Helping people make better decisions in the care home market

Final report for the Competition and Markets Authority

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Disclaimer

This report was written for the Competition and Markets Authority. It therefore assumes a relatively high level of knowledge about the care home market and an understanding of behavioural insights. It does not provide a great detail of background relating to the care home market, nor does it explain key concepts in depth. The views expressed in this report are those of the Behavioural Insights Team only.

Executive Summary

1. In July 2017, the Competition and Markets Authority (CMA) commissioned the Behavioural Insights Team (BIT) to consider how to improve decision making in the care home market. The focus of the CMA's commission was on decisions relating to the use of residential and nursing homes by people aged 65 years or older.[1] This report feeds into the wider CMA study into the care home market.

2. This report has two parts. First, we discuss the behavioural barriers to optimal decision making in the care home market. Second, we propose three specific remedies to mitigate these barriers that aim to be low-cost, feasible and high-impact.

3. We define good decisions in the care home market to be those:
   a) Which are made without time pressure or emotional stress;
   b) Which use accurate information about care homes; and
   c) Where the consumer's needs and preferences are known and taken into account.

4. At the highest level we identify two main barriers to good decision making by those choosing care homes:
   a) **Lack of early planning for potential need.** This is true of both financial planning, and for understanding care options and funding before care needs become acute. The lack of planning happens partly because the care system is poorly understood and partly because people do not want to think about a difficult choice that may never need to be made.
   b) **Difficulty of making a complex choice under time pressure and emotional stress.** The process for shortlisting and choosing a care home is complex. This is partly because relevant and accurate information is hard to access. In addition, there is often a sudden trigger event, like a fall, which means that a care home place needs to be found quickly. Many decisions need to be made under time pressure and emotional strain. These will be important decisions that link to wider aspects of a person's life such as their financial situation.

5. We propose three remedies to mitigate these barriers in decision making in the care home market.

6. First, **prompt people before the point of need**. The decision to enter a care home often occurs under time pressure and emotional distress. Accepting that the ability to make well-informed decisions at that point is limited, prompts should be designed to engage people with care home decisions before the

immediate point of need. For instance, when their care needs grow, or when they reach a certain age. This includes prompts to increase awareness of the need to fund care.

7. Second, **create decision support tools**. Government, in partnership with the Voluntary, Community and Social Enterprise (VCSE) sector, should develop decision support tools to help people plan how to meet their care needs early on, and to navigate the complexity of care home decisions at the point of need. The main objective of the decision support tools is to give people a bird's eye view of processes, maximise the accessibility of existing information, and enhance ease of understanding.

8. Third, **improve information on the price, quality and features of care homes, and the ability to compare these features**. Only 14% of care home websites currently provide information about prices and only 3% include terms and conditions.[2] This makes it incredibly time-consuming to compare care homes. Government should mandate that care homes publish up-to-date data for key metrics such as indicative prices and the services they offer. This will improve the way the market works and enable easier comparison between care homes on comparison websites. Government should also ensure better signposting of care home comparison sites (or "shortlist generators"), for instance through the tools discussed in Remedy 2. Finally, government should work with an existing body that runs a shortlist generator to trial behavioural features (e.g. personalised lists, alerts, prompts) with the aim of making it as easy as possible to compare between care homes in order to improve decisions. To test the efficacy and the exact design of the remedies we have given high-level details of how a trial could be developed in each area. Figure 1 summarises the remedies we propose according to their timing in the care home journey and the behavioural barriers they address.

9. The proposed remedies aim to help people plan for care, assess the quality of their care home options and help them make the best decision. However, to be most effective, we recognise these remedies will need to operate within wider market reform. This broader market reform is outside the scope of this report but is being considered by the full CMA market study. Ultimately, though, improved decision-making will strengthen the consumer's voice in the care home market, incentivise care homes to improve quality standards, and ease some of the anxiety faced by individuals and relatives when making one of the more difficult decisions of their lives.

Figure 1: Summary of remedies for improving decisions in the care home market

	Lack of early planning for potential need		Difficulty of choice
Timing	Planning future needs	Approaching point of need	Point of need
Behavioural barriers	• Optimism bias • Discounting • Status-quo bias	• Guilt and anxiety • Omission bias • Availability bias	• Information and choice overload • Satisficing • Availability bias • Hot state decision making • Anxiety
Remedies	• Prompts to increase awareness of care home costs (Remedy 1) • Prompts to increase engagement (Remedy 1)	• Prompts to increase engagement (Remedy 1) • Decision support tool to support early planning (Remedy 2) • Improved information and ability to compare care homes online (Remedy 3)	• Decision support tool to navigate system (Remedy 2) • Improved information and ability to compare care homes online (Remedy 3)
When & by whom?	• **When people are considering their future income** (e.g. making changes to their pension) • **Salient moments** (e.g when helping parent with their care needs) • **When people reach a certain age (e.g. 60)** – universal letters by NHS & local authority (LA)	• **When need grows** – by medical staff & LA staff • **When people enter risk group** – letters by NHS & LA • **When people reach a certain age** (e.g. 75) – universal letters by NHS & LA	• **When urgent need is realised** – provided by medical staff and LA workers
Who receives these?	• Individual	• Individual • Relatives/representatives	• Individual • Relatives/representatives

Introduction

10. In December 2016, the Competition and Markets Authority (CMA) launched a market study into care homes for the elderly in the UK. The study's focus is on the provision of care services for people aged 65 years or more in residential homes and nursing homes.[3] There are around 433,000 people in both types of care homes in the UK, of which 41% fully fund their own care ('self-funded'[4]).[5] The market study update report, released in June 2017, concluded people interacting with the care home market found it difficult to access information, were confused about funding options, and were not clear how to find and choose homes.[6]

11. Following these initial findings, the CMA commissioned the Behavioural Insights Team (BIT) to identify and develop proposals to help prospective care home users and their families to make good decisions. These proposals will inform the recommendations of the CMA's final report. The work consisted of four stages. In the first stage, BIT interviewed several individuals from the care home market sector[7] and conducted desk-based research. Next, we facilitated an idea generation workshop with CMA staff drawing on our experience in applying behavioural insights to policy problems. The third stage was to write up a report that includes remedies to improve decisions in the care home market. Finally, the three remedies proposed in the report were discussed in detail at a roundtable with stakeholders from the sector. The feedback we received was integrated into the remedies.

12. Separately, the CMA commissioned a market research company, Research Works, to undertake a series of in-depth interviews with people at various stages of needing and considering care. Their study explores perceptions, experiences, and views on possible remedies including: support with navigating the care system, provision of information, encouragement to consider care needs in advance, and complaints and redress. The Research Works study is reporting separately but will be published with the market study at the end of November. The CMA's aim is to use these two pieces of complementary work to inform the final market study report.

13. Prior to commissioning the research mentioned above, the CMA also commissioned Ipsos MORI to do some qualitative research with decision makers in the care home market (family members and friends of residents in a care home, care home residents themselves and social care representatives). The sample covered around 80 care home placements in 24 residential and nursing homes for the elderly across the UK to understand various issues. These included

the context for entering a care home; information and support when finding a home; the process of finding a care home; their experiences of funding care; their ability to understand contract terms; the scope to move care home; and experiences of providing feedback and making complaints about care homes. The findings from this research were published in August 2017, and have been referenced throughout this report.

14. We define good decisions in the care home market to be those:
    a) Which are made without time pressure or emotional stress;
    b) Which use accurate information about care homes; and
    c) Where the consumer's needs and preferences are known and taken into account.

15. It is important to note that there are both structural and behavioural barriers to good decision making in the care home market. While this report focuses on overcoming behavioural barriers, the CMA is considering wider changes to how the care home market works. These more structural factors will have an impact on any remedies that we propose. For example, there may be ways of collating and presenting information differently and in a way that enables better decision making. However, if an individual is reliant on local authority funding and there is only one care home in the area that the local authority will fund, the way that information about that care home is presented will not enable a better decision to be made. Therefore, the remedies proposed in this report would be most effective as part of a suite of remedies to improve the care home market, and also potentially the wider care market.

16. After a brief introduction to behavioural insights, this report has three sections:

    I.   The care home journey
    II.   Barriers to effective decision making in the care home market
    III.   Remedies to help people make better decisions in the care home market

A brief introduction to behavioural insights

17. Behavioural insights draws on several disciplines concerned with how people behave and make decisions, particularly psychology and economics. It is also closely associated with rigorous testing of new approaches in policy and service design. A focus of the work is on how people deviate from the strictly 'utility maximising' decision making that is sometimes assumed in economics and by policy makers, but which does not take into account the limits of human

cognition. Systematic deviations from behaviour that is classified as strictly 'rational' are called behavioural biases. The term biases is not meant to be pejorative; it simply describes systematic and predictable patterns of behaviour.

18. As predicted by behavioural insights, there is strong evidence that consumers do not always make decisions based purely on a deliberate weighing up of costs and benefits.[8] A useful approach to analysing how people make decisions is offered by "dual process" models. The academic literature in psychology argues that individuals have two basic modes of thinking. The most famous explanation of these modes is given by Daniel Kahneman, in his description of System 1 and System 2 thinking.[9] System 1 operates quickly and with little effort. It is used to perform more automatic tasks such as buying our normal cereal in the supermarket. System 2 is more deliberate, and is used to perform tasks that require cognitive and mental effort, such as comparing the outputs of a spreadsheet.[10]

19. System 1 requires less effort because it relies on heuristics, such as 'what decision did I make last time?' or 'what are other people doing?'. We use System 1 for easier and more routine decisions, and reserve System 2 for more difficult and less common ones because it requires more effort. This division works well for most decisions, but can go awry. For example, when we are mentally tired or we lack sufficient information, we can resort to using System 1 even for complex and difficult decisions where System 2 would improve the decision.

20. This report explores how policy makers and government can think about decision making, and the implications of behavioural insights in the care home market. We then propose ways to improve decision making based on the behavioural science literature.

I. The care home journey

21. Individuals have varied journeys through the care home system and before they enter it. However, based on qualitative work conducted as part of the CMA care home market study, we can identify five stages that all people who need a care home go through:[11]

    a) **In advance of care home need.** Some people will be healthy until a sudden event, such as a fall, creates the need to enter a care home. Others will have emerging needs which can be met at home, or in an alternative form of supported housing, before a care home is required.

b) **Realising the need for a care home**. A trigger event will often mean that a person needs to move into a care home. This will often involve an assessment of needs by a social worker, medical staff or both. It will also often be following a hospital admission, in which case decisions need to be made rapidly to allow for discharge.

c) **Understanding the financial implications and available support.** Once the need for a care home is established, individuals or their families need to understand whether they are eligible for financial support from the state. This will have an impact on which care homes they can choose from. Self-funded individuals will have to consider how to pay for their care. This may include applying for a loan from the local authority until potential care home resident's house is sold. However, due to the urgency of the decision, some self-funders only engage with these details after visiting care homes, or even after signing a contract.[12]

d) **Shortlisting care homes.** State-funded individuals typically receive a shortlist of care homes from their social worker. Self-funded individuals potentially have a wider choice, and can seek assistance from their local authority, but typically search for a care home without local authority support. They (or the representative assisting their search) often do this by searching online and/or asking people in their social networks for recommendations.[13]

e) **Visiting and choosing a care home.** Both state-funded and self-funded individuals (and their representatives) usually visit care homes to finalise their choice. Typically, 3-4 care homes are visited unless there is less choice in their area, they have a strong recommendation from a trusted source, or they have a respite placement.[14]

II. Barriers to effective decision making in the care home market

22. It is hard to think of a consumer market where decision making is more complex and emotionally charged than the care home market. Life changing decisions often need to be made quickly and at a time of severe emotional distress. People may be confronting their own mortality, or that of a relative, as well as where they will spend their remaining life. Anxiety is high because of negative perceptions of care homes, and the strong resistance many older people have to leaving their home and losing their independence. Consequently, the prospect of sending a loved one into a care home can cause family members feelings of immense guilt. Interviews suggest many cannot "bear the thought" of relatives being sent into care.[15]

23. As a result, there is significant scope to improve this decision making environment. There are two specific and overarching barriers which make the decision more difficult:

a) **Lack of early planning for potential need:** financial planning and engagement with future care decisions tend to be avoided or delayed. This means decisions are required at the point of need, which leads to time pressure and emotional stress; and

b) **Difficulty of making a complex choice under time pressure and emotional stress:** the process for shortlisting and choosing a care home is complex. This is partly because relevant and accurate information is hard to access (where access is defined in its broadest possible sense, including whether people know where to go for information and whether they can get relevant, high quality information with minimal effort). But it is also because it is difficult to interpret and use the current information to select a care home that best meets the consumer's needs and preferences. Difficulty of choice is further compounded by the fact that a sudden event, like a fall, often triggers the need to quickly find a care home, and decisions need to be made under time pressure and emotional strain.

24. Figure 2 presents these overarching barriers alongside the more specific behavioural barriers that are underpinning them. These will be explored in turn.

Figure 2: Behavioural barriers to better decision making in the care home market

	Lack of early planning for potential need		Difficulty of choice
Timing	Planning for future needs	Approaching point of need	Point of need
Decision	Do I plan how to fund my future care needs?	What are my preferences? Do I plan for all scenarios?	What is the best care home for me?
Behavioural barriers	• Optimism bias • Discounting • Status-quo bias	• Guilt and anxiety • Omission bias • Availability bias	• Information and choice overload • Satisficing • Availability bias • Hot state decision making • Anxiety

Lack of early planning for potential need

25. Lack of early planning can be broken down into two components:

    a) Planning for future need
    b) Approaching point of need

26. **Planning for future need** relates primarily to considering financial costs of entry into a care home. Most people do not save, nor make other financial preparations such as downsizing, to cover potential future care home fees. A survey conducted in 2014 suggested that only 27% of the population had planned for how they would fund potential care.[16] Individuals are often surprised by the need to pay for their care and are financially unprepared when a need to move into a care home arises.

27. Lack of planning is despite potentially substantial care home costs, and the fact that many people need to pay the fees themselves. Research shows that average fees for care homes in 2015/16 were £600 per week for residential homes and £726 per week in nursing homes.[17] This research also reflects big differences across regions, with fees going up to nearly £900 per week for those with nursing needs in the South East of England.[18]

28. It should be noted that a lack of financial planning is not necessarily "irrational" as most people never need to enter a care home. Therefore, there is significant uncertainty about whether an individual will need to pay for a care home in the future.[19] It is also hard to know how much the total costs will be, as people spend different periods of time in care homes, and because fees vary according to the services required and region the care home is in. Half of people aged 65 or more are estimated to need to spend up to £20,000 on care, while 1 in 10 will need to spend over £100,000.[20]

    "When it comes to your health, you never know what your health needs will be in later life – so that makes it very hard to plan for."[21]

29. The classic market solution to uncertain, high cost events is an insurance market in which everyone pays a premium based on risk. However, a combination of low consumer awareness and high potential costs means that demand for insurance products has not been sufficient to allow a market to develop.[22]

30. The fact that high uncertainty is hindering early financial planning might be exacerbated by the safety net that government provides. Anyone living in the UK with assets under a certain threshold (£23,250 in England and Northern Ireland, £30,000 in Wales and £26,500 in Scotland) is eligible for full state support with

their fees. This may provide a disincentive to save in the middle to lower end of the income distribution.

31. **Approaching point of need** refers to reflecting on care requirements and preferences before the point at which a person needs to move into a care home. Early consideration of preferences is especially important as a decision is often required when the individual is in a frail state. This means that they will frequently have support in making decisions. Ipsos MORI finds that care home decision makers are usually representatives and close relatives of the individual in need.[23] This means that communicating preferences in advance of the need to enter a care home can quicken decisions and ensure they better reflect the individual's preferences.

32. Generally, people have a strong preference to maintain their independence rather than enter a care home. A significant majority of people (79%) that were asked where they would prefer to receive their end of life care opted to receive it at home. Only 8% preferred to receive it in a care home.[24] Similar patterns can be found in relation to preferred place of death, in most countries.[25] [26] Many individuals actively resist the option of moving into a care home,[27] and families and health professionals are reluctant to initiate discussions about care homes until there is an urgent need.[28]

> "My mum's adamant she's not going into a home... From us being kids she has always said, don't put me in a home. But it has got to that point where we are going to have to do it..."[29]

> "She refuses to discuss going into a home, says don't put me in. We don't know what to do." [30]

Behavioural barriers to planning for future need

33. Table 1 shows the specific behavioural barriers that prevent early engagement with care decisions. These are reinforced by the strong emotions that are likely to be at play in these important decisions.

Table 1: Behavioural barriers that can deter planning ahead

Behavioural barriers	Explanation	Relevance to the care home market
Guilt and anxiety	Affect and emotions have a significant impact on our judgements and risk perceptions.[31][32] Negative feelings cause us to underestimate the benefits and overestimate the risks of options that elicit these feelings.[33] Feelings of anxiety and fear have both been shown to increase risk aversion in various lab experiments.[34][35]	"We probably delayed it longer than we should have, because of guilt. I couldn't bear the thought of him being in a nursing home and not knowing where he was, and wanting to come home and all the upset around that."[36] The decision about whether to move a loved one into a care home is emotionally charged. Relatives report feeling guilty and anxious for having to move their loved ones into a care home, and associate it with a personal failure.[37][38] These feelings are likely to be fuelling avoidance of this difficult decision.
Availability bias	We tend to judge the likelihood of an event based on examples that come readily to mind.[39] Forty-five per cent of British adults describe their perceptions of the quality of care homes as negative, and more than half (52%) of adults in the UK believe that there is abuse and neglect in care homes.[40] This is likely to be partially influenced by the mixed quality that can be found in care homes.[41]	"We're concerned about alarming stories of poor care in some homes."[42] "You hear the horror stories, and you still worry about the mistreatment of patients." [43] A handful of negative stories, readily available in the media, are highly memorable and have a disproportionate effect on people's perceptions of the quality of care homes.[44] Both these factors mean that people have negative associations with care homes. This is likely to be putting people off from early engagement with the care home market.
Optimism bias	We tend to underweight the probability of bad outcomes happening to us compared to other people.[45]	"It's too far in the future. You always think you won't need it – and I hope I don't!"[46] People see the option of moving into a care home as a negative one. This can lead them to underestimate the probability it may happen, and dismiss the need to plan for future care needs.

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Behavioural barriers	Explanation	Relevance to the care home market
Discounting ('Present bias')	People tend to overly discount costs and benefits that occur in the future. This tendency is exacerbated if the future is particularly uncertain.[47] [48]	"There is too much going on in people's lives, in my case caring for my wife, to actually spend any time thinking you know what I'm going to find out how this is all put in place."[49] The future benefit associated with effort today - such as the need to plan how to fund future needs or to make preparations for an older person's move into a care home - is likely to be underweighted. This is especially true for early financial planning, which requires action far in advance of the care need developing, with a significant risk that a care home may never be required.
Status-quo bias	We have a tendency to not make active choices unless our attention is actively and effectively drawn to it, or if we have no other choice.[50] This underpins our tendency to stick with previous decisions or simply refrain from action altogether.	"For me nothing has prompted me to think about care in the future…"[51] There is rarely a point in people's lives when their attention is drawn to whether or not they might need to go into a care home. A notable exception is if a relative requires a care home (we will come back to this situation later). People can therefore easily avoid this question, and tend to be forced to make decisions only when the care need is urgent.
Omission bias	We perceive a negative outcome as worse if it is the result of an active, rather than passive, choice.[52] [53]	People have a strong preference to avoid *actively* doing something that would potentially lead to a negative outcome because they feel less responsible for the potential harm. This includes entering, or placing their loved one, in a care home.

Difficulty of choosing a care home

34. The second major barrier to improved decision making in the care home market relates to shortlisting and choosing a home. At this stage, the need for the individual to go into a care home is realised, and the individual, or the individual's representatives, are faced with the need to find and rapidly understand a large volume of information and then navigate a number of complex systems and decisions. Often the time available to make the decision is limited because needs are immediate and there is high competition for limited care home spaces.[54]

"I now have the number for social services to ask for advice – before that I wasn't sure where to go. If not, I'd have gone via a doctor. I don't think it is easy – there's not a lot of information out there."[55]

35. For a person to make a good decision in the care home market they are required to understand information in four main areas:

   a) **Information about care needs and the care available in care homes and at home.** The first question is about the needs of the older person and whether they are best met at home or if more support is required. If more support is required then the next question is about the type of home required: a residential home, a nursing home, or a home that can meet more complex needs like dementia. This is often not straightforward – people report not understanding the difference between the types of care home until actually visiting them.[56]

   "We didn't know the difference between residential care and nursing care and who pays and who doesn't pay. It's very complicated. I have a degree, I am not stupid but it was very difficult."[57]

   b) **Information about financial support.** To determine which care homes are available to them, people need to understand care home fees and whether they are eligible for support from the local authority or the NHS (in the form of Continuing Healthcare (CHC)[58]). If the individual is self-funding, their current home may need to be sold to pay for care. Depending on the finances of the individual, a temporary loan from the council may be required. These processes are complex and typically require a lot of form filling. Families describe this stage as confusing and stressful.[59] Some have mentioned not engaging with costs and finances until after they have signed a contract.[60]

"We were getting letters that were actually quite complex and quite confusing. 'You can find out more on leaflet INF4/PC', and all that sort of stuff and you're like oh my God what's this?"[61]

c) **Information to shortlist homes.** Self-funders typically find a care home independently. Some people report that they struggle to know where to start. For instance, in a survey conducted in England by Independent Age the most common way for people with no experience to begin shortlisting homes was through a search engine (mostly Google), before looking on local authority websites (16%), CQC ratings (16%), or NHS Choices (16%). An additional 22% reported not knowing where to look.[62] Searching online and using one of the available directories allows families to find lists of care homes in their local area.[63] However, information regarding the availability of rooms or beds, prices, and terms and conditions is rare.[64] There is also very little information that allows users to assess the quality of the care home. While regulator ratings do exist, they are often out of date by the time people visit a care home.[65] Consequently, they do not always match people's experiences, which can lead to some mistrust in them.[66] People who receive state funding typically receive a list of care homes from the local authority. Qualitative work conducted as part of the CMA market study suggests there are misconceptions about the right to choose a home yourself (rather than go to a specific home the social worker offers), the right to ask for a care home outside the local authority area, and the right to set up third party top-ups to receive care that is more expensive than the local authority upper rate.[67]

"I think if we had had a bit more information about what was available and whether you were allowed to choose. I don't know if we could have said, oh no I don't want that one, I want this one. I just assumed that because it was government funded, it was like this is what's available."[68]

"I didn't know whether we could choose, because the state was paying for everything for her."[69]

d) **Understanding what to look for when visiting a care home.** The final choice of care home is typically made by visiting a few. Much like when people choose a home to live in, they want to ensure the home 'feels right'.[70] Charities and local authorities publish detailed guides with information and tips about what to ask when visiting a care home.[71] However, qualitative work and interviews we conducted suggested that many people do not know that these guides exist – even though they would find them useful.[72]

36. Difficulty of choosing a care home is driven by the ability to find and assess the available information. The difficulty in finding and interpreting information about care homes, along with the emotional nature of the decision, can lead people to rely on intuitive decision making (using System 1) rather than a more reasoned approach (using System 2). Unfortunately, for complex decisions which the individual has not faced before, intuition can lead to biased decisions. These biases are presented in Table 2.

Table 2: Behavioural barriers to choosing a care home

Behavioural barriers	Explanation	Relevance to the care market
Information and choice overload	Having too much information and choices hinders our ability to process it and make a considered decision. Scarcity of time,[73] complex choice sets, and lack of expertise exacerbate information and choice overload.[74] [75] In such cases, we are more likely to rely on mental shortcuts and rules of thumb, and to stick with the status quo, rather than careful consideration of costs and benefits. [76]	"There was a bewildering range of care options that we didn't know existed...and it seemed there were no hard and fast rules as to how they were treated."[77] Care home decisions involve a lot of complex information that is difficult to process, especially due to the need to make decisions rapidly, which leads to reliance on mental shortcuts that can bias decisions.
Satisficing	When a large amount of effort is required to make the right decision, we often choose a satisfactory option rather than make the 'optimal decision'.[78] This is particularly common under information and choice overload or when information is not complete.	"I didn't necessarily have a list of requirements, I was just basing my decision on what I knew of my dad and what he would like and not like, and then some of them I think I looked at a few and I thought, oh God, that just looks grim."[79] When the effort required to search for the best care home is too big or expectations of quality are low, people often settle for a 'good enough' option rather than conducting an extensive search for the best choice for them.[80]
Availability bias	We tend to judge the likelihood of an event based on examples that come readily to mind.[81] Consequently, we tend to give disproportionate weight to the most recent or salient information we receive.	"When you look at residential or nursing homes, you're looking at bricks and mortar. You're not really getting a taste of what the care is like or what the staff is doing..."[82] The combination of lack of trusted quality indicators, and rapid decision making, means that people are relying on imperfect

Behavioural barriers	Explanation	Relevance to the care market
		information and potentially unauthoritative sources (such as friends or family that are easy to approach) to make choices. One example of this can be seen in that fact that some people that receive recommendations for a care home choose to visit fewer care homes than those that do not receive advice.[83]
Hot-state decision making	The timing and emotional state we are in can lead us to make different choices. More specifically, physical discomfort (such as pain) or emotionally charged states lead to more impulsive behaviours. [84] For example, in the context of medical treatments, invasive treatment options (such as surgery) are often excessively chosen by patients who have been just diagnosed, compared to patients that are given more time to make a decision.[85]	Choices of care home are often made under time pressure and emotional load (such as guilt and anxiety). This may be leading people to make choices they would not have made if given more time and emotional support.
Anxiety	Experimental evidence has suggested that people are less able to distinguish between good and bad advice while in a state of anxiety. In particular, individuals are less able to distinguish between advice being given from a source that might have a conflict of interest and a source which does not.[86]	"The social worker would try to push what suited them as opposed to what suited us as a family and my brother."[87] An inability to judge information could be problematic if advice is given from different standpoints. For instance advice from a care home manager, a doctor and from a social worker could all conflict.[88]

III. Remedies to help people make better decisions in the care home market

37. In this part we discuss the possible remedies to help people mitigate the behavioural barriers identified in Part II and make better decisions in the care home market.

38. In order to develop recommendations that can be implemented quickly and effectively we have focussed on remedies that:
    a) Are relatively low-cost;
    b) Do not require significant system change; and
    c) Would be possible to test at a small scale before wider roll-out.

39. In developing these proposals, we have assumed willingness to develop 'supported decision making' in the care home system. This is a remedy being considered by the CMA to assist those in need, and their relatives, in understanding the care home market and their choices. Supported decision making may consist of enhanced written and online materials as well as direct support from people ('support intermediaries') that take a role similar to existing dementia advisors, providing personalised supported or assisted decision making services for users and their representatives. The channel (in person, by telephone, or online) and the intensity of support given will be devised to fit the needs of the person and their family, and the level of care needed. The remedies we propose would enhance supported decision making.

40. With this in mind, BIT proposes three remedies. These remedies are summarised in Figure 3 according to their timing in the care home journey and the behavioural barriers they address. The remedies are:
    a) Implementing early prompts to encourage engagement with care home decisions (both planning and financial);
    b) Creating decision support tools that can help people understand the process of selecting a care home; and
    c) Improving information about care homes, and the ability to compare between them. Existing comparison sites ('shortlist generators') should be developed to enable easier shortlisting of care homes. This would be done by ensuring that key information is published by care homes, relevant organisations are signposting people to trusted websites, and it is as easy as possible to compare care homes and generate good shortlists on them.

Figure 3: Summary of remedies for improving decisions in the care home market

	Lack of early planning for potential need		Difficulty of choice
Timing	Planning future needs	Approaching point of need	Point of need
Behavioural barriers	• Optimism bias • Discounting • Status-quo bias	• Guilt and anxiety • Omission bias • Availability bias	• Information and choice overload • Satisficing • Availability bias • Hot state decision making • Anxiety
Remedies	• Prompts to increase awareness of care home costs (Remedy 1) • Prompts to increase engagement (Remedy 1)	• Prompts to increase engagement (Remedy 1) • Decision support tool to support early planning (Remedy 2) • Improved information and ability to compare care homes online (Remedy 3)	• Decision support tool to navigate system (Remedy 2) • Improved information and ability to compare care homes online (Remedy 3)
When & by whom?	• **When people are considering their future income** (e.g. making changes to their pension) • **Salient moments** (e.g when helping parent with their care needs) • **When people reach a certain age (e.g. 60)** – universal letters by NHS & local authority (LA)	• **When need grows** – by medical staff & LA staff • **When people enter risk group** – letters by NHS & LA • **When people reach a certain age** (e.g. 75) - universal letters by NHS & LA	• **When urgent need is realised** – provided by medical staff and LA workers
Who receives these?	• Individual	• Individual • Relatives/representatives	• Individual • Relatives/representatives

Remedy 1: Early prompts

"You haven't ever really thought about it and suddenly you realise that you can't do what you want to do... it's something that doctors or something should start saying to people to think about."[89]

Rationale

41. Decisions about care homes are often made under acute time and emotional pressure. Sudden changes in circumstances, such as a fall or a sharp deterioration in a person's health, are common reasons for entering a care home. A survey by the Citizens Advice Bureau found that over half of relatives of potential care home users had to find a home in under a month, and 20% in under two weeks.[90]

42. Early prompts aim to create a moment (or moments) of focus on the potential need for care in the future, before a crisis. Timely prompts have successfully increased organ donation rates,[91] attendance at cancer screening appointments[92] and charitable giving.[93] In this market, prompts could be used to overcome biases such as optimism bias and omission bias and bring potential future care needs to the front of people's minds. They could also be used to correct misperceptions of the market, such as the misperception that social care is fully state-funded in the same way as most secondary care in the NHS.

43. In this report we focus on prompts which improve decisions about care and specifically care homes. Prompts could be used for a broad range of care decisions including considering making financial provision, home adaptation, domiciliary care, and setting out preferences for when a care home is required in the future.

44. Below we discuss prompts about financial provision as well as earlier engagement with the system. In each case we consider the following four aspects of a prompt:
    a) **Aims:** what behaviours should the prompts be trying to change?
    b) **Content:** what information and/or message should the prompt convey?
    c) **Moments:** when should the prompt be delivered?
    d) **Messenger:** who should deliver the prompt?[94]

Aims

45. Government has a role in prompting people to consider the potential future costs of care. The aim of a prompt would be to increase awareness of potential future care costs, and thereby to encourage some level of financial provision. If the objective is to encourage additional saving, the prompts need to leave enough time to build up significant savings. Alternatively, a prompt could be closer to the potential need to encourage consideration of how a person's existing estate may be used if a care home is needed.

46. It should be noted that, given the current economic incentives, a prompt may have limited impact on encouraging people to save. It would be difficult to encourage people to save for a potentially very large but uncertain cost, especially when most people want to avoid moving into a care home. A more attractive option might be an insurance product that people could be prompted to take up. Interviews conducted by Research Works as part of the CMA care home market study suggest that people are open to considering such an insurance product, although this research did not provide any detailed product propositions.[95]

Content

47. The prompts would provide people with accurate yet simple way to understand information about:
    a) the likelihood they will need a form of care;
    b) the average costs associated with each option; and
    c) the current threshold above which people pay for their own care.

48. While there are several ways to present information that conveys uncertain outcomes, it is generally agreed that people find it hard to understand probabilities.[96] Natural frequencies ('25 out of 100 people will go into a care home') have been found to be easier to comprehend than probabilities and percentages in certain contexts, such as communicating the risks of cancer screenings.[97] Also, graphic visualisations are particularly useful when the aim is to grab the attention of the audience, and when information is complex.[98] For instance, a frequency tree[99] could be designed to provide more detail, such as the likelihood that a person will need to pay for more complex care (e.g. in a nursing home).

49. In any case, messages that communicate complex information should be pre-tested before use in the field to ensure they can be understood by the relevant target audience. One example of a way this could be tested is given in Box 1 below.

Moments

50. There are number of timely moments that could be considered:
    a) **When people are considering future income** - for example, when they are making changes to their pension contributions or writing a will for the first time. The prompt could take the form of a letter or a pop up message on the websites where the person is making changes to their pension contributions or their will.
    b) **Salient moments** – people assisting a loved one in finding appropriate care describe this experience as sobering.[100] This is a timely moment to prompt people of middle age to consider their own future care. More specifically, we suggest online prompts as relatives of people looking for care homes often search online for care homes. However, at the point of searching, they are likely to be worried about finding a care home for their loved one, rather than making plans about their own future care needs. To solve this, they could be prompted to sign-up to receive a delayed email (for instance 3 months after sign-up) that includes guidance about financial provision.
    c) **Universal letters at a specific age (e.g. 60).** Universal letters with brief guidance (e.g. as described in Remedy 2) could be sent to everyone approaching a certain age. We suggest the timing should be at least a few years before retirement. This already occurs with pensions: everyone approaching retirement is prompted to engage with the UK Pension Wise Service.[101]

Messenger

51. The obvious messengers are the bodies involved in social care (Local Authorities, the NHS, and Health and Social Care trusts in Northern Ireland). Another possibility is partnering with financial institutions. However, both of these messengers might be perceived as having hidden agendas of either cutting costs or increasing profits. We therefore recommend testing whether messages from a highly regarded independent body (such as Age UK or another charity or consumer group) are better at increasing engagement with the information provided. The idea of testing varying messengers in this way is integrated into the trial proposed in Box 1.

Box 1: Trial of different messages on an online platform – financial planning

Target group: People in the UK aged 40-50.

Target behaviours: Comprehension of and engagement with information about the likelihood of needing to enter a care home, the costs of care homes, and financial support.

Overall design: Participants are randomly allocated to see one of 4 messages below, where the messenger and the way information is presented vary. Information will cover the likelihood of needing a care home, the costs attached to it, and in which circumstances people will need to pay for care.

- Standard messenger + information in text
- Standard messenger + information visualised
- Independent messenger + information in text
- Independent messenger + information visualised

Primary outcome measure: Comprehension of information could be measured by asking a number of comprehension questions after seeing the materials.

Secondary outcome measure: Engagement, which can be measured by asking people how they intend on behaving in the future ('stated intentions').

Delivery: A randomised controlled trial (RCT) could be run on Predictiv by BIT. Predictiv is an online platform that enables users to run RCTs with an online population of pre-recruited participants. It can be used to test different versions of interventions, to determine which are most effective at achieving the desired outcome. Recommended sample size is between 4,000-5,000 participants.[102]

Prompts about earlier engagement with the care system

Aims

52. Prompts to increase early engagement with care decisions have three aims:
    a) To encourage people to reflect on, and make decisions based on, their personal care preferences. This may include questions such as – do they want to receive care at home or move into a care home? In which circumstances, if any, would they prefer to move into a care home?
    b) To understand the available care options (including what support is available to help them maintain independence at home) or which care homes are in their area. This should include information about the pros and cons of each option (e.g. care quality, ability to meet social needs, and costs).
    c) To encourage people to communicate their preferences to their family or representatives in advance of need. This could be done by encouraging them to complete a questionnaire about their preferences, and/or or to have conversations with family members, possibly together with a support intermediary.

Content

53. The prompts could provide people with short and simple guidance that signposts to more detailed information about care (such as decision support tools discussed in Remedy 2), and/or encourage them to complete a questionnaire about their preferences which they then share with family. At the more intensive end of the spectrum, the prompt could be an invitation to attend an appointment with a professional such as a support intermediary, ideally together with a representative they would like to bring along. For people at higher risk (if a risk-based approach as discussed below, is used), an appointment could be pre-booked to set a default they can opt-out of.

Moments

54. Prompting people to engage with the care system in advance of need could be appropriate at several different moments. We outline three main ways people could be identified and prompted:
    a) Universal prompts to older people reaching a certain age (e.g. age 75): This would be an automatic communication such as a letter, text or email generated based on GP records. It would aim to help normalise early discussions about care needs because people will not feel targeted for reasons that are personal to them (e.g. deteriorating health, after a fall).

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Universal prompts could be used to raise awareness of the care system and help people begin to consider their preferences.

b) **Risk-based prompts:** Risk factors after a certain age such as physical illness, depression, previous hospitalisations, gender, ethnicity, living alone, and not having a partner are predictors of care home needs.[103] Predictive models for one's likelihood of entering a care home have been developed in specific contexts, such as for people who suffer from Alzheimer's disease. These models use observational data extracted from clinical records and Hospital Episode Statistics. A model could be developed which uses this kind of data in order to predict the risk of entering a care home. It would use factors that may not suggest a need on their own, but when combined with other factors suggest an individual is at risk of requiring care in the (near) future.

c) **Prompts at salient moments:** These could be prompts delivered at times when people may be more receptive to thinking about care home decisions because they are focused on another aspect of their health. For example, when people are being discharged from hospital for a more minor condition they could be given guidance and prompted to have a discussion with a support intermediary.

Messengers

55. We discuss the two most promising messengers for prompting people to engage with the care market early:

a) **General Practitioners (GPs) and other authoritative health staff** are well placed to identify when a person might need to consider a care home and are highly trusted by the public.[104] Prompts may include letters signed by GPs or direct delivery of prompts by health staff following certain health events (such as a fall or a routine check in which a need is identified). One problem with choosing health staff as messengers could be the association with the NHS – which might mislead people to think adult care services are free. This should then be clarified in communications. Also, considering the rising workload and immense pressures on NHS staff, making it as easy as possible for health staff to deliver prompts will be key. We suggest automating letters from GP surgeries, which would limit the impact on GP resources.

b) **Local authorities**, which are in charge of the provision of adult social care in England, Wales, and Scotland (and Health and Social Care Trusts in Northern Ireland) are a natural channel for delivering prompts. For example, prompts could be delivered when people make enquiries that relate to lower levels of need such as home adaptation. However, qualitative work has reflected mixed views about the level of trust in social services. While some people report positive experiences, some older individuals are afraid of engaging

with social workers out of the fear that 'they might put them in a care home'.[105] Also, some relatives expressed a concern that social workers may have hidden agendas.[106]

Prompts to relatives

56. Relatives often make care decisions on behalf of older family members. This means that prompts should ideally also target the relatives of people that may need care in the future. For example, relatives could be prompted to seek advice from a support intermediary. However, this would require identifying relatives using data from the healthcare system and may be difficult in practice.

57. A possible trial to increase early engagement with care decisions in presented in Box 2.

Box 2: Trial of prompts to increase early engagement with care decisions

Target group: People in one or more local authorities in the UK, aged 75-85.

Target behaviours: Making an appointment with a care intermediary.

Overall design: Participants are randomly allocated in one of 3 trial arms: described below:

- Control – participants do not receive a letter from the local authority.
- Treatment letter 1 – participants receive a letter prompting them to read information and make an appointment with a care intermediary.
- Treatment letter 2 - participants receive a letter similar to the above but which draws on additional behavioural principles such as creating a default by pre-booking the appointment.

Two illustrative examples of letters are presented in Figures 4 and Figure 5. Several other variations to letters could be considered, such as changing the messengers or varying the messages themselves. The final design of any letter(s) should be based on further research and if possible, qualitative pre-testing (such as interviews).

Primary outcome measure: The percentage of people that book a phone call or an appointment with a care intermediary. If possible, a survey could also be conducted after the prompts (and/or the appointment) to capture improved understanding of the care home system.

Delivery: A randomised controlled trial could be run jointly with a Clinical Commissioning Group and/or a local authority (or ideally with a number of them to increase external validity). A local VCSE sector body could be partnered with to deliver the care advice. Then, letters could be sent out based on GP records listing a particular phone number to dial (that is different between the treatment arms) which would allow us to see if they were responding the prompt or not.

Figure 4: Example of a prompt to increase early engagement

Charity | Local Authority

Dear Tim,

Most people prefer to maintain their independence and receive care in their home. For some, that's not possible.

Preparing for all options makes future decisions easier. Today might be a good moment to think about your future care options. I work as an advisor for [independent body].

I'm here to help if you have any questions about your future care needs. In addition, below are some tools recommended to help you navigate the care system.

• Guidance on support for staying at home [link and attached]
• Quick questionnaire to help understand your potential care home preferences [link and attached]
• Guidance for choosing a care home [link and attached]

Please get in contact if you have any questions.

Yours sincerely,

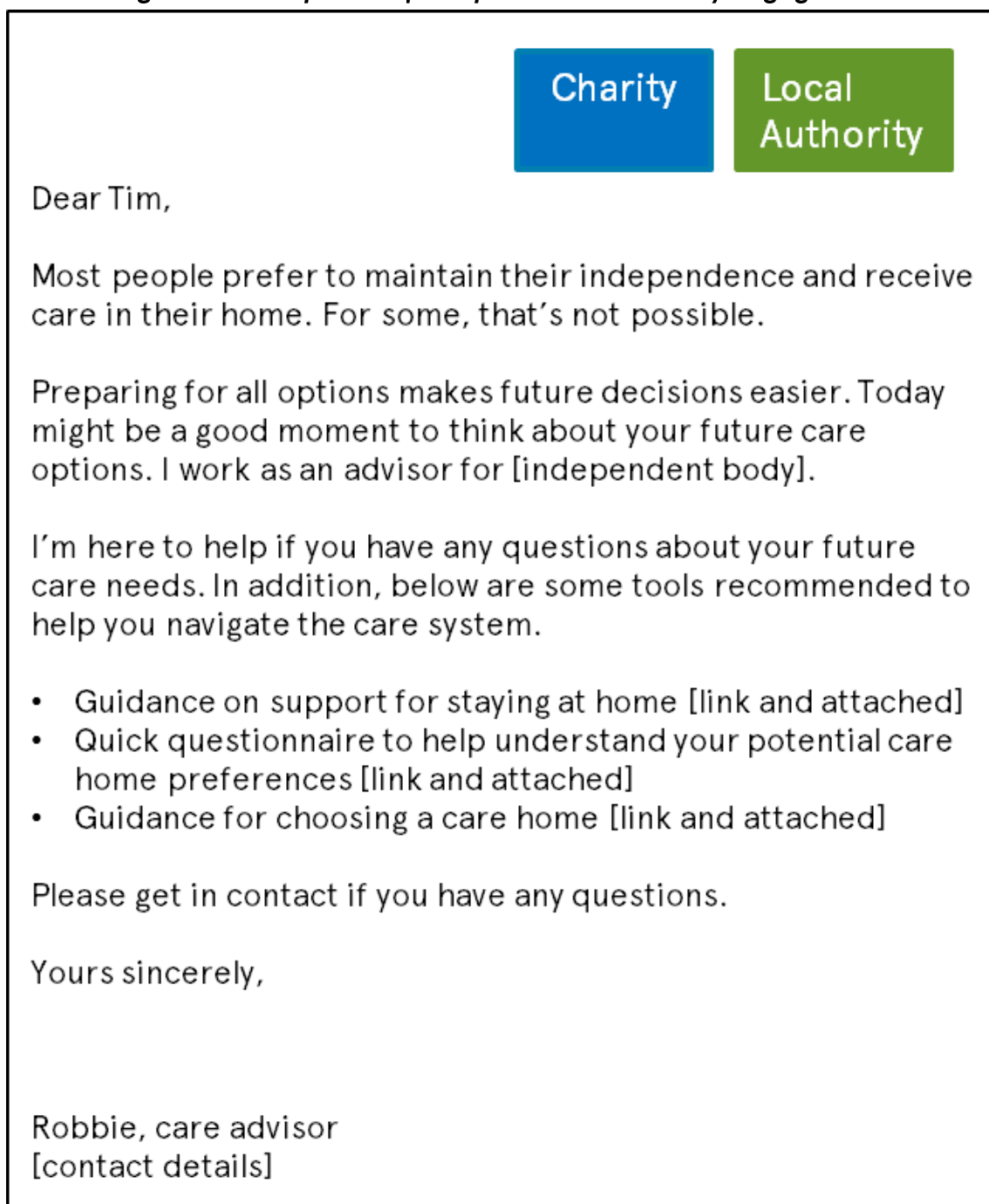Robbie, care advisor
[contact details]

Figure 5: Example of a prompt with pre-booking

Charity

Local Authority

Dear Tim,

Most people prefer to maintain their independence and receive care in their home. For some, that's not possible.

To help you prepare for all options, we have booked you an appointment with [independent body] for a chat about your potential future care needs for 10th November at 5pm.

This is a free consultation offered by your local council. If you can attend please call or text 'YES' to [number] to confirm .

In addition, below are some tools recommended to help you navigate the care system.

• Guidance on support for staying at home [link and attached]
• Quick questionnaire to help understand your potential care home preferences [link and attached]
• Guidance for choosing a care home [link and attached]

Yours sincerely,

Robbie, care advisor
[contact details]

Remedy 2: Decision support tools

"I had to jump through so many hoops and we had to have so many assessments and forms to fill in and it was an absolute nightmare. It's almost like everything's hidden under stones, you can't find it." [107]

Rationale

58. 22% of people do not know where to begin looking for information on care homes.[108] Those in the system complain about the 'nightmare' of forms, and the difficulty of finding clear information.

59. There are multiple sources of information describing the process for individuals within the care home system. The market lacks one clear authoritative source that is trusted and signposted by all stakeholders. VCSE providers such as Age UK provide useful information. However, our fieldwork and the qualitative work of Ipsos MORI and Research Works suggest information remains difficult to access, and could be simplified for easier comprehension.

60. Simple decision support tools such as well-researched checklists and clear guidance can simplify and improve decision making. BIT's work shows that providing decision support tools can help people navigate pension decisions[109] and employment support programmes.[110] For instance, sending people a Pension Passport (one side on A4 paper of consolidated information), rather than a 50-100 page information pack, increased the proportion of customers visiting the Pension Wise website from 1% to 11%.[111]

Decision support tools

61. We recommend the design and trialling of two decision support tools for the care home market in co-operation with the VCSE sector. We propose the two short decision support tools address **early planning for care needs** and **choosing a care home at point of need**.

62. The objective of the decision support tools is to give people a bird's eye view of processes, maximise the accessibility of existing information, and enhance how easy it is to understand it. The decision support tools would provide clear guidance about steps required to navigate the care home market, and signpost users to the location of detailed information such as Age UK's *Finding a care*

home.[112] They could also aim to increase the ease of understanding information like this.

63. The tools could be introduced through prompts (as discussed in Remedy 1) or when the need for a care home is identified in hospital or the wider care sector. They would ideally be provided through numerous providers in the care system such as by the VCSE sector, GPs or at hospital discharge. The effectiveness of delivery of the decision support tools at different times and contexts should be trialled.

64. We suggest the tools are developed, at first, as one sheet of double-sided paper in physical and digital form. Information should be simplified for easy understanding with signposts to more detailed information if required. Over time aspects of the tool could be developed into an interactive web-based questionnaire. This would ask individuals and relatives a series of questions and then provide personalised information. However, given the lack of consistent guidance in existence across the current system, we suggest starting with simpler decision support tools for early planning and choosing a care home, which can be quickly trialled and implemented without need for a technology solution.

65. **A decision support tool for supporting people with early planning** for care needs would be targeted at individuals and relatives where a need is not yet apparent. We suggest it includes guidance in three areas:
    a) **Planning:** understanding the main costs of care as well as the likelihood of needing different types of care. It could also include the advantages and disadvantages of receiving care at home versus going into a care home.
    b) **Practicalities:** actions individuals can take to put in place practical requirements if they wish to stay at home. Practicalities should provide individuals with basic options, such as downsizing or installing new amenities, which may allow them to avoid a care home.
    c) **Preferences:** actions individuals can take now to make future care home decisions easier if they are needed. For instance, it may give individuals and relatives guidance about important factors to consider when choosing a care home (e.g. the type and location of a care home).

66. The tool should signpost to further materials relating to early preparation for care, as well as to the option to consult a local support intermediary. Signposts could also include links to one of the care home shortlisting websites discussed in Remedy 3, where options could be easily explored.

67. **A decision support tool for choosing the right care home** is targeted at individuals and relatives at the point of need. Again, it should be developed cooperatively across the sector. We suggest it includes guidance in three areas:

   a) **Financing:** information on financing options for those in immediate need of care. This should include giving guidance on qualification for local authority funding, the option to use top-ups, and the role of continuing healthcare funding. Guidance should signpost to existing care home calculators, the basic rights of all individuals interacting with the care home system, and where to find further information on financial assessments.

   b) **Shortlisting:** suggestions for how to shortlist care homes to visit. This should cover steps for making a list of individual preferences (if not already completed), how to compare different care homes (such as using a 'shortlist generator' discussed in Remedy 3), and where to go for further information. Shortlisting should help individuals and relatives select 3-5 care homes to visit.

   c) **Visiting:** suggestions for comparing visited care homes and making a final decision. This guidance should provide individuals and relatives with guidance about which information to seek in order to assess the care homes they visit, compare their relative merits and signpost to further advice if needed.

68. Figure 6 illustrates one possible aspect of the decision support tools – checklists for assisting individuals and relatives to shortlist care homes and assess care homes during a visit. These are not final products but rather illustrative prototypes. The checklist could be included in, or linked to, the decision support tool.

Figure 6: Example prototype checklists to be incorporated into decision tools

Checklist for shortlisting care homes

❏ Regulator rating is 'Good'
   ❏ *Look at ratings for past years [link]*

❏ Home fees are affordable, including all extra fees

❏ Care home covers my / my relative's needs

❏ Care home close enough to family and friends

❏ Staffing levels are good (e.g. x% staff/person or more)

❏ Staff turnover is low (e.g. x% in the past 3 month or less)

❏ Staff is well qualified

❏ Manager is present on site

❏ Feedback / reviews are good

If you have any questions about visiting care homes, contact [phone, link]

Checklist for visiting care homes

Basics
❏ There is a nice atmosphere
   ❏ *Staff and residents chatting*
   ❏ *Fresh air & good temperature*

❏ It is clean and hygienic
   ❏ *Check the rooms, bathrooms, windows*

❏ Food is tasty and tailored to residents' needs
   ❏ *Check sample menus*

❏ There is a wide-range of outdoor and indoor activities offered (e.g. at least 5)

❏ Several lounges and social areas are available

❏ There is regular access to a GP and other health staff such as opticians, dentists

❏ They are able to handle to your specific preferences

Staff & Management
❏ Staff is welcoming

❏ Staff speak your preferred language

❏ There are no set visiting hours

If you have any questions about visiting care homes, contact [phone, link]

69. The two decision support tools aim to provide clear guidance for individuals and their relatives as they navigate the care home market. In a simplified format – such as the two-pager – they could be trialled at various points in the care journey. Given the complexity of the market, we have not presented full prototypes of the tools in this report. We recommend the tools are developed in close consultation with key stakeholders to ensure accuracy and sensitivity. The approach should be tested and an example trial is illustrated in Box 3. Alternative trials could be run using the tools at different prompt points such as those highlighted in Remedy 1.

Box 3: Trial of a decision support tool for choosing a care home

Target group: Individuals (and their relatives) who are at the point of discharge from hospital but need to choose a care home before they can be discharged.

Target behaviour: Increased use of available resources to make an informed choice when selecting a care home.

Design: Individuals and relatives are randomly allocated into two groups:

- Treatment group which is given the decision support tool to help them consider finance options, shortlist and choose a care home.
- Control group which receives the status-quo information.

Trackable links to signposted information should be included in the treatment and control information to give data on initial usage. If possible, participant contact details will be sought for a follow-up survey on satisfaction with choice.

Primary outcome measure: Visits by individuals to signposted places such as shortlisting websites and checklists.

Secondary outcome measure: Satisfaction with chosen care home and the process to choose it.

Delivery: A randomised controlled trial would be run with a group of hospitals, the VCSE sector, and an evaluation partner. An assessment of likely sample size will need to be made with alternative communication channels (e.g. local authorities) used if there are insufficient numbers at the hospital discharge point. The evaluation partner will work with hospitals to identify points to introduce the decision support tool and implement the trial.

Remedy 3: Improve information and the ability to compare care homes

"It would have been nice, with hindsight, to have a list of all the care homes in front of you with details of everything they provide and their prices all in black and white so that you can just tick or cross the boxes appropriately."[113]

Rationale

70. When searching for a care home there is, on the one hand, a large volume of information to navigate and digest. On the other hand, many of the core indicators necessary to make decisions (such as vacancies, prices, and quality indicators) are hard to find.

71. Making it easy for people to accurately shortlist care homes online would shorten the search process and alleviate some of the time constraints and stress associated with choosing a care home. If well-designed, providing consumers with information on quality should increase competition on quality as well as price and location, and drive excellence in the market. It is important to note that users would need a reasonable level of digital literacy to use these tools, and that people will want to access information in a variety of ways. The main users of these websites are likely to be representatives assisting the older people. This could be friends and family, or a professional such as a social worker or support intermediary.

72. Some websites that help people to shortlist care homes in local areas already exist. These are run by government, commercial bodies, or charities trying to support people with their care home decisions.[114] There are three ways to improve these websites from a behavioural perspective:
    a) Ensure that information is up-to-date, high quality, and that it covers all core aspects of choosing a care home including quality metrics like consumer reviews or complaints data. This is a crucial step to turn comparison sites into more useful 'shortlist generators';
    b) Relevant market actors such as support intermediaries, social workers, and hospital staff need to signpost people to trusted shortlist generators as currently few people are aware they exist; and
    c) Websites should be designed to make it as easy as possible to directly compare care homes and create shortlists.

73. Shortlist generators must supply consumers with up-to-date, high quality information that covers the core information required to generate a good shortlist of care homes to visit. This includes the information in Table 3.

Table 3: information required to generate a good shortlist of care homes

Basic information	Quality measures
Vacancies	Regulator ratings and their evolution over time[115]
Indicative prices, including extra fees for special services	Quantitative quality measures (such as staff turnover and qualifications, whether there is a registered manager in place, hospital admissions, safeguarding referrals, complaints, average review ratings)
Type of care (e.g. residential, complex, dementia)	Qualitative quality indicators such as residents' feedback and commentaries (e.g. similar to those collected by Ipsos MORI, available on Your Care Rating)[116]
Facilities (e.g. ensuite, bed rails, ground floor)	
Type of stay available (e.g. long, respite)	

74. The majority of this information is not available on existing comparison sites. The main reason for this is that it is not published by most care homes. In fact, a spot check by Which? in 2017 found that only 14% of care home websites provided information about prices and only 3% included terms and conditions.[117] Other information, such as quality indicators, can be difficult to find, patchy, or not updated frequently, which means that they cannot support people's decisions. It is vital for the efficacy of the websites that this type of information is included.

75. Government should ensure care homes publish key metrics. This includes doing so in a consistent and machine readable format that can be utilised by shortlist

generators. We suggest reporting of this data is made compulsory to the relevant national quality inspectorates (such as the CQC in England, the Care Inspectorate in Scotland, CSSI Wales, and the RQIA in Northern Ireland). Another option could be adding these reporting requirements to local authority and CHC procurement contracts.

76. An important aspect to consider with publication of metrics is enforcement. Currently, care homes are required to publish the ratings they received from the regulators, yet not all care homes do so. The main arm of enforcement is the inspections themselves. These are not undertaken frequently enough to ensure publication of live data that changes daily. One advantage of requiring that data is published in a machine readable format is that enforcement could be automated.

77. The main quality measures of a care home are the ratings by the national inspectorates. While this goes some way to capturing quality, many actors in the market believe they are not sufficient by themselves.[118] Building on the work conducted by VCSE sector organisations, the CQC in England has recognised the need to reach agreement about quality indicators that go beyond the inspections themselves.[119] If this is taken forward it should also be made as easy as possible to include in comparison sites.

Signposting to trusted shortlist generators

78. Government, government agencies, and the VCSE sector should work together to ensure that people can find a suitable shortlist generator. This means that whether people are getting guidance from nurses, social workers, or charity advice lines they are being signposted to good quality shortlist generators. One delivery channel could be the decision support tools discussed in Remedy 2.

79. In terms of the levers that the government has available, one possibility might be to invest in NHS Choices and gearing the wider system to signpost there. It is possible to trial an approach where different actors in the system signpost people to NHS Choices and subsequent increases in traffic are measured. Signposting could be done at GP surgeries, at discharge wards, and by social workers, and each could offer a specific web link. This means that even though users end up at the same website, it would be possible to see which source generated the traffic.

80. It is not enough to ensure that quality information about care homes exists online. Rather, information must be aggregated and presented in a way that allows people to easily make meaningful comparisons in order to improve their choices. There are risks with having too many, as well as too few, metrics. Therefore, testing will be required to determine how many metrics should be presented on these websites, and which ways of aggregating and presenting them are most useful.

81. We also suggest trialling behavioural improvements to an existing shortlist generator. Possible changes to the website include:
    a) Incorporating standardised quality metrics;
    b) Generating a personalised list of suggested 'best' available options based on a short survey;
    c) Prompting people to understand key features they may not have thought of before, such as the type of care home (e.g. residential or nursing). One way to do this is to require that people fill in these features when searching;
    d) Prompting users to set up text or email alerts when a new vacancy occurs;
    e) Including pop-up alerts when people navigate towards suboptimal options (e.g. when they click on 'contact information' for a low quality care home when a better one exists in the vicinity for the same price); and
    f) Programming the website to ensure that a dominant option within a given choice set is always included and highlighted.

82. A method for testing changes to shortlist generators is discussed in Box 4.

Box 4: Trial of adding behavioural features to shortlist generators

Target group: Individuals using a shortlist generator.

Target behaviour: Improving the quality of the care homes in the shortlists users make on a shortlist generator as well as use of the information provided in it.

Design: Users are randomly allocated into two (or more) groups:
- Control group – participants sees the regular website
- Treatment group – participants see the websites with a certain set of behavioural changes (such as personalisation, prompts or alerts).

Detailed ideas for possible changes to the website variations are given in paragraph 81.

The outcome measure will vary to mirror the changes being tested. For example, if people are prompted to vary their search terms and look at certain metrics within the list, the following outcome measures could be suitable:

Primary outcome measure: The quality ranking of the care homes in the shortlists generated by users.

Secondary outcome measure: Engagement with the information provided in the list, measured by 'click-throughs' corresponding to the prompts provided.

Delivery: Working with NHS Choices would be one practical way of testing new approaches in the short term, but lessons from trialling would be applicable to other comparison sites. Visitors to websites could be randomly allocated to either a control group or one of the variations chosen (this is often called A/B testing of websites). Multiple ideas can be trialled separately or as a bundled intervention. The final number of trial arms and changes tested will largely depend on the level of traffic to the website.

Conclusion

83. Moving to a care home is a life-changing decision which will always involve some anxiety. It is connected with thoughts about the end of a person's life and a loss of independence they have enjoyed. In many cases these decisions are made more difficult because they are taken under considerable time pressure and in a system which is difficult to understand and navigate. This can lead to people ending up in a care home that does not best meet their needs and budget.

84. In this report we have considered whether behavioural science can help improve care home decision making. We identify two specific barriers to good decision making in this market:

    a) **A lack of early planning for potential need.** This encompasses a lack of financial planning, consideration of future care preferences, and preparation to meet future needs (including actions to help maintain independence such as home adaptation).

    b) **Difficulty of making a complex choice under time pressure and emotional stress.** Often a trigger event means that a care home needs to be found quickly. Important and complex decisions need to be made under time pressure, but it can be difficult to access information.

85. We have suggested three remedies that help people overcome these barriers. First, prompt people before the point of need. Second, create tools to support decision making. Third, improve information about, and the ability to compare, care homes.

86. Given available evidence, we believe these remedies will improve decision making. We have suggested trials that could test their design and efficacy. However, to be fully effective wider reform is necessary. One specific recommendation we make is that care homes should be mandated to provide more detail about their services. This should be part of a wider suite of measures to improve the way this market works.

87. The proposed remedies aim to help people plan for care, assess the quality of their care home options, and help them make their best decision. Ultimately, improved decision making will strengthen the consumer's voice in care home market, incentivise care homes to improve quality standards, and ease some of the anxiety faced by individuals and relatives when making one of the more difficult decisions of their lives.

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[3] Residential homes are care homes in which only accommodation and personal care are provided. Nursing homes also provide nursing services.

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