the Adult Social Care Outcomes Framework*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof. Accessed 30 March 2021.

Oung C (2020) 'Supporting those who deliver social care: what can England learn from the rest of the UK?', Nuffield Trust blog, 15 April. www.nuffieldtrust.org.uk/news-item/supporting-those-who-deliver-social-care-what-can-england-learn-from-the-rest-of-the-uk#caring-for-the-people-doing-the-caring. Accessed 30 March 2021.

Oung C, Curry N and Schlepper L (2020) 'How much social care does each country fund?', Nuffield Trust blog, 18 March. www.nuffieldtrust.org.uk/news-item/how-much-social-care-does-each-country-fund. Accessed 30 March 2021.

Oung C, Schlepper L and Curry N (2020) *Adult social care in the four countries of the UK*. Article series, Nuffield Trust www.nuffieldtrust.org.uk/comment-series/adult-social-care-in-the-four-countries-of-the-uk. Accessed 30 March 2021.

Public Policy Institute for Wales (2015) *The Care Home Market in Wales: Mapping the sector*. Public Policy Institute for Wales. http://ppiw.org.uk/files/2015/11/The-Care-Home-Market-in-Wales-mapping-the-sector.pdf.

Rabiee P and Glendinning C (2014) 'Choice and control for older people using home care services: how far have council-managed personal budgets helped?', *Quality in Ageing and Older Adults* 15(4), 210–19.

Roberts C and Barnard K (2017) 'Key issues facing the UK residential care home sector: An age old problem?', *DLA piper*, 8 February. www.dlapiper.com/en/

uk/insights/publications/2017/02/an-age-old-problem-the-collapse-of-care-homes. Accessed 07 April 2021.

Scourfield P (2011) 'Caretelization revisited and the lessons of Southern Cross', *Critical Social Policy* 32(1), 137–48.

Shared Lives Plus (2020) 'Latest England figures – resilient Shared Lives should be at the heart of a rebuilt care system'. https://sharedlivesplus.org.uk/resilient-shared-lives-should-be-at-the-heart-of-a-rebuilt-care-system. Accessed 30 March 2021.

Sherlaw-Johnson C, Crellin N, Hutchings R, Oung C, Rolewicz L, Elias L, Kumpunen S, Castle-Clarke S, Cummins L, Fulop N, Doherty P, Harrison A and Scobie S (2021: forthcoming) *Evaluation of the Care City Wave 2 Test Bed: Final report*. Nuffield Trust.

Skills for Care (2020a) *The State of the Adult Social Care Sector and Workforce in England*. Skills for Care. www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf.

Skills for Care (2020b) *Individual Employers and the Personal Assistant Workforce*. Skills for Care. www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Individual-employers-and-the-PA-workforce/Individual-employers-and-the-PA-workforce.pdf.

Slasberg C, Beresford P and Schofield P (2012) 'How self directed support is failing to deliver personal budgets and personalisation', *Research, Policy and Planning* 29(3), 161–77.

Social Care Future (2020) 'Priorities for the comprehensive spending review', Social Care Future blog, 24 November. https://socialcarefuture.blog/2020/11/24/priorities-for-the-comprehensive-spending-review. Accessed 31 March 2021.

Social Care Institute for Excellence (2021) *Challenges and Solutions: Commissioning social care during COVID-19*. Social Care Institute for Excellence. www.scie.org.uk/files/care-providers/coronavirus/guides/commissioning-challenges-and-solutions.pdf.

UK Homecare Association (2018) *The Homecare Deficit 2018: A report on the funding of older people's homecare across the United Kingdom*. UK Homecare Association.

UK Homecare Association (2019) *An Overview of the UK Homecare Market*. UK Homecare Association.

Wachman R (2011) 'Southern Cross's incurably flawed business model let down the vulnerable', *The Guardian*, 16 July. www.theguardian.com/business/2011/jul/16/southern-cross-incurable-sick-business-model.

Whitfield D (2012) *In Place of Austerity: Reconstructing the economy, state and public services*. Spokesman.

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