Research into uptake of Section 18(3): final report

For the Department of Health and Social Care

Reuben Balfour, Margaret Blake, Tania Borges and Laura Threadgold, Ipsos
Ivo Vlaev, University of Warwick

Published 7 November 2024

This research was commissioned under the previous administration (11 May 2010 to 5 July 2024) and therefore does not reflect the policies of the current government. The views expressed are the authors' and do not necessarily reflect those of the government.

Contents

Executive summary

The Department of Health and Social Care (DHSC) commissioned Ipsos to conduct a study on the likely uptake of Section 18(3) (S.18(3)) of the Care Act 2014 when it is extended to enable self-funding care users (self-funders) to ask Local Authorities (LAs) to commission a care home place to meet their eligible needs.

Currently self-funders are likely to pay higher rates for a care home place. The policy will allow self-funders to access the same rates as state-funded care users although they will continue to bear these costs themselves. It will also increase the number of people for whom the LA commissions care. In practice, where a person requests that their LA commission their care under S.18(3), the LA will offer options which it would put in place for someone eligible for LA funding. This research aimed to estimate (in broad terms) take up of S.18(3) by those entering residential care for the first time as well as provide insight into decision making factors.

The research involved a survey which ran from 30 March to 5 April 2023. The survey was completed by 1,290 eligible KnowledgePanel panellists who were either potential self-funders aged 65+ and not yet receiving care, or panellists who may need to arrange care for a potential self-funder in the future. The survey asked about whether they would explore options with the LA and about the likelihood of taking up an offer of a care home place from the LA. It also included a Discrete Choice Experiment (DCE) that asked a yes/no take up question, based on a randomised combination of attributes and cost savings for the care home offered by the LA. This was designed to enable analysis of what drives take up behaviour. The DCE was supplemented with a 'behavioural model' that also included varying care home attributes and cost savings. Lastly, the survey collected information about attitudes and concerns around organising care.

Key findings

- There is uncertainty surrounding the uptake of S.18(3) because the information people have on S.18(3) and its impacts on the care received will affect take up. Nonetheless, about three-quarters of participants would involve the LA in exploring the options for care for themselves or their relative to understand more about the offer.
- The care on offer through the S.18(3) route will likely affect whether self-funders ask the LA to go ahead and arrange the care. The attributes of the offer which most affected potential uptake were the quality of the care (CQC rating), whether the location is near their preferred area or not, the quality of the facilities and the overall weekly costs and savings.
- Participants thinking about care for themselves when moving from the community show a lower preference for S.18(3) than other groups. Thus, uptake of S.18(3) would be more likely when a relative is arranging care on behalf of someone or when the person arranging their own care is in a challenging situation with limited options (e.g. coming out of hospital).
- For participants considering care for themselves, a greater motivating factor for taking up the policy is concern about their ability to pay for the care, whereas for those arranging care on behalf of a relative, preserving their assets is more important.
- There are few demographic differences in likelihood of taking up S.18(3).

- Uptake is likely to be higher in LAs where there are higher levels of trust in the LA among self-funders.
- In designing the communications plans for this policy and preparing LAs for its implementation, it will likely be important to consider how and when to communicate information about the policy to overcome any trust issues.

Table A: Main elements of the survey and key findings

Main survey elements and key findings
Overall summary: The findings indicate considerable uncertainty about whether participants would ultimately choose to take up S.18(3), with participants reporting that it 'would depend'. Those who indicate that they are likely or unlikely vary their answer according to what the offer looks like and the circumstances of needing care. Bearing this uncertainty in mind: • **The findings indicate that 74% of participants would at least explore options with the LA before coming to a decision.** • **When asked a general question on whether they would ultimately take up S.18(3), 47% of participants said they were either very likely (8%) or likely (39%) to take up S.18(3).** • **The DCE showed that the desirability of the care homes offered and the size of the saving affect take up. When presented with a choice of care homes of 'middle' desirability, 57% of participants said they would ask the LA to arrange their care, with quality of care (CQC rating) and location having the greatest effect on potential take up.**
The survey asked participants about taking up S.18(3) in three ways:
1. **General questions about whether participants would explore options with the LA and likely uptake of S.18 (3):** Findings indicate that a high proportion of participants would likely choose to explore options with the LA (74% of participants said they would explore options with the LA about arranging care). What is offered would then determine the decision about whether to ultimately go ahead and arrange the care through the LA (see section 3 for more detail). When asked a general question about uptake following the DCE, almost half (47%) said they were either very likely or likely to take up S.18(3), with 8% saying they were very likely. Nearly a quarter (23%) said it would depend and 4% did not know (see Figure A). The proportion of participants indicating that they are likely or very likely to take up S.18(3) was higher when the question was asked second time, after participants engaged with the policy information in more detail.
2. **The Discrete Choice Experiment: participants were shown scenarios depending on their eligibility routing through the survey. They were presented with a description of an LA's care home offer with a randomised combination of attributes, ranging from the care**

home's location and quality to how much they might save. Based on this LA care home offer, they were asked whether they would or would not take up S.18(3).

The DCE analysis explored uncalibrated preference for a 'middle' offer, based on the middle level of each randomised attribute, as well as 'worst' and 'best' offers. More than half of participants (57%) said they would prefer taking up the 'middle' offer over not taking it up. See section 4 for more detail on the DCE and analysis.

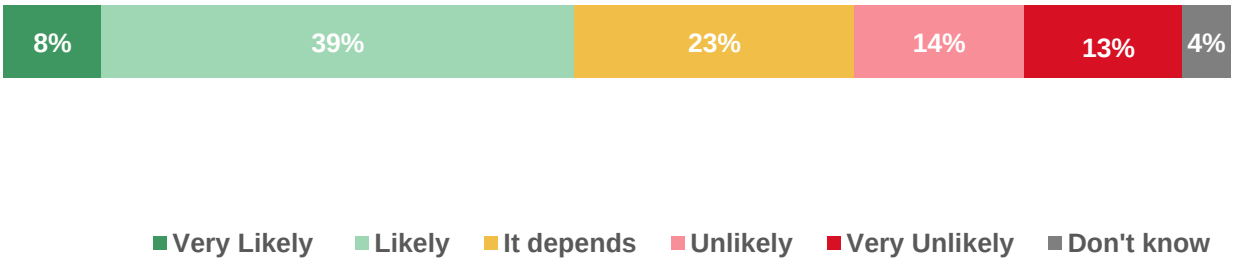
Analysis showed that even among the group indicating they were generally likely to take up S.18(3), preference for take up then varied according to the specific offer in the DCE. Among those who indicated they were generally likely to take up S.18(3), uncalibrated preference for taking up S.18(3) varied from 9% for the 'worst' offer to 96% for the 'best' offer. The group who indicated they were generally unlikely to take up S.18(3) varied their preference less according to the offer (from 3% to 48%) but this still showed nearly half expressing a preference for a favourable offer even if overall they said they were unlikely to take up S.18(3). Detail on the offers are described below in 'factors influencing decision making'.

3. **Behavioural model: participants were also presented with five models of care home offer from 'very poor' to 'very good'. They were asked how likely they would be to take up S.18(3).**

Participants were presented with and asked to consider five behavioural models to understand how differences in care home offer might influence uptake (see section 5 for more detail). Overall, the better the care home offer from the LA, the more likely participants were to say that they would take up S.18(3). For example, eight in ten of participants said they would be likely to take up S.18(3) for the 'very good' offer (51% very likely and 30% fairly likely), compared with less than one in ten who said they would take up the 'very poor' offer (2% very likely and 7% fairly likely).

Further detail on the policy, the weighting and methodology are provided in section 1 and 2 of the report and in the Annex.

Figure A: Overall likelihood of taking up S.18(3)



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

Factors influencing decision making

The Discrete Choice Experiment (DCE) was used to understand how the preference for uptake of S.18(3) varies by its attributes, the circumstances in which a move to a care home is being considered, and individual demographics.

Participants were shown one of four scenarios depending on whether they were responding about arranging care for themselves or for someone else, with a random selection between needing care when moving from hospital or from their own home. They were presented with 12 combinations of illustrative care home offers from the LA. These varied by number of care homes to choose from, CQC rating, quality of facilities, location, waiting time to be placed in home, cost per week and saving compared with the self-arranged cost.

The DCE showed that the characteristics of the offer from the LA under S.18(3) was a more important factor influencing uptake of S.18(3) than participant characteristics.

Analysis was conducted to understand which aspects of the care offer have the biggest impact on preference:

- **Quality of care** was the most impactful attribute: compared with an offer of a care home rated 'good', while holding all other factors constant, a care home rated as ‘requires improvement’ reduced preference by 40 percentage points and a care home rated ‘outstanding’ increased preference by 11 percentage points.
- **Location** was also an important factor with preference falling by 28 percentage points when the offered care home was not located near the preferred area, compared with a 'middle' offer with the care home near their preferred area.
- **Higher costs and lower savings** of an LA care home offer had a negative impact on preference for taking up S.18(3), and greater savings had a positive impact on preference. For example, participants showed the lowest preference for a care home costing £850 a week with no saving (11 percentage points less than a 'middle' offer of £850 with a £340 saving) and the highest preference for a cost of £650 per week with a saving of £260 (5 percentage point increase compared to the ‘middle’ offer).
- **Negative characteristics** such as ‘requires improvement’ CQC rating and the care home not being located near preferred area had a bigger impact on preferences than positive attributes such as an ‘outstanding’ CQC rating or the home being within their preferred area (see section 4.3.1 for more detail), when compared to the middle level on each attribute. Choice and waiting time to be placed in care home had limited impact on preference.

Analysis of the overall uptake questions, DCE and the behavioural model showed that there were limited demographic differences in uptake, however some differences were identified:

- Men expressed a higher preference for taking up the worst offer compared to women.
- Differences were identified depending on **whether participants were arranging care for themselves or someone else**. The impact of the options on offer on take-up preference was greatest for those arranging care for someone else, when considering the quality of care and location. This suggests that people considering care for others may prioritise ensuring that the

person they are arranging care for is placed in a home with a good standard of care, close to their preferred location.

- The findings show a complex relationship between **financial status** and preference for take up, mediated by whose care is being considered. The link between finances and preference was reduced as participants received more information about, and understanding of, the policy during the survey.

- The findings suggested some **regional differences,** with those in the South expressing a higher preference for uptake compared with those from London, Midlands and the North. Sample sizes limited more granular analysis.

- Those who **trusted their LA** (81%) were more likely to ask the LA to arrange the care and see what the options would be compared with those who distrust their LA (62%). Those with trust in their LA were also more likely to say they were likely to take up S.18(3) than those who distrust their LA (59% vs. 32%).

More detail on the differences in general likelihood of uptake and preferences according to who the care was being arranged for, demographic characteristics, financial status and region are explored in the analysis in sections 3, 4 and 5.

Wider influences on uptake

The survey also explored participants' views, attitudes, experiences and behaviours on issues relating to adult social care. Analysis of this data found the following:

- Affordability (76%), cost of adult social care (73%) and loss of home or other assets (68%) are of greatest concern in relation to the cost of adult social care.

- Previous contact with LAs was limited; over half (54%) of participants reported no use of the listed local authority services. Around one in ten (14%) participants reported having contact with local authority adult social care services within the last five years with the most commonly used LA service being birth, death or marriage registration (20%).

- Two thirds (66%) of participants reported no previous experience of arranging adult social care, with only one in five (18%) reporting experience in helping to arrange a care home place or home care for a relative or friend.

- Around half (52%) reported trusting their LA compared with under a third (29%) of participants reporting distrusting their LA. Perceptions that the LA was poorly run (67%) or an underfunded organisation (50%) were the most common reasons for distrust in the LA.

- Participants expect to leave behind an inheritance, with around a third (30%) expecting to leave £250,000 or more (reflecting the eligible sample for this research being self-funders or those caring for or supporting a self-funder). However, one in five (22%) said they did not know how much they intended to leave as an inheritance.

- Most participants (58%) favoured protecting assets from care costs in order to leave behind more inheritance for their family.

- There was a lack of planning for older age reported by participants. Around half (48%) of participants reported having done none of the listed things to plan for their future.

Section 6 includes more detail on the wider findings.

1 Introduction

1.1 Policy overview

Section 18(3) (S.18(3)) of the Care Act 2014 enables self-funding care users (self-funders) to ask Local Authorities (LAs) to commission care to meet their eligible care needs, which the self-funder then pays for through the LA. This gives self-funders access to the rate charged to the LA for care, which is typically lower than the self-funder rate. The LA rate is typically lower for a variety of commercial and economic factors such as an LA's ability to negotiate potentially lower rates as part of contracting for a significant number of long-term placements with a provider. Self-funders will still be responsible for paying for their own care through the LA, while the LA will offer options which it would put in place for someone eligible for LA-funding.

Since 2015, self-funders with eligible needs have been able to access S.18(3) for domiciliary care. The extension of S.18(3) to residential care forms part of wider charging reforms planned for adult social care. These reforms are intended to contribute to fairness in the system, including by allowing self-funders to access the same rates as state-funded care users.

1.2 Overview of the research project

Ipsos were commissioned by the Department of Health and Social Care (DHSC) to conduct a study on the likely uptake of S.18(3) of the Care Act 2014 among new care users. The policy has implications for LAs and care providers since it will affect the number of people for whom the LA commissions care and the price paid to providers for that care. Understanding the scale of the uptake is important for making preparations for the implementation of the policy.

1.2.1 Aims and objectives

The aim of the research is to provide estimates (in broad terms) of take up of S.18(3) by those entering residential care for the first time as well as important insights into the key factors that influence the decision-making process. In particular, the study aims to provide insight into the following:

- the proportion of individuals who are very likely to take up S.18(3), regardless of the policy details or way it is communicated (for example, because paying a lower rate for a care home place is of primary importance)
- the proportion of individuals who are very unlikely to take up S.18(3) regardless of the policy details or way it is communicated (for example because paying a lower rate for a care home place is not a priority and they do not want to involve the LA in their care)
- the proportion of individuals whose decision may be influenced by specific policy details or the way the policy is communicated, and what these influencing factors would be

DHSC also need information on the factors likely to influence uptake, which may include the characteristics of individuals as well as the nature of the offer from the LA.

DHSC requested that the research should generate behavioural insights. The Theoretical Domains Framework (TDF) was used as an overarching framework during the research and particularly for presenting the implications. The TDF provides a comprehensive, theory-informed approach to identify determinants of behaviour which maps to COM-B (capability, opportunity and motivation). To inform this,

DHSC directly commissioned an external academic behavioural expert to work alongside Ipsos on the research.

1.2.2 The survey

The approach taken to answering these questions was to conduct a survey which included:

- questions about the characteristics of participants which might have a bearing on likelihood of taking up S.18(3)
- details about the policy to inform participants so they could answer questions on likelihood of uptake
- general questions on the likelihood of uptake of S.18(3) and participants' approach to it
- a Discrete Choice Experiment (DCE) and behavioural model to explore how the characteristics of the offer from the LA influence uptake
- permission to recontact to enable qualitative research to explore unanswered questions from the survey.

1.2.3 Work undertaken to date

The research began in January 2023 with a qualitative scoping phase, designed to identify attributes and test stimulus materials for the DCE choice sets used in the survey and to understand the factors which might influence uptake. The following scoping activities were conducted:

- **Three stakeholder interviews with LA staff and an umbrella body for the care sector**. Stakeholder interviews were held to aid understanding of what factors are most likely to determine take up of S.18(3) and the expected risks and advantages for individuals and the sector.
- **Five depth interviews and three online focus groups with the general public.** These were conducted to obtain views about what factors people consider when arranging care for themselves or for someone they support. The purpose of the interviews and groups was also to explore factors affecting people's decisions about whether to involve the LA in arranging a care home place in the future or to arrange the care themselves.
- Submission of a scoping report to DHSC detailing the findings from the scoping activities. The findings were also shared with DHSC policy teams for review and feedback.
- Presentation and discussion of the scoping activity findings and implications with DHSC and DHSC's externally commissioned academic behavioural expert. A meeting was held to discuss the scoping findings, and identify key implications for the questionnaire and DCE design.

1.3 Report structure

The remainder of this report details the steps taken to deliver the survey and discusses the survey findings. It includes the following sections:

- Section 2 describes our methodological approach to the main stage of the project, including the design and development of the questionnaire and DCE, sampling approach, fieldwork, and analytical approach (including weighting).

- Section 3 details the findings on likely uptake of S.18(3), focussing on general questions about uptake, without any specific details of the care home offer if arranged by the LA. The aim is to understand the overall likelihood of the LA option being explored and taken up. The section also explores how individuals' characteristics influence the likely uptake of S.18(3).

- Section 4 presents the results of the DCE and factors that influence decision making. This includes how the characteristics of potential LA care home offers can influence likely uptake and the extent to which this influence varies according to individual characteristics.

- Section 5 examines the findings from the behavioural model module of the survey, which presented participants with five different LA care home offers ranging from 'very poor' to 'very good'. This includes exploration of how individual characteristics and attitudes may influence uptake.

- Section 6 outlines wider findings from the survey about factors which may influence the uptake of S.18(3), such as trust in LAs and previous experience of care.

- Section 7 describes the conclusions and implications of the research findings. It draws together the findings on likelihood of uptake to provide a range of estimates of the overall likelihood of taking up S.18(3) at the initial enquiry stage and then at the point of going ahead with the arrangement.

A separate Annex includes more detail on the methods for the research, some additional analysis not included in the main report and the questionnaire.

1.4 Presentation of statistics in this report

In sections 3, 5, and 6 the differences between two statistics are only reported when they are statistically significant at the 95% confidence level unless the report specifically mentions they are not. Where the term 'significant' is used in the report it refers to statistical significance at the 95% confidence level. In section 4, presenting the results of the DCE, it is not possible to test for statistical significance because the data has been modelled from choice data and there is unknown error in the modelling which we cannot measure. Therefore, differences are presented in section 4 when the observed difference and the unweighted sample size were sufficiently large in the analyst's judgement.

Throughout the report, we have used combined figures for some analysis where necessary because of small sample sizes. For example, to enable analysis by region, responses have been grouped where base sizes were too small to conduct meaningful analysis at individual region level. Elsewhere, we have grouped responses to compare binary positions (e.g. trust and distrust of LA have been grouped from a question which allowed participants to select from four trust categories).

1.5 Understanding the presentation of uptake in the report

The survey asked participants about taking up S.18(3) in three ways:

- **Likely uptake:** participants were asked two direct questions about how likely they would be to take up S.18(3). Once at the beginning of the survey after being provided with information

explaining the policy, and a second time after participants had completed the DCE (see section 3 for more detail).

- **DCE:** participants were shown scenarios depending on their eligibility routing through the survey and presented with combinations of care home offer. Based on the LA care home offer, they were asked whether they would or would not take up S.18(3) (see section 4 for more detail).
- **Behavioural model:** participants were presented with five models of care home offer from 'very poor' to 'very good'. They were asked how likely they would be to take up S.18(3) (see section 5 for more detail).

The three ways of asking the question are important because they enable us to conduct different types of analysis to understand participant responses and behaviour, as well as what factors influence decision making. They are also important in terms of how we interpret the findings which should be considered when reading the report. For example, the DCE analysis presents the preference share of participant responses to DCE, whilst the likely uptake questions present participants' reported likelihood of taking up S.18(3) when asked a question directly about the general policy.

The different ways in which the questions have been asked mean that it is not possible to compare figures from the findings against one another. The figures from the three question types should be considered in their own right and context.

2 Methodology

This section describes our approach to the main stage of the project and the delivery of the survey. It covers the design and development of the questionnaire and DCE, description of the KnowledgePanel which hosted the survey, our sampling approach, overview of the fieldwork and analytical approach including weighting.

2.1 Design and development of the questionnaire and DCE

The design and development of the questionnaire content and DCE attributes and levels were informed by findings from the scoping activities. The scoping involved three interviews with stakeholders as well as five interviews and three focus groups with the general public. They explored the factors considered when arranging care and the factors which would affect decisions about whether to involve the LA in arranging care. The interviews and focus groups were also used to test attributes for the DCE. The full results from this phase are published in a separate report.

A draft questionnaire and DCE materials were prepared by the research team at Ipsos and shared with DHSC (including DHSC policy colleagues) and the external behavioural expert for review, feedback and agreement.

The questionnaire module aimed to:

- collect information about participants' care needs and responsibilities
- test scenarios and care packages to understand which factors about care home provision are most important to participants in deciding how to arrange their care, through a Discrete Choice Experiment (DCE)
- gather perceptions on the likely uptake of Section 18(3)
- gather perceptions on the costs of care, financial planning and LAs (and their services)

2.1.1 Survey content

The survey contained the following sections:

- screening and eligibility
- likelihood of taking up Section 18(3):
  - explanation of the Section 18(3) policy
  - initial likelihood question
  - DCE with 6 attributes and 12 tasks for participants using one of four scenarios
  - five likelihood questions as part of a behavioural model with varying quality of offer
  - final likelihood question and information on how participants would approach the LA about taking up S.18(3)
- other questions about context, attitudes and experience

More details on the survey content, including questionnaire and DCE materials, can be found in section 4 of the main report and in the report Annex. The findings from the scoping activities are set out in the scoping report. The KnowledgePanel sample had completed registration questionnaires and so there was existing information about the demographic characteristics of the participants which was also used for analysis.

2.2 Survey design

The survey was carried out online, and designed using a 'mobile-first' approach, which took into consideration the look, feel and usability of a questionnaire on a mobile device. This included a thorough review of the questionnaire length to ensure it would not over burden participants from focusing on a small screen for a lengthy period, avoiding the use of grid style questions (instead using question loops which are more mobile friendly), and making questions 'finger-friendly' so they're easy to respond to. The questionnaire was also compatible with screen reader software to help those who need it.

2.3 The Discrete Choice Experiment

A DCE is an analytical tool for understanding which features of a proposition or service consumers really value. It offers advantages over direct questioning techniques by teasing out which features really matter, rather than taking what participants state as being important at face value. The method works by splitting a product (for example the offer of S.18(3)) into its component parts, known as attributes (such as location), and within each of these attributes we can test different options, known as levels (for example, the care home being in the desired location or further away).

Participants are subjected to a small number of possible combinations of these levels. Using Bayesian analytical techniques[1] we can determine the impact of preference for any combination of attribute levels. These techniques are explained in more detail in Annex A.

2.3.1 How the DCE was used for this project

The DCE was set up by Ipsos' specialist data analytics team and integrated within the survey. The DCE contained six related attributes focused on characteristics of a care home, place, or the process of organising it. Each of the attributes had multiple levels that were tested. Full description of the attributes and levels can be found in Table 4.2 in section 4.

To add behavioural insight to the DCE data, participants were asked about their likely uptake intent on a 4-point scale for five fixed combinations (also known as concepts) which simulated an LA offer of a care home place. The fixed combinations spanned from 'very poor' to 'very good'. For example, the 'poor' offer was a care home which was one of 2 options offered by the LA, rated 'good' by the CQC with a basic standard of facilities, located near their preferred area, with a wait time for being placed there of 6 months (4 months longer than self-arranged), at a cost of £850 per week (a saving of £170 per week). It

[1] The analysis of the choice data was conducted using a Hierarchal Bayes (HB) algorithm. The HB technique fits a Multinomial Logit Model (MNL) to each individual participant using an iterative approach that maximises the posterior likelihood. In other words, HB finds the optimum set of utility parameters given the observed participant data and given the knowledge about the rest of the sample.

It is called 'hierarchical' as participant data (lower model) is supplemented by the data for the total sample, known as the population (upper model). This additional information from the 'population' strengthens the estimation for individual participants by looking at how different the participant data is compared to the population data.

was important to ensure that a mix of undesirable and desirable concepts was tested so that the full spectrum of concepts was covered. The full range of combinations is shown in section 5.1.

For each of the concepts, 'utility' score or desirability of each concept was derived from the main DCE analysis. This included the preference data which indicated in a binary way whether they would take up S.18(3), with a choice between *'Yes, I would accept the offer and ask the local authority to arrange the care'* and *'No, I would look for other care options myself*'. Regression analysis was then carried out, at the participant level, to identify a relationship between the utility of a concept and the likely uptake intent.

A decision was made to present the analysis without calibration modelling which would have weighted down the preference shares. Calibration is commonly used in consumer market research DCEs where there is a tendency for consumers to overstate whether they would buy one product over another. In these contexts, calibration is applied to adjust the DCE results to levels more consistent with actual consumer behaviour. The calibrations used in consumer research are based on data from that context and are unsuited to social research, for which there are no available data to base the calibration on. Any alternative calibration would be based on subjective assumptions rather than being evidence-based. Therefore, the recommendation by Ipsos and the academic behavioural expert commissioned by DHSC is that uncalibrated analysis is presented. More detail on the reason for presenting uncalibrated results is provided in Annex A.

The outcome of the analysis was fed into a dynamic excel-based simulation tool (DCE simulator) that provides an understanding of what features make S.18(3) desirable to participants and how adjustments to the LA offer could influence levels of uptake. The DCE simulator enabled the calculation of the utility of the product and from the regression modelling it was possible to determine the potential uptake intent for the concept. This data was then overlayed with uptake intent data onto the share of preference data to get a more realistic measure of actual uptake.

This DCE simulator also offers a multitude of analysis options to gain valuable insights. For example:

- comparing a simulation across filters (such as age, gender, financial status and likelihood to take up S.18(3)) to identify key participant characteristics affecting preference,
- attributing sensitivity to identify which levels have the largest impact on preference
- profiling to understand the composition of participants (demographically)

The research team used the tool to conduct analysis of the DCE data. The findings from this analysis are presented in section 4. The findings present a guide to what factors may influence uptake and which scenarios and circumstances may see the highest uptake. Preference shares should not be taken as a definitive indication of the percentage of people needing a care home place taking up S.18(3).

2.4 Behavioural approaches

The research has involved a behavioural approach to considering the likely uptake of S.18(3) and the factors which affect decisions about arranging care. As well as using a Discrete Choice Experiment (DCE), consideration was given to how the survey content aligns to a behavioural framework. The

Theoretical Domains Framework[2] which maps to COM—B, was considered since it contains domains relevant to the kinds of decisions which would be made around arranging and paying for care. The questionnaire content was assigned to the domains which included content and factors to be considered in the analysis relating to:

Capability

- knowledge (experience of formal care and contact with the LA)
- behavioural regulation (planning for future care needs)

Opportunity

- environmental context and resources (receipt of care, assets and financial circumstances)

Motivations

- social and/or professional role and identity (role as a carer)
- beliefs about consequences (concerns about the costs of care and trust in LA)
- intentions (approach to taking up S.18(3))
- goals (attitudes to paying for care using savings and assets

Findings from the behavioural approaches are set out in section 7.

2.5 Target audience for survey

The project specification defined the target audience for the survey as ‘older individuals who are not yet accessing formal care but may do so in the near future’. However, S.18(3) would not be applicable for people with assets below the upper capital limit (expected to be £100,000 after charging reform), as they would be eligible for LA means tested support, so they were excluded from the study. Decisions about moving to a care home are often joint decisions made between family members so we recommended at the proposal stage that the research also survey families of those who may access formal care in the future.

During scoping, we explored and tested the relevance of these definitions. Based on the findings, we revised the definition of the target audience. The three participant types are presented in the table below.

[2] A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems by Atkins et al. (2017) https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0605-9

Table 2.1: Participant types for survey routing

Participants responding on behalf of themselves	Aged 65 or older, with assets of £100,000 or more (a potential self-funder under new expected capital limit rules) and either has care needs (without intense formal care), or has no care needs or intense needs and does not care for or support anyone who is a potential self-funder aged 65 or older. Participants meeting these criteria were asked questions about needing to access a care home for themselves
Participants responding on behalf of someone else	Aged 65 or older who care for or may support a potential self-funder aged 65 or older and who themselves have assets under £100,000 (that is, not a potential self-funder) or with assets of £100,000 or more and no care needs or with intense needs. Participants meeting these criteria were asked questions about supporting a family member or relative needing to access a care home
	Aged 30 to 64 who care for or may support a potential self-funder aged 65 or older. People aged under 30 were not included as they are less likely to be caring or supporting someone aged 65 and over and the issues raised by the research may not seem relevant to them. Participants meeting these criteria were asked questions about supporting a family member or relative

These target audiences were used to define the routing through the questionnaire and the wording for the questions. The term ‘potential self-funder’ is used as a convenient shorthand throughout the report to reflect that:

- a proxy measure of wealth (owning a home and assets of over £100,000 for individuals responding about themselves) was used rather than a financial assessment
- for those reporting on someone they care for or support, the proxy measure of wealth is based only on owning a home
- they would only be a self-funder if they developed eligible care needs and chose to purchase care to meet those needs
- financial circumstances may change and at the point of needing care their financial circumstances may mean they would not be a self-funder

A detailed breakdown of the eligibility route can be found in Annex A.

Some participants aged 65+ could fall into two eligibility categories. If someone was both a potential self-funder aged 65+ and cared for another potential self-funder aged 65+ they were asked about care for themselves. The exceptions were that potential self-funders aged 65+ with no existing care needs or existing intense care needs who cared for another self-funder aged 65+, who were asked about care for a relative rather than themselves. Potential self-funders aged 65+ with no care needs or intense care needs who did not care for a self-funder aged 65+ were asked about care for themselves, just like other self-funders.

2.6 Sampling

The sample was drawn from Ipsos' UK KnowledgePanel. The UK KnowledgePanel is a random probability online panel. It provides an accessible random probability alternative to face-to-face and telephone based methods, and offers a high quality and efficient means of obtaining survey results using a single data collection method.

2.6.1 Panel recruitment

Panellists are recruited to the KnowledgePanel via a random probability unclustered address-based sampling method. This means that every household in the UK has a known chance of being selected to join the panel. Letters are sent to selected addresses in the UK (using the Postcode Address File) inviting them to become members of the panel. Invited members can sign up to the panel by completing a short online questionnaire or by returning a paper form. Up to 2 members of the household are able to sign up to the panel. Members of the public who are digitally excluded can register to the KnowledgePanel either by post or by telephone, and are given a tablet, an email address, and basic internet access (see further information below) which allows them to complete surveys online.

2.6.2 Achieved sample

Survey fieldwork ran from 30 March to 5 April 2023. A total of 1,290 eligible KnowledgePanel panellists aged 30 and over completed the survey module and are included in the findings presented in this report. A detailed breakdown of the fieldwork outcome (including sample size and number answering the initial screening questions) is available in Annex A. The achieved sample was slightly higher than the target minimum sample of 1,000 which was selected to enable analysis of sub-groups (for example demographic groups, whose care was being considered and DCE scenarios alone or in combination). The complexity of relationships found, for example between whose care was being considered and finances and by region means that, at times sub-group analysis has been limited by the overall sample size.

2.7 Weighting

Weighting is required to reduce the risk of bias in survey estimates because the characteristics of those who respond to a survey do not perfectly match the profile of the population. Weights are produced to make the weighted achieved sample match the characteristics of the population as closely as possible.

To ensure the survey results are as representative of the target population as possible, a weighting specification was applied to the data in line with the target population profile (more information is set out in Annex section A). Weighting was applied to all cases who completed the screening module and were screened out or who were screened in and completed the survey. This is because we know the population profile of those invited to answer the screening questions (those aged 30+) but not those eligible for the module (which depends on their financial status and caring responsibilities). The weights were calculated after excluding cases for quality control reasons (inconsistent routing through questionnaire and completing the survey in less than 5 minutes).[3] The justification for this cut off is explained in more detail in the Annex.

[3] This cut off was decided after exploring response timings, taking into consideration the median length of the module (16 minutes) and the amount of information which participants were given to read and the number of questions, balanced with the aim of not excluding those who had responded to the survey properly but faster than others (we found that younger people tended to respond faster than older people which may relate to their ability to navigate online and process information more quickly). After discussion a cut off of 5 minutes was agreed.

Two members per household are allowed to register on the KnowledgePanel. Therefore, we employed a design weight to correct for unequal probabilities of selection of household members.

Calibration weights have also been applied using the latest population statistics, at the time of analysis, relevant to the surveyed population to correct for imbalances in the achieved sample. The variables for weighting were selected based on KnowledgePanel standard practice as well as additional variables requested by DHSC (sexual orientation) or important because of the subject matter of the survey. The data were weighted by highest educational qualification and National Statistics Socio-economic Classification (NS-SEC) to account for socio-economic differences in financial decision making.

The target and achieved weighted sample profile is detailed in Annex A.

3 Likely uptake of S.18(3)

The following section explores the overall likely uptake of S.18(3) across participants. It also includes detailed findings on the relationship between key demographics, characteristics, and attitudes associated with the likelihood of taking up S.18(3). This is based on general questions about likelihood of taking up S.18(3) without any detail on the offer from the LA, compared with what would be available as a self-funder.

Participants were eligible to take part in the survey module if they were potential self-funders (i.e. have assets above £100,000) aged 65+ and did not use intense formal care, or were aged 30+ and cared for or supported someone who met the criteria for a potential self-funder. Participants aged 65+ who would be potential self-funders were asked questions about likely uptake of S.18(3) when considering arranging care for themselves. Participants aged 65+ who were not potential self-funders or who had no care needs or intense care needs and those aged 30-64, who cared for or supported someone else were asked questions about likely uptake if they were arranging care for a family member (see section 2 for more detail on the rules for this).

The focus here is on overall intention to take up S.18(3), how participants would go about this and relationships with the characteristics of participants. To understand how differences in what is offered under S.18(3) in terms of cost, timings and quality of provision may affect uptake, refer to section 4.

Likely uptake of S.18(3): key findings

Participants were asked about the likelihood of taking up S.18(3) at two points during the survey: (1) after they had been provided with information explaining S.18(3); (2) once they had completed the DCE module. The reason for asking this question at two stages was to understand how likelihood of uptake changed after considering S.18(3) in a worked scenario with details about the options.

Findings from the survey show a lower proportion of participants said they would take up S.18(3) at the first question (34%), compared with the second question (47%). This indicates people may be more likely to take up S.18(3) once they know more about the policy and have considered how it may affect the care available to them compared with arranging it themselves.

To understand this further, participants were asked whether they would explore the options with the local authority, and the timing of this in the process of arranging the care. Most participants said they would contact the LA about arranging care to find out what they could offer. When asked how they would go about arranging care, nearly three quarters (72%) said they would ask the local authority to arrange the care and compare this to what would be available if they arranged it themselves.

Analysis also explored characteristics associated with S.18(3) uptake. Findings show that previous experience of care, trust in LA, financial circumstances (for example concern about cost of care, value for money) and gender (men were more likely to take it up) were associated with uptake. There was also variation in uptake by region, with those in the South more likely to take up S.18(3) compared with overall, whilst those in the North were more unlikely to take it up compared with overall.

3.1 Uptake of S.18(3)

Participants were asked questions about the likelihood of taking up S.18(3) at two stages during the survey. The first question was asked towards the beginning of the survey after they had been provided

with information explaining the policy. They were asked a second time after completing the DCE module to understand how likelihood of uptake changed, if at all, once participants had considered the policy in more detail and had a greater understanding of the care which might be available (through the DCE). Figure 3.1 below shows responses to the two likelihood of uptake questions at both points in the survey. This section only covers responses to the general uptake questions. Analysis of the DCE and behavioural model questions are covered in sections 4 and 5.

3.1.1 Overall likelihood of uptake

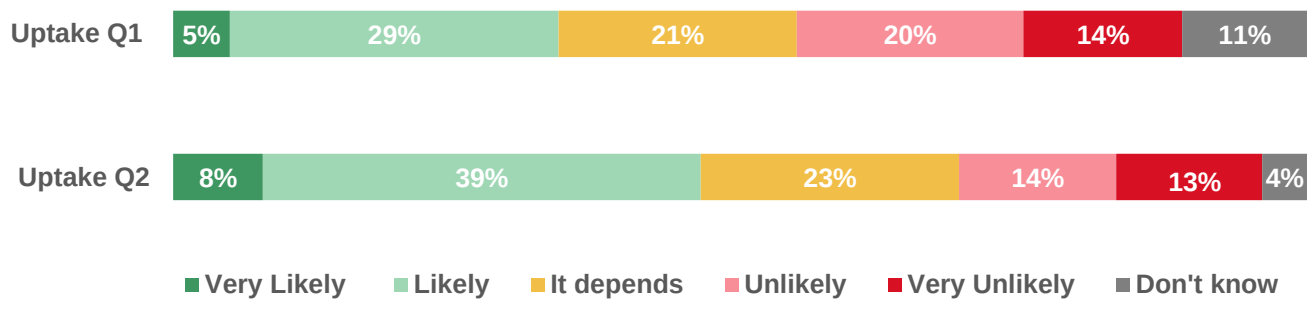
Overall, when shown general information on S.18(3), around one third (34%) of participants were likely (likely or very likely) to report taking up S.18(3) and around one third (34%) of participants reported being unlikely (unlikely or very unlikely) to do so. Fewer participants (5%) said they were very likely than said they were very unlikely (14%). Almost a quarter (21%) reported that their likelihood of uptake would depend. A further 11% said they did not know.

Participants were asked a second question on likelihood of uptake, following the DCE task. The DCE task required participants to consider whether they would take up S.18(3) in a specific scenario, considering a variety of care options (see section 4 for more details). Following the DCE, when asked another general question about uptake without any details of the offer, the proportion of participants reporting being likely to take up S.18(3) increased to nearly half (47%), while the percentage reporting being very likely increased to 8%. The percentage reporting being unlikely to take up S. 18(3) fell from one third (34%) to around one quarter (26%) and the percentage being very unlikely to take it up remained similar at 13%. Those reporting 'it would depend' remained relatively consistent (23%), but the percentage reporting they did not know reduced to 4%.

This suggests people may be more likely to take up S.18(3) once they know more about the policy and have considered how it would work in a variety of potential circumstances, especially if having more detail indicates that what would be offered is better than first assumed. The second question may provide a more accurate indication of likely uptake than first, because by the time they were asked the second question, participants had a better understanding of what might be offered to them under S.18(3) and what factors were important in their decision making. However, this would depend on whether taking part in the DCE had led them to have a realistic impression of the offer of care they might get from the LA under S.18(3).

Figure 3.1 shows the likelihood of uptake of S.18(3) when asked the first and second uptake questions.

Figure 3.1: Comparison of uptake likelihood at first and second uptake question



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

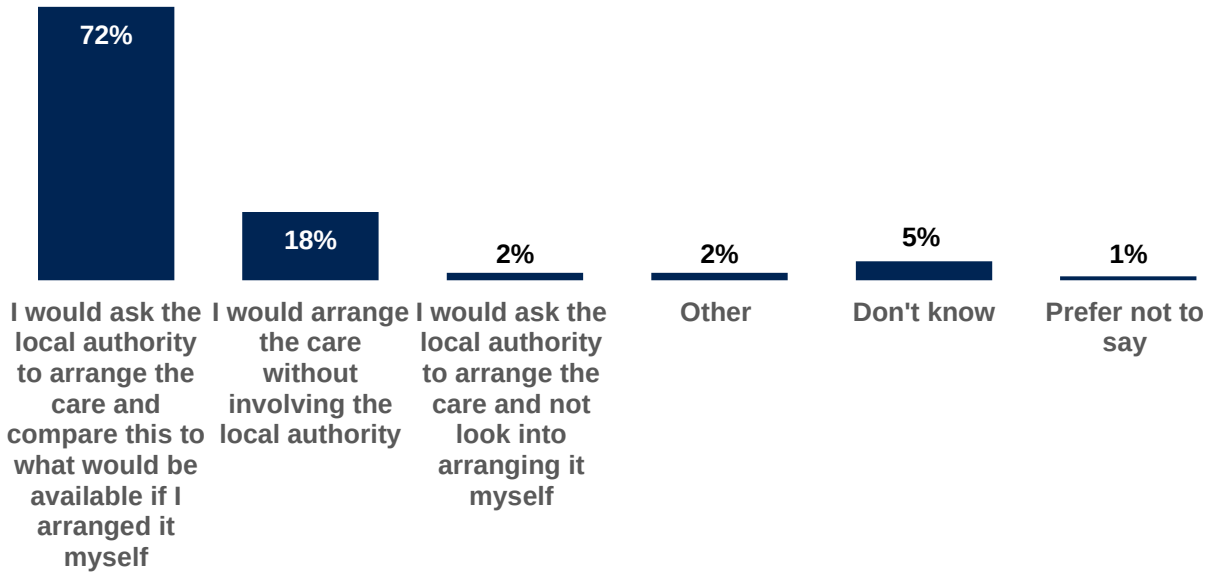
3.1.2 How and when care is arranged

Scoping work prior to the survey showed that there are two stages in taking up S.18(3). The first is contacting the LA to find out about eligibility for a care home place and what the LA could offer. The second is making a decision to go ahead and ask the LA to arrange the place and pay for the care at the LA rate, on behalf of the self-funder with care needs (who would then refund the local authority). Both of these stages have implications for LA resourcing, with the latter more long-term and onerous than the first.

The general questions about likelihood of uptake were worded in a way which combined these elements. The DCE explicitly tried to make it clear that the decision was about going ahead and asking the LA to arrange the care for the given offer. To understand the extent to which participants might consider S.18(3) as an option but not necessarily go ahead and get the LA to arrange the care, participants were asked whether they would explore the options with the LA and the timing of when they would contact them.

Around a third to almost half of participants said they would be likely to take up S.18(3). However, when asked a direct question about it, the majority of participants said they would contact the LA about arranging the care for themselves or their relatives in order to find out what they could offer. When asked how they would go about arranging care, nearly three quarters (72%) of participants said they would ask the LA to arrange the care and compare this to what would be available if they arranged it themselves. In contrast, only 2% of participants said they would ask the LA to arrange the care without looking into it themselves. Less than one fifth of participants (18%) would arrange the care themselves without involving the LA. Figure 3.2 shows participant responses about how they would ask the LA to arrange the care.

Figure 3.2: How participants would go about arranging care

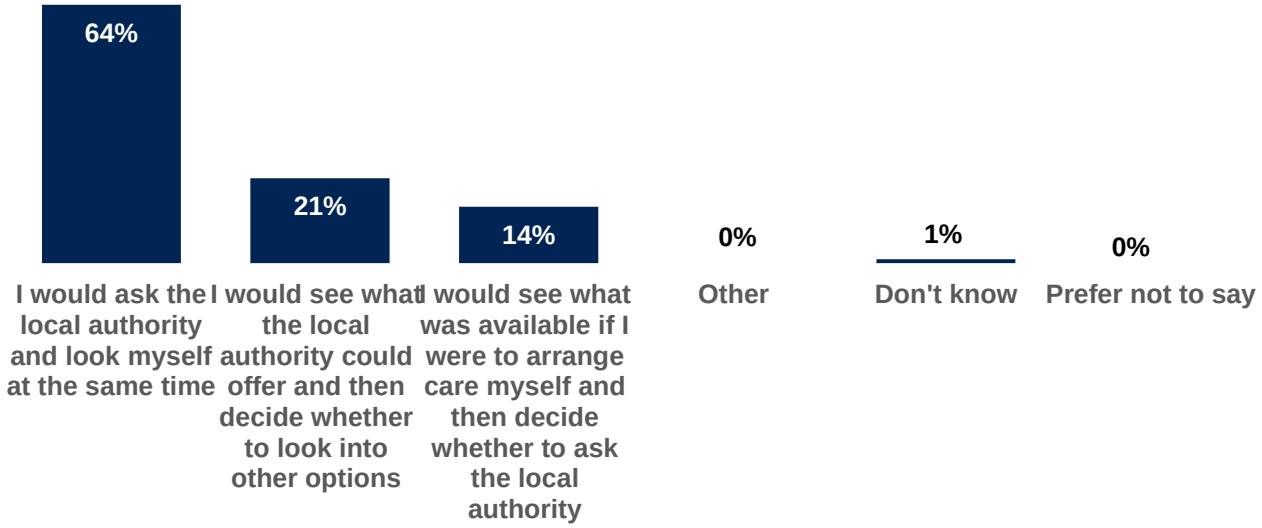


Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

Those who said they would ask the LA to arrange the care, while also comparing this to what would be available if they arranged it themselves, were asked when they would approach the LA to arrange care. The majority (64%) of participants who would involve the LA would ask the LA and look for care themselves at the same time. One in five (21%) of participants would approach the LA before deciding to

look into other options and 14% would first see what was available themselves and then ask the LA. Figure 3.3 shows participant responses to when they would ask the LA to arrange the care.

Figure 3.3: Percentage change in preference share compared to 'middle' offer



Base: All eligible for module and would arrange care with LA and self (n=795 (weighted) – n=945 (unweighted))

There was no significant variation between different groups of participants in when they would involve the local authority when arranging care. However, this may be a result of the small base sizes.

Findings from the open response question provide greater insight into participant views towards how they would involve the LA in arranging care. The general theme among those who would value the LA's involvement in the process is that participants favour looking for other offers at the same time as the LA to maximise the options and enable them to make an informed decision.

> **"I think the best way forward is for both the LA and the individual to do their own research on available care using, share the results so a fully informed decision can be made."**
> (age 45, supports a self-funder, Q1 take up of S.18(3) 'unlikely')

> **"I would keep all options open, it should be up to the individual to decide what level of care they would like."**
> (age 62, supports a self-funder, Q1 take up of S.18(3) 'unlikely')

> **"I think local authorities should be involved to some extent in all decisions about adult care except perhaps for the very wealthy."**
> (age 82, considering care for self, Q1 take up of S.18(3) 'It depends')

3.2 Characteristics associated with S.18(3) uptake

There are several characteristics associated with S.18(3) uptake.

3.2.1 Previous experience of formal care

There was a significant association between the likelihood of S.18(3) uptake and previous experience of care. Participants with previous experience of formal care, either for themselves or others, were shown to be significantly less likely to take up S.18(3) compared to overall (39% vs. 34%). In addition, those with no experience of formal care were shown to be significantly more likely to take up S.18(3) compared

to overall (38% vs. 34%). However, in contrast, considering the first step of taking up S.18(3), those with previous experience of formal care (75%), were more likely to ask the local authority to arrange the care and compare this to what would be available if they arranged it themselves than those without previous experience of formal care (67%).

3.2.2 Trust in LA

There also appeared to be a significant association between trust in LA and likelihood of S.18(3) uptake. Participants who trust their LA were significantly more likely than those who do not trust their LA to take up S.18(3) (59% vs. 32% in the second uptake question after the DCE). In addition, those who trust their LA were also more likely to ask the LA to arrange the care and see what the options would be (first step of taking up S.18(3)), compared with those who distrust their LA (81% vs. 62%). A breakdown of trust in LA is detailed in section 6.3.

3.2.3 Financial circumstances

Participants who reported being most concerned about the cost of care or value for money were more likely to take up S.18(3) compared with overall (39% vs. 34%). In contrast, those most concerned about their assets and inheritance were more likely than those concerned about the cost of care or value for money to say they were unlikely to take up S.18(3) (40% vs. 30%), when first asked about uptake. These differences were reduced when asked about uptake for a second time, though those concerned about cost of care or value for money were still more likely to take it up (52%) than participants overall (47%).

When first asked about likelihood of S.18(3) uptake, the association between concerns about the cost of care and likelihood of uptake appeared to vary according to whether participants are arranging care for themselves, or for someone else. Among those asked about arranging care for themselves, participants concerned about the cost of care or value for money were significantly more likely to take up S.18(3) (44%) compared with those concerned about their assets and inheritance (29%). In contrast, among those asked about arranging care for someone else, participants concerned about the impacts of care costs on assets and inheritance were significantly more likely to take up S.18(3) than those concerned about the cost of care or value for money (49% vs. 30%). Following receiving more information about S.18(3) in the DCE, when asked the second uptake question, the significant association did not remain. This suggests that once people have more information about and understanding of the policy, differences in likelihood of taking up S.18(3) based on cost concerns are reduced.

Participants were asked about the financial circumstances (from very weak to very strong) of the person for whom decisions about taking up S.18(3) were being considered. Those who considered their financial situation to be medium (4-5 on a scale of 1-7) were significantly more likely to say they were likely to take up S.18(3) (38%) than those with a strong (6-7) financial situation (28%). Although not statistically significant, because of small sample sizes, those with a weak (1-3) financial situation had a similar likelihood to those with a medium financial situation (39%). Following receiving more information about S.18(3) in the DCE, when asked the second uptake question, the significant association did not remain. Again, this suggests that once people have more information about and understanding of the policy, the differences in likelihood of taking up S.18(3) based on financial concerns are reduced.

3.2.4 Demographic characteristics

The uptake of S.18(3) varied by gender. Across both uptake questions, male participants (41% for first question and 56% for second question) were significantly more likely than female participants (29% for first question and 39% for second question) to take up S.18(3). Having more information after answering the DCE seemed to increase rather than reduce the gender differences. Gender differences may be

partly explained by the gender differences found in previous experience of caring which is associated with a lower likelihood of uptake: a significantly higher proportion of females (67%) reported having cared for someone (now or in the past) compared with males (50%).

However, the gender differences remain when comparing participants with prior caring experience. Amongst those with prior caring experiences, male participants (40%) were still significantly more likely than female participants (28%) to take up S.18(3), an effect which remained after receiving more information in the DCE.

The findings suggest there may be variation in the likelihood of S.18(3) uptake across regions of England. A significantly higher percentage (39%) of participants in the South region of England were likely to take up S.18(3) compared with overall (34%). In addition, a significantly higher percentage (43%) of those in the North regions of England were unlikely to take up S.18(3) compared with overall (34%). Sample sizes are too small for analysis by region and financial circumstances or by more granular regional breakdown and exploration of the reasons for regional differences.

Retired participants were significantly more likely (51%) than those working full-time or part-time (42%) to take up S.18(3).

There did not appear to be a significant difference in likelihood of uptake across age group, ethnicity, urbanity, Index of Multiple Deprivation (IMD) quintile, sexual orientation, marital status, or education. However, those aged 30-44 years (81%) were more likely to take the initial step of asking the LA to arrange the care and see what the options would be, compared with those aged 75 and over (65%).

4 Factors influencing decision making

A Discrete Choice Experiment (DCE) is an advanced analytic technique that aims to understand what is most important to individuals when making decisions. For this research a DCE was used to inform how the uptake of S.18(3) can vary by its attributes and the characteristics of the local care home market, the circumstances in which a move to a care home is being considered, and individual demographics. More information about the methodology of the DCE is provided in section 2.

Factors influencing decision making: key findings

A Discrete Choice Experiment (DCE) was used to inform how the uptake of S.18(3) might vary according to circumstances, the care offered and participant characteristics. Participants were shown one of four scenarios depending on their eligibility routing through the survey and presented with 12 combinations of a care home offer. The DCE analysis explored preference for the 'middle' offer (considering choice, quality of care and facilities, location, waiting time and cost). The results are presented uncalibrated. The findings show that over half of participants would prefer to take up the 'middle' offer over not taking it up.

Analysis was conducted to understand which attributes have the biggest impact on preference. Quality of care had the biggest impact of all attributes, followed by location of care home and then by cost of care and savings. Quality of facilities was also shown to be important. However, number of care homes to choose from and waiting time to be placed in care home had limited impact on preference. Negative characteristics have a stronger impact on reducing preference than positive characteristics on increasing preference for S.18(3) when comparing them with the 'middle' offer.

Differences were identified depending on whether participants were arranging care for themselves or someone else. The impact of the care offered on preference for taking up S.18(3) was smaller for those arranging care for themselves, compared with those arranging care for someone else. This suggests that people considering care for others may be more concerned about ensuring the person they are arranging care for is placed in a home that offers a good standard of care and is in a convenient location.

The findings show a complex relationship between financial status and preference for take up of S.18(3), mediated by whose care is being considered. There were limited differences in uptake by financial status, though those considering arranging care for themselves with the weakest perceived financial situation expressed the lowest preference for S.18(3).

In line with the findings about overall uptake, those in the South expressed a greater preference for taking up S.18(3) compared with those in London, the Midlands and the North.

4.1 Presenting the Discrete Choice Experiment

Participants were eligible to take part in the survey which included the DCE if they were potential self-funders aged 65+ or were aged 30+ and cared for or supported someone who is a self-funder. The methodology section (section 2) explains more about the eligible sample.

Eligible participants were introduced to the S.18(3) policy and its service requirements (for example, a small admin fee, a financial and a care needs assessment), associated charging reform policies such as the care cap, care quality ratings that indicate the quality of care provided, and the standard of facilities available in care homes. Following this they were assigned to one of four scenarios. All the scenarios participants were presented with followed the same format (see an example of a scenario at the end of this paragraph). The scenarios varied between being asked to imagine it was themselves (the

participant), or that it was their relative, needing care (see section 2.5 for more details). Within these two options, participants were randomly assigned to a scenario in which they were asked to imagine the person is in hospital needing to go into a care home or a scenario in which the person is at home and needing to move into a care home. See Table 4.1. for a more detailed overview of each scenario presented.

Scenario example:

Now imagine that the year is 2025. You need to move permanently to a care home as soon as possible because you need full time care, and your needs cannot be fully met at home. Currently you are in hospital and must be discharged into a care home. If you need to wait for a long-term care home place, you could be placed in a temporary care home. It is expected that you would be in the long-term care home for at least 2 years.

You are not eligible for local authority funded support and will have to pay for a care home place yourself. If you cannot pay from your income and if your remaining assets and savings got down to £100,000 or you reached the cap of £86,000 on the overall qualifying personal care costs you have paid, your local authority would help fund your care.

You have a choice of whether to:

- ask the local authority to arrange it for you (you will still pay), or
- arrange the care yourself

Table 4.1: Allocation of scenarios across eligible participants

	Sample	Type of entry point into a care home (randomly assigned)	Who would need care (based on sample type)	Verbatim text used
Scenario 1	Self-funders aged 65+[4]	Hospital entry point (Needing to move from hospital into a care home)	Themselves	You need to move permanently to a care home as soon as possible because you need full time care, and your needs cannot be fully met at home. Currently you are in hospital and must be discharged into a care home. If you need to wait for a long-term care home place, you could be placed in a temporary care home.
Scenario 2	Self-funders aged 65+[4]	Community entry point (Needing to move from own home into a care home)	Themselves	You need to move permanently to a care home as soon as possible because you need full time care. You are living at home and your needs cannot be fully met there.
Scenario 3	Aged 30+ who cared for or supported someone who is a self-funder	Hospital entry point (Needing to move from hospital into a care home)	A relative	Your relative, who you provide care and support to, needs to move permanently to a care home as soon as possible because they need full time care. Currently they are in hospital and must be discharged into a care home. If they need to wait for a long-term care home place, they could be placed in a temporary care home.
Scenario 4	Aged 30+ who cared for or supported someone who is a self-funder	Community entry point (Needing to move from own home into a care home)	A relative	Your relative, who you provide care and support to, needs to move permanently to a care home as soon as possible because they need full time care. They are living at home and their needs cannot be fully met there.

[4] If someone was both a self-funder aged 65+ and cared for another self-funder they were asked scenarios 1 or 2. The exceptions were that self-funders with no care needs or intense care needs who cared for another self-funder were asked scenarios 3 or 4. Self-funders aged 65+ with no care needs or intense care needs who did care for a self-funder were asked scenarios 1 or 2, just like other self-funders.

Once participants were shown their scenario, they were asked to imagine that the local authority made an offer to arrange the care in a care home and were shown their best offer. This best offer displayed a different combination of attribute levels, enabling several characteristics to be considered each time. An example of attribute characteristics is shown below. These attributes were developed based on key informant interviews, focus groups with the general public about what factors matter most to them, and a discussion with DHSC about the variation in care home offers available from LAs. The levels were set based on the likely ranges on the attributes and avoiding extremes (such as an inadequate CQC rating or very expensive costs).

Figure 4.1: DCE exercise example

Imagine the local authority offered you care and the following was their best offer:

Choice of care homes if the local authority arranges the care	The care home is one of 3 options offered to you by the local authority
Quality of Care (CQC rating) if the local authority arranges the care	The care home is rated 'Requires Improvement' by the CQC
Quality of Facilities if the local authority arranges the care	The care home has a basic standard of facilities, room size and food
Location if the local authority arranges the care	The care home is not located near your preferred area
Waiting period from contacting the local authority for assistance to being placed in the long-term care home place (Note: The wait time for self-funders is approximately 2 months)	4 months (2 months longer than self arranged)
Cost of care home if the local authority arranges the care (saving compared with arranging it yourself)	Costs £650 per week (no saving)

Would you accept the local authority's offer and ask them to arrange the care?

Please select one option only.

◯ **Yes** I would accept the offer and ask the local authority to arrange the care

◯ **No** I would look for other care options myself

Participants were asked if they would accept the local authority's offer displayed on the screen and ask them to arrange the care. They could answer 'yes I would accept the offer and ask the local authority to arrange the care' or 'no I would look for other care options myself'. The intention of the wording was to make it clear that they were being asked about the decision to go ahead and ask the LA to commission the care and arrange the place in the care home, not just whether they would enquire with the LA about the options.

The combination of levels was varied across each attribute so that the trade-offs that participants used in their choices could be identified. No combination of offers presented to an individual participant were ever the same. This made it possible to measure participants' preferences within the context of several factors at one time, representing the real-life decision-making environment more accurately.

Participants were shown 12 offer combinations, and the order in which the attributes were shown ('choice of care home' to 'cost of care home') was reversed for half of the sample ('cost of care home' to 'choice of care homes'). Table 4.2. describes the attributes, and levels of these, used in the DCE.

Table 4.2: Description of each attribute and level used in the Discrete Choice Experiment

Attribute	Level
Choice of care homes if the local authority arranges the care	The care home is one of 4 options offered to you by the local authority
	The care home is one of 3 options offered to you by the local authority
	The care home is one of 2 options offered to you by the local authority
Quality of Care (CQC rating) if the local authority arranges the care	The care home is rated Outstanding by the CQC
	The care home is rated Good by the CQC
	The care home is rated Requires Improvement by the CQC
Quality of Facilities if the local authority arranges the care	The care home has a premium standard of facilities, room size and food
	The care home has a good standard of facilities, room size and food
	The care home has a basic standard of facilities, room size and food
Location if the local authority arranges the care	The care home is located within your preferred area
	The care home is located near your preferred area
	The care home is not located near your preferred area
Waiting period from contacting the local authority for assistance to being placed in the long-term care home place (Note: The wait time for self-funders is approximately 2 months)	6 months (4 months longer than self arranged)
	4 months (2 months longer than self arranged)
	2 months (the same as self arranged)
Cost of care home[5] if the local authority arranges the care (saving compared with arranging it yourself)	Costs £850 per week (saving £340 per week)
	Costs £650 per week (saving £260 per week)
	Costs £850 per week (saving £170 per week)
	Costs £650 per week (saving £130 per week)
	Costs £850 per week (no saving)
	Costs £650 per week (no saving)

4.2 Preference for taking up S.18(3): A 'middle' offer

A DCE provides the opportunity for participants to consider their preference for taking up their local authority's offer of a care home, considering different combinations of characteristics. In this section, findings from the DCE are used to explore preferences for a 'middle' offer and how these vary by scenario, if at all. This 'middle' offer was designated as being the middle level for each attribute, or where there was no middle level (where there were 6 levels for costs) being a level that was in the middle in terms of preference shares. This 'middle' offer is presented to provide a baseline for exploring the effects of different levels of each attribute on preferences, and as an offer which would be more likely across LAs than much better or worse offers (though further research with LAs would be needed to confirm

[5] Care home costs and saving were provided by DHSC policy team and developed to reflect current market rates.

this). Table 4.3. shows participants' preference shares overall and by scenario to take up S.18(3) for a 'middle' offer. This was selected as the middle offer on the behavioural model questions. The analysis method is explained in more detail in section 2 (methodology) and in the Annex. It should be noted that the reported preference shares are raw and uncalibrated. Calibration is commonly used in consumer market research DCEs where there is a tendency for consumers to overstate whether they would buy one product over another. In these contexts, calibration is applied to adjust the DCE results to levels more consistent with actual consumer behaviour. The calibrations used in consumer research are based on data from that context and are unsuited to social research, for which there are no available data to base the calibration on. Any alternative calibration would be based on subjective assumptions rather than evidence. Therefore, the recommendation by Ipsos and the academic behavioural expert commissioned by DHSC is that uncalibrated analysis is presented. Preference shares should not be taken as a definitive indication of the percentage of people needing a care home place taking up S.18(3).

Across scenarios, three in five participants would accept a 'middle' offer and ask the LA to arrange the care (57%). The preference shares of participants deciding to take up S.18(3) for their relative moving from hospital (56%), or their home/community (64%), were similar to the average preference share. But when thinking about themselves, participants entering the care system were less likely to take up S.18(3) (from hospital (52%), from the community (51%)).

Table 4.3: Preference share (all and by scenario) to take up S.18(3) for a 'middle' offer

	'Middle' offer characteristics
Choice of care homes	The care home is one of 3 options offered to you by the local authority
Quality of Care (CQC rating)	The care home is rated Good by the CQC
Quality of facilities	The care home has a good standard of facilities, room size and food
Location	The care home is located near your preferred area
Waiting period	4 months (2 months longer than self-arranged)
Cost of care home	Costs £850 per week (saving £340 per week)
Preference share (PS) overall	**57%**
PS in scenario 1 (Hospital entry for individual)	52%
PS in scenario 2 (Community entry for individual)	51%
PS in scenario 3 (Hospital entry for relative)	56%
PS in scenario 4 (Community entry for relative)	64%

Base: All eligible for DCE (n=1,275 (all), 245 (scenario 1), 244 (scenario 2), 392 (scenario 3), 394 (scenario 4) (unweighted))

4.3 Attributes and levels

4.3.1 Which attributes have the biggest impact on preference?

Next, we looked at the change in participants' preferences for taking up S.18(3) in comparison to their preference for the 'middle' offer (described in section 4.2). The difference in preference share is always in comparison to the middle offer and the attributes presented in Figure 4.2. (overleaf) show which attributes, and levels, have the biggest impact on preference for taking up S.18(3). The key findings are:

- The impact of choice on preferences was small with some limited choice being preferred over too much or too little. Having 3 options of care homes to choose from was preferred to having 4 (-2 percentage points) or 2 options (-1 percentage points) which, in comparison, have a small negative impact on the preference for S.18(3).

- Quality of care (CQC rating) had the biggest impact out of all the attributes on preference. The negative impact of a care home rated as 'requires improvement' (-40 percentage points) was greater than the positive impact of being rated 'outstanding' (+11 percentage points) in comparison to a good CQC rating.

Analysis of responses to the open response question highlighted the importance participants placed on quality of care:

> **"To me the quality of care is far more important than the facilities available."**
> (age 78, asked about supporting someone else, Q1 take up of S.18(3) 'It depends')

Participant responses also highlight that people may seek to gather more information about what CQC rating would mean in practice and consider the specific care home offered:

> **"For me the main factor would be quality of care. I would not accept a place that requires improvement without fully understanding exactly what that meant."**
> (age 43, asked about supporting someone else, Q1 take up of S.18(3) 'very unlikely')

- Quality of facilities was less important than the quality of care (CQC rating) but showed a similar pattern. A basic standard of facilities had a greater negative impact on preferences (-13 percentage points) than the positive impact a premium standard of care had (+6 percentage points) compared with a good standard of facilities.

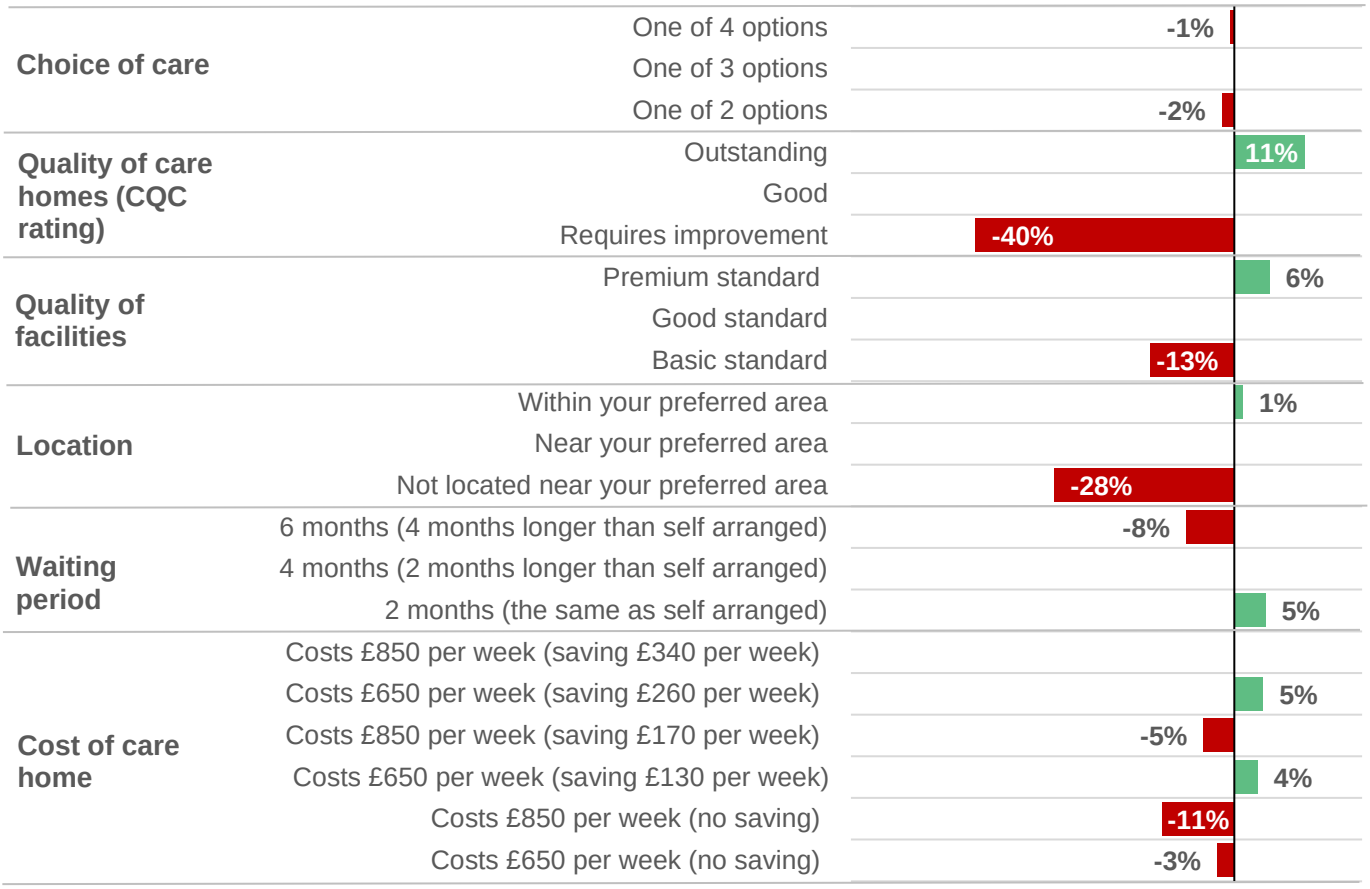
- Location had limited impact when considering whether the care home is within or near participants' preferred area. However, a care home not being located near their preferred area had a strong negative impact on preference (+1 percentage points within preferred area, 0 percentage points near preferred area, -28 percentage points not located near preferred area) compared to a care home near their preferred area.

- Overall, the waiting time to be placed in a care home had a limited impact on preferences. Participants preferred waiting 2 months for a care home placement (+5 percentage points) than 4 months, while waiting 6 months had a negative impact (-8 percentage points).

- Both the cost of the care and the saving compared with arranging care for oneself, had an impact on preference. Higher costs and lower savings had a negative impact on preference and greater savings had a positive impact on preference. Participants showed the lowest preference for the cost of the care home being £850 a week with no saving (-11 percentage points) and the highest preference for a cost of £650 per week and a saving of £260 (+5

percentage points) compared to the 'middle' offer. Compared to the 'middle' offer of a cost of £850 per week (saving £340), high costs (£850) with lower savings (£170 per week) and no savings (£0), and lower costs (£650) with no savings (£0), had a negative effect on preferences (-5, -11 and -3 percentage points, respectively).

Figure 4.2: Percentage change in preference share compared to 'middle' offer



Base: All eligible for DCE (n=1,275 (unweighted))

The findings suggest that participants may use heuristics to make decisions about whether to take up S.18(3), using approaches such as 'elimination-by-aspects'. For example, they may first consider the quality of care, then cost, then location and make their decision primarily on those factors. This is to some extent a limitation of a DCE in that participants may not be able to consider every attribute in full for every decision, however it is effective in highlighting which factors are most important in driving their decision. Quality of care, cost and location were highlighted as important in the scoping work. Choice was considered to be important in the scoping work but the results of the DCE suggest that it may be less about the number of options than about ensuring all the options for arranging care have been considered (as seen in the results for how the LA would be involved in sections 3 and 5).

4.3.2 Does the scenario affect which attribute has biggest impact on preference?

The overall pattern for attributes and levels was the same, whether someone was arranging a care home for themselves or a relative and whether they were thinking about moving from hospital or their own home (see Figure 4.3).

However, differences in preference shares varied by scenario:

- The CQC rating 'requires improvement' had a greater negative impact when participants were deciding to take up S.18(3) on behalf of a relative (either from hospital entry, -41 percentage points; or community entry, -52 percentage points), in comparison to deciding about themselves (from hospital entry, -33 percentage points; from community entry, -30 percentage points).
- The same pattern is observed when considering location of care home. The care home not being located near their preferred area had a greater negative impact when deciding on behalf of relative (either from hospital entry, -28 percentage points; or community entry, -37 percentage points), in comparison to deciding about themselves (from hospital entry, -22 percentage points; from community entry, -21 percentage points).

There were two instances of a differing pattern by scenario. Those being asked about entry for themselves from their own home (scenario 2):

- had only a very slight preference for premium standard facilities compared with good (+2 percentage points)
- would rather a care home place within their preferred area more than participants in other scenarios (+5 percentage points)
- were less opposed to waiting for 6 months in comparison to participants in other scenarios (-2 percentage points).

Figure 4.3: Difference in preference share (percentage points) compared to 'middle' offer by scenario (if by hospital for self (scenario 1), community entry for self (scenario 2), hospital for a relative (scenario 3), community entry for a relative (scenario 4))

Base: All eligible for DCE (n=1,275 (all), 245 (scenario 1), 244 (scenario 2), 392 (scenario 3), 394 (scenario 4) (unweighted))

4.3.3 Which combinations of levels and attributes have the lowest and highest preferences?

Based on the findings in Figure 4.2 which showed how different attributes and levels affected preferences compared with a 'middle' offer, a 'worst' and 'best' offers were modelled to identify the combinations which would lead to the overall lowest and highest preference shares for the sample as a whole. These combinations and their preference shares are shown in Table 4.4 below.

Overall, the preference for the 'worst' offer is 6% compared with a preference of 79% for the 'best' offer. Scenario 2 (community entry point for individual) showed the greatest preference for the 'worst' offer (13%) and the lowest preference for the 'best' offer (73%), as did Scenario 1 (hospital entry point for individual (73%)). Earlier findings in Table 4.3 showed this group preferred the 'middle' offer the least (51% compared with 57% overall).

Table 4.4: Combination of levels and attributes with the lowest and highest preference share, that is, 'worst' and 'best' offer

	'Worst' offer characteristics	'Best' offer characteristics
Choice of care homes	2 options offered	3 options offered
Quality of Care (CQC rating)	Rated Requires Improvement by the CQC	Rated Outstanding by the CQC
Quality of facilities	Basic standard of facilities, room size and food	Premium standard of facilities, room size and food
Location	Not located near preferred area	Located within preferred area
Waiting period	6 months (4 months longer than self-arranged)	2 months (the same as self-arranged)
Cost of care home	Costs £850 per week (no saving)	Costs £650 per week (saving £260 per week)
Preference share (PS) overall	**6%**	**79%**
PS in scenario 1 (Hospital entry for individual)	4%	73%
PS in scenario 2 (Community entry for individual)	13%	73%
PS in scenario 3 (Hospital entry for relative)	7%	80%
PS in scenario 4 (Community entry for relative)	1%	85%

Base: All eligible for DCE (n=1,275 (all), 245 (scenario 1), 244 (scenario 2), 392 (scenario 3), 394 (scenario 4) (unweighted))

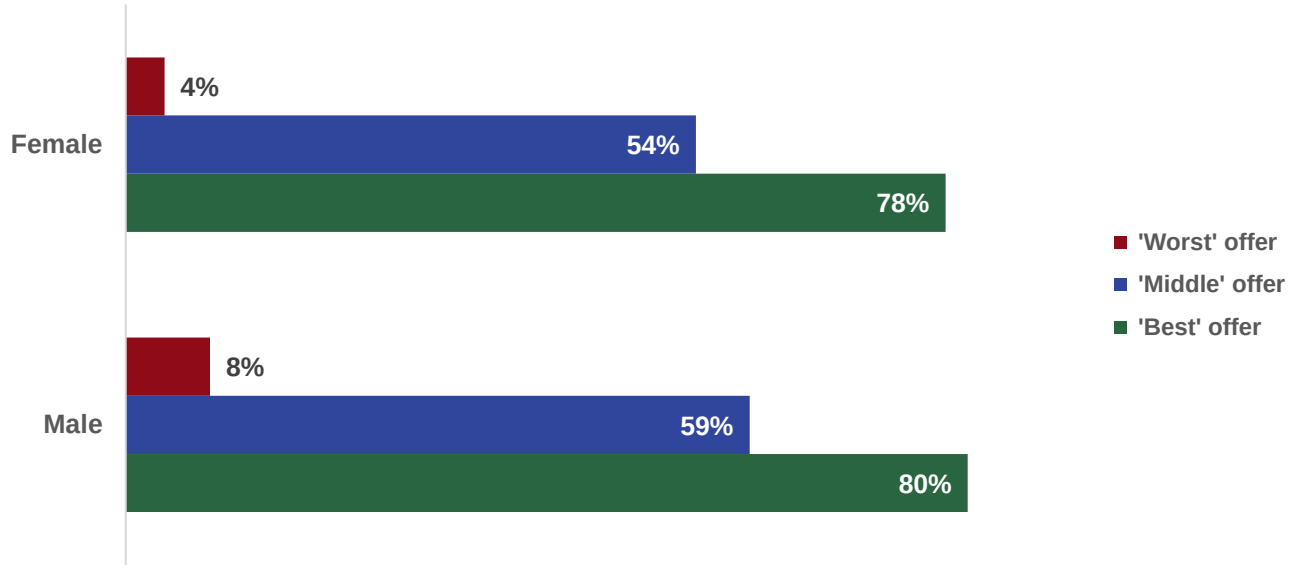
4.4 Demographic differences in preferences

In this section we compare demographic differences in the preference for the 'middle', 'best' and 'worst' offers to explore whether the attributes and levels affect preference in consistent ways for different groups.

4.4.1 Gender

There were limited gender differences in preference for taking up S.18(3), especially for the best offer. Men's preference for taking up the worst offer was twice that of women (8% v 4%). See Figure 4.4.

Figure 4.4: Preference share by gender and type of offer



Base: Male participants eligible for DCE (n=628); Female participants eligible for DCE (n=643) (unweighted)

The patterns of the attributes and levels are largely the same for men and women (see Figure 4.5), suggesting that the factors driving their decision making on this matter are consistent. Though there are a few small exceptions:

- where the waiting period is 6 months, there is a greater negative impact on women's preferences for taking up S.18(3) (-9 percentage points) than men's (-6 percentage points)
- where the cost of a care home is £850 (no saving) per week, there is a greater negative impact on women's preference for taking up S.18(3) (-12 percentage points) than men's (-10 percentage points).

Figure 4.5: Difference in preference share (%) compared to 'middle' offer by gender

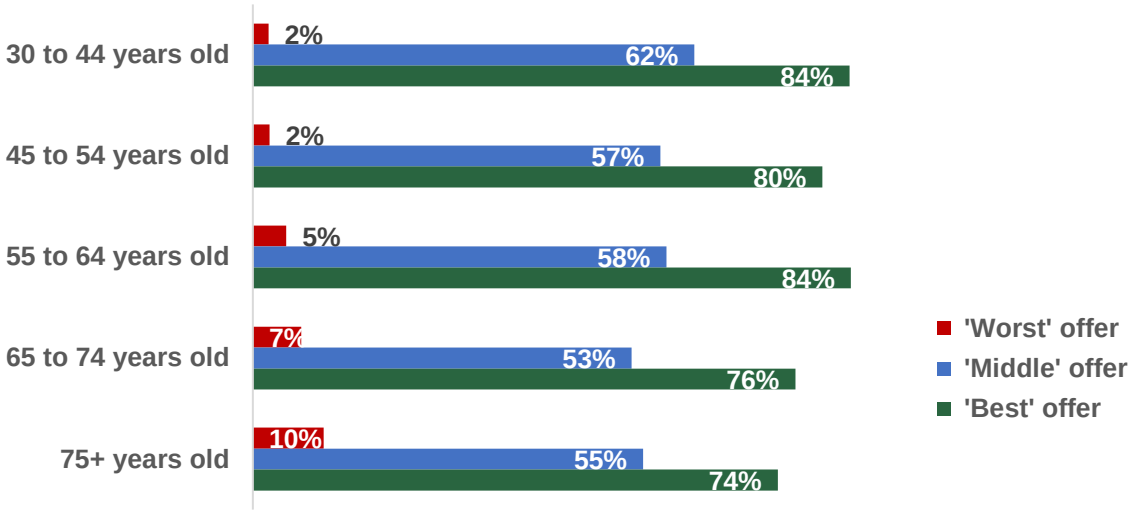
Base: Male (n=628) and female (n=643) (unweighted) participants eligible for DCE

4.4.2 Age

Figure 4.6 shows participants' preference for taking up S.18(3) by their age and type of offer presented ('worst', 'middle' or 'best').

Participants' age did not have much of an impact on their decision to take up a 'middle' offer. However, 30 to 44 year olds, and 55 to 64 year olds, were more likely than all other age groups to accept the 'best' offer (84% vs. 76% for 65 to 74 year olds and 74% for 75+ year olds). Participants' preference for taking up S.18(3) if provided with the 'worst' offer was very low across all age groups, the lowest being amongst the younger age groups (30 to 44 years old, 45 to 54 years old, 2% compared with 10% for 75+ year olds).

Figure 4.6: Preference share by age and type of offer

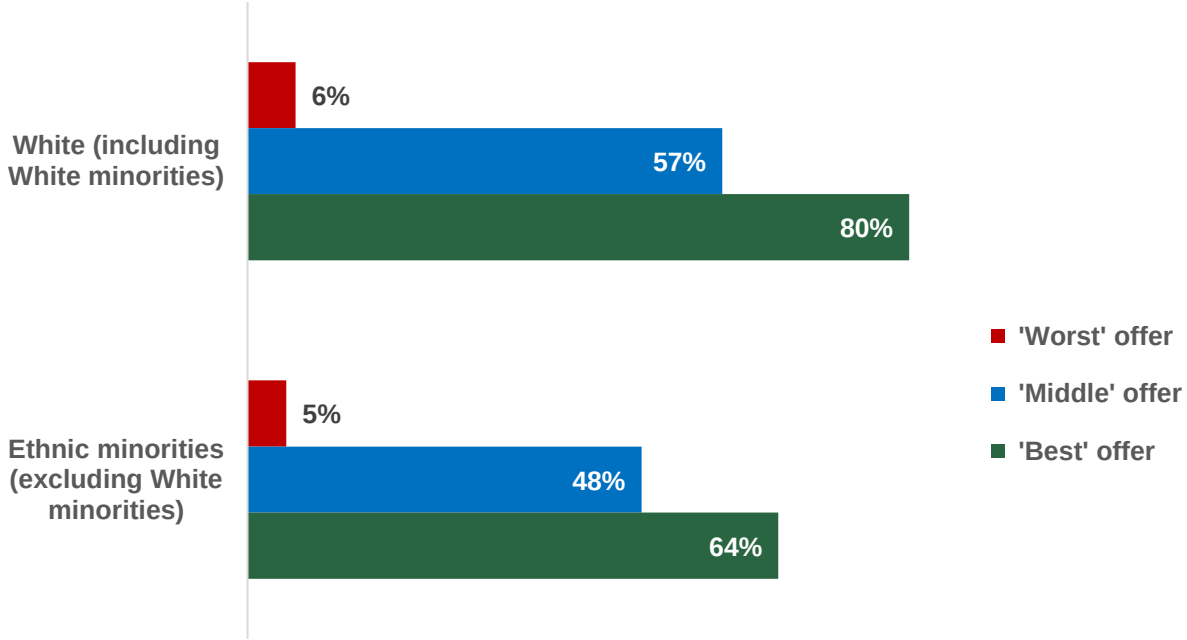


Base: 30 to 44 year old participants eligible for DCE (n=145); 45 to 54 year old participants eligible for DCE (n=206); 55 to 64 year old participants eligible for DCE (n=213); 65 to 74 year old participants eligible for DCE (n=481); 74+ year old participants eligible for DCE (n=230) (unweighted)

4.4.3 Ethnicity

Participants from an ethnic minority background (excluding White minorities) were less likely than the White ethnic group (including White minorities) to accept the ‘best’ offer, 64% and 80% respectively, and the ‘middle’ offer, 48% and 57% respectively. See Figure 4.7. below.

Figure 4.7: Preference share by ethnicity and type of offer



Base: White (including White minorities) (n=1215) and ethnic minorities (excluding White minorities) (n=48) (unweighted) eligible for DCE

4.4.4 Other demographic differences

Analysis by tenure, marital status and health conditions showed few clear differences and have therefore not been presented here. Financial status was found to be important, and this is explored in section 4.6 after considering how preferences varied according to whose care was being considered.

4.5 Patterns in take up according to whether arranging for self or other

Analysis was carried out to explore how the preference for different attributes and levels varied according to whether the care decisions being considered in the DCE were for themselves or a relative (split between 65+ and 30-64 for those considering care for a relative). Starting with the 'middle' offer, those aged 65+ arranging care for a relative were most likely to prefer S.18(3) (62%), while those aged 65+ arranging care for themselves were least likely to prefer S.18(3) (52%). Participants between 30 and 64 years old (who were asked about arranging care for others) had a similar level of preference to those aged 65+ considering care for others (59%).

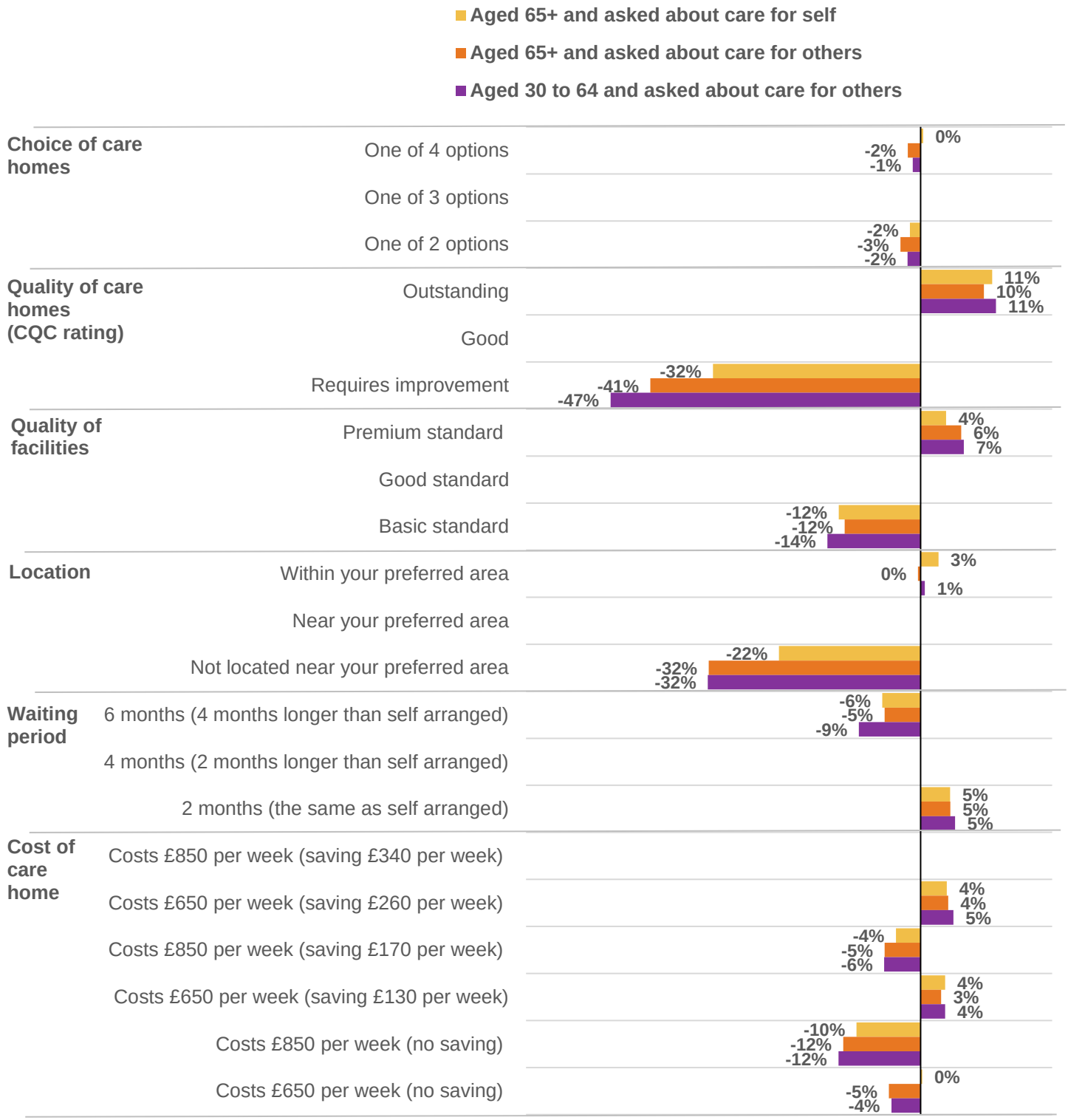
The same attributes were important for all three groups and the direction of impact on preference for the levels was consistent, suggesting overall that the same factors drive preferences. However, there are differences in the strength of negative and positive impacts of attributes and levels on preference (Figure 4.8).

Generally, the impact of the care offered on preferences was less for those considering care for themselves than it was for those considering care for others. The negative impacts of a 'requires improvement' CQC rating was much less for those aged 65+ considering care for themselves (-32 percentage points) than it was for those aged 65+ considering care for others (-41 percentage points) or 30 to 64 years old considering care for others (-47 percentage points). The positive impact of a premium standard of facilities was less for 65+ year olds considering care for themselves (+4 percentage points) than participants considering care for a relative (+6 percentage points, 65+ years old, +7 percentage points, 30 to 64 years old). These findings suggest that people considering care for others, who are more likely to take up S.18(3), may prioritise ensuring the person they are arranging care for is placed in home with a good standard of care.

The location of the care home not being near their preferred area had a particularly negative impact on participants who were asked about care for others (-32 percentage points, vs. -22 percentage points if asked about their own care). This may reflect the impact it would have on them when considering their journey to visit the relative in the care home.

The impacts of cost and savings on preferences were less for those aged 65+ considering care for themselves than they were for those considering care for others. For example, if the cost of care home was £650 per week with no savings the preference shares of those arranging care for others were reduced by -5 percentage points for 65+ and -4 percentage points for those aged 30-64, in contrast to a 0 percentage point difference in preference share for 65+ year olds considering care for themselves.

Figure 4.8: Difference in preference share (percentage points) compared to 'middle' offer by age and if asked about care for themselves or a relative



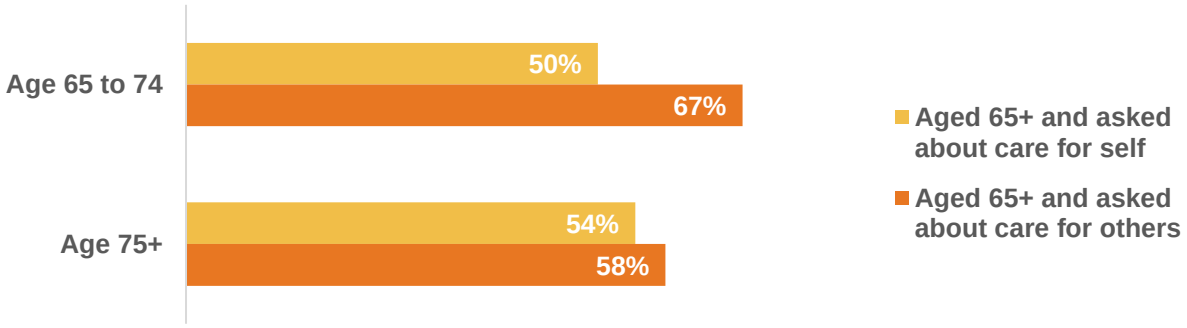
Base: 65+ years old asked about care for self (n=489), 65+ years old asked about care for others (n=222), 30-to-64 years old asked about care for others (n=564) (unweighted) eligible for DCE

4.5.2 How do demographic differences vary according to whether arranging for self or someone else?

Although there are limited gender differences in preference overall, analysis shows gender differences according to whether care is being considered for oneself or a relative. Among those aged 65+ considering care for others, men expressed a lower preference than women for taking up S.18(3) (57% and 69% respectively). Among those aged 65+ considering care for themselves, men expressed a higher preference for S.18(3) than women (57% and 46% respectively).

There were also age differences amongst the 65+ age group. Overall, when looking at the 'middle' offer, those asked about care for others were more likely to express a preference for accepting S.18(3) than those who were asked about care for themselves. This difference was particularly strong for those participants aged between 65 and 74 years old (67% care for others vs. 50% care for self). The difference was weaker for those aged 75+ (58% care for others vs. 54% care for self).

Figure 4.9: Preference share by age and whether for self or other for the 'middle' offer



Base: 65+ years old asked about care for self (n=489) and 65+ years old asked about care for others (n=222)

4.6 Finances and concerns about costs

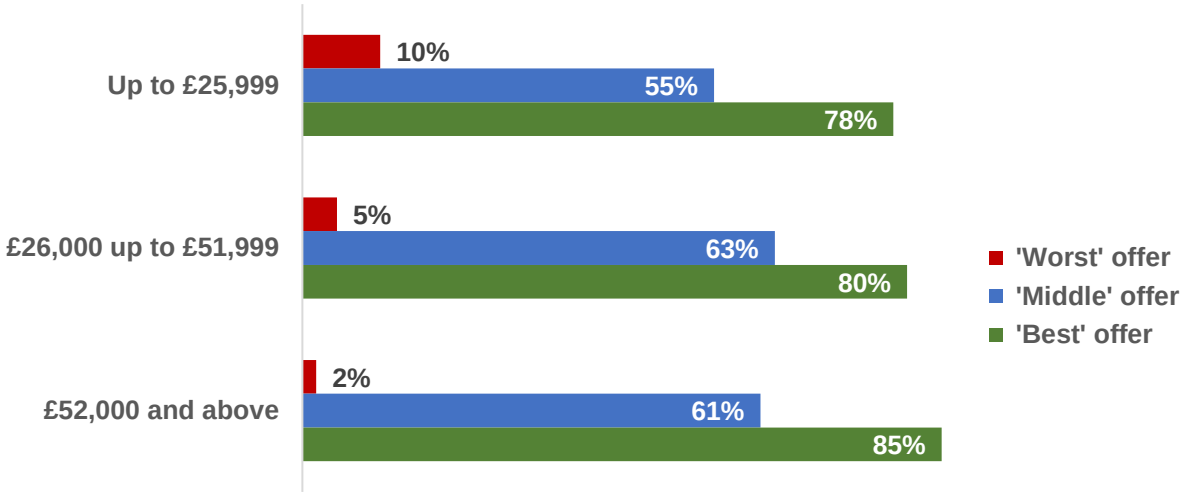
The findings show a complex relationship between financial status and preference for taking up S.18(3) mediated by whose care is being considered. Among those considering arranging care for themselves, those in the strongest financial situation were least likely to take up S.18(3), while among those aged 65+ considering arranging care for others, those in the strongest financial situation (whether their own or that of the person they are supporting) and those most concerned about the impacts of the costs of care on assets and inheritances were most likely to take up S.18(3). For the youngest group considering arranging care for others, financial circumstances do not have much bearing on preferences. The findings are outlined in more detail below.

4.6.1 Income and assets of the participant

Information about income reflects the household income of the person responding to the survey (who was not always the person for whom decisions about care were being considered in the DCE). Nonetheless it is interesting to look at the association between preference for S.18(3) and the household income of the participant. Lower income (up to £25,999 per annum) participants were less likely than higher income participants (£26,000-£51,999, and £52,000 and above) to express a preference for asking the local authority to arrange the care when offered a 'middle' and a 'best' offer. They were more likely to accept the 'worst' offer even if to a small degree (10%, vs. £26,000 up to £51,999, 5%, and £52,000+, 2%).

Higher income participants' preference share increased with the quality of the offer. Two thirds would accept the local authority's 'middle' offer, and almost nine in ten participants with incomes of £52,000 and above would accept the local authority's 'best' offer (85%). Figure 4.10 shows preference share by income and type of offer.

Figure 4.10: Preference share by income (per annum) and type of offer



Base: Income up to £25,000 (n=304), £26,000 up to £51,999 (n=438), £52,000 and above (n=321) eligible for DCE

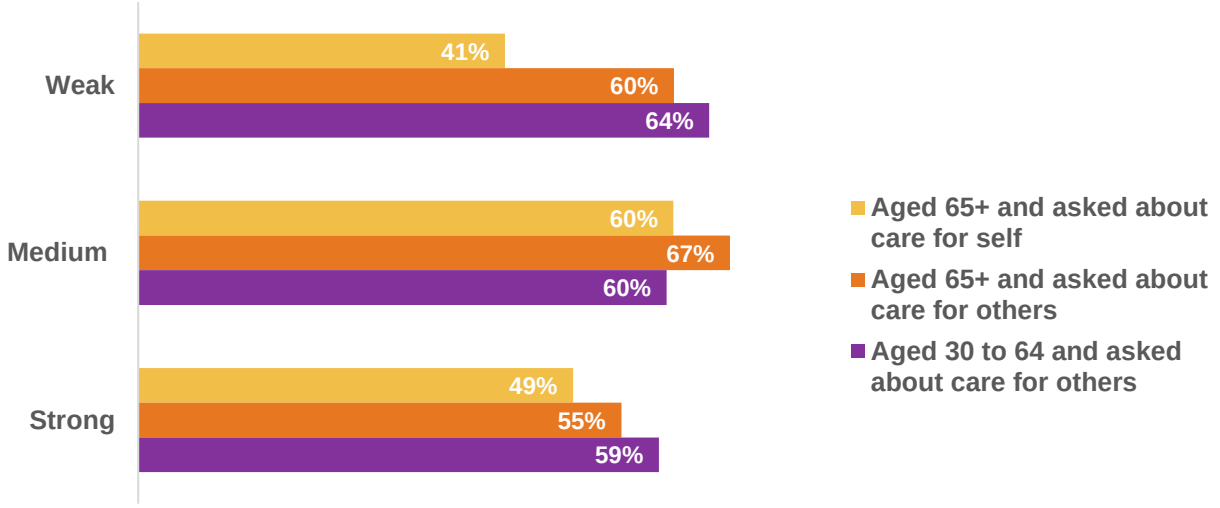
When analysis by income was carried out split by whether someone aged 65+ was considering care for themselves or others, among those considering a 'middle' offer' of care for themselves, those with the highest incomes (£52,000 and above) were least likely to express a preference for S.18(3) (44%). Although based on small numbers (43), those considering care for others showed a quite different pattern with 66% of those with incomes of £52,000 and above expressing a preference for S.18(3).

4.6.2 Patterns in take up according to the financial status of the person whose care is being considered

Participants were asked about the financial situation of the person for whom they were answering the questions in the DCE. Responses of 1-7 from very weak to very strong were grouped into weak (1-3), medium (4-5) and strong (6-7). The findings show that the relationships between preference for S.18(3) and the financial status of the person for whom care is being considered depends on who is making the decision and their age.

For those arranging care for others, there was little difference in likely uptake according to the perceived financial status of the person needing care. For all levels of perceived financial status, those aged 65+ arranging care for others were more likely to express a preference for taking up S.18(3) than those arranging care for themselves. This disparity was greatest for those in the weakest perceived financial situation where those aged 65+ arranging care for themselves had a preference share of 41% compared with 60% of those aged 65+ arranging care for themselves. The group with the lowest preference for taking up S.18(3) was those with a perceived weak financial situation considering arranging care for themselves.

Figure 4.11: Preference shares by participants' financial situation (weak, medium, strong) by age and whether arranging for self or other

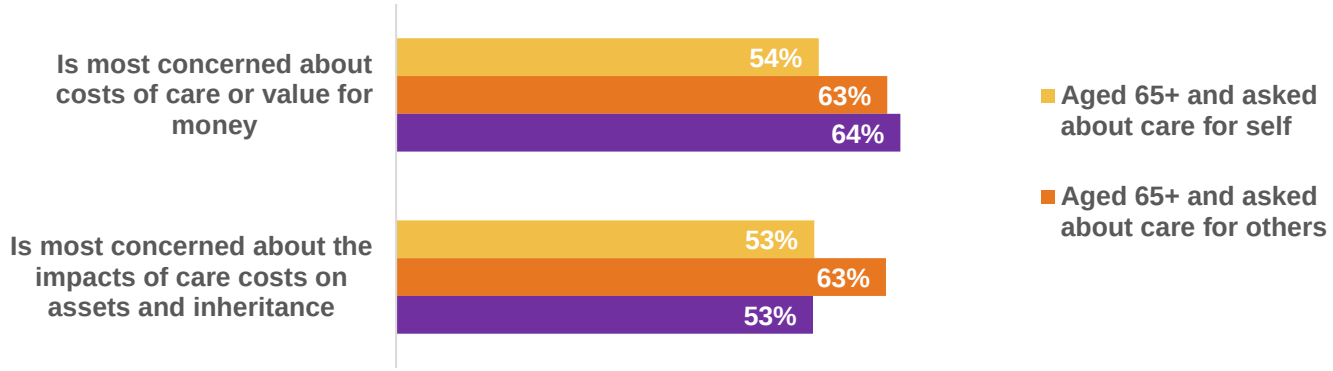


Base: 65+ years old asked about care for self (n=489), 65+ years old asked about care for others (n=222), 30-to-64 years old asked about care for others (n=564) eligible for DCE

Participants aged 65+, if considering arranging care for themselves or others, were equally likely to express preference for S.18(3) whether they were most concerned about costs of care or value for money, or the impact on assets and inheritances (see Figure 4.12). Those aged 30 to 64 (considering arranging care for others) were more likely to take up S.18(3) if they were most concerned about costs of care or value for money than if they were concerned about the impact on assets and inheritances (64% vs 53%).

When comparing those who were most concerned about the impacts of care costs on assets and inheritances exclusively, those aged 65+ considering arranging care for others expressed a higher preference for taking up S.18(3) (63%) than those aged 65+ arranging care for self (53%), and aged 30 to 64 arranging care for others (53%).

Figure 4.12: Preference shares by participants' primary concerns about care costs and whether arranging for self or other



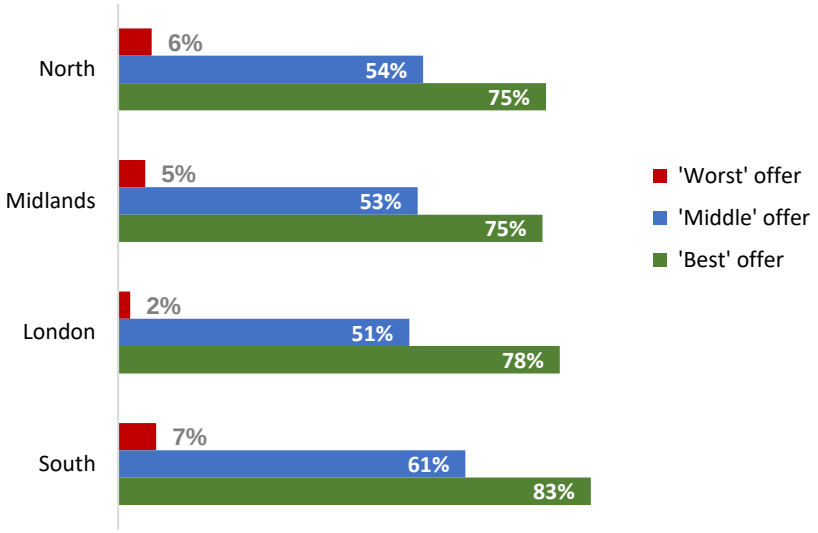
Base: 65+ years old asked about care for self (n=489), 65+ years old asked about care for others (n=222), 30-to-64 years old asked about care for others (n=564) eligible for DCE

4.7 Regional patterns in preferences

Participant responses were broken down into nine regions across England. However, base sizes were too small (i.e. <100) to enable meaningful comparison between regions. To enable some comparison, figures were calculated by grouping the England regions into four. The results are detailed below.

Participants in the South expressed a higher preference for taking up S.18(3) than participants in the London, Midlands, and the North. This was consistent across 'middle' (61% for South and 51-54% for the other regions), 'worst' and 'best' offers (Figure 4.13).

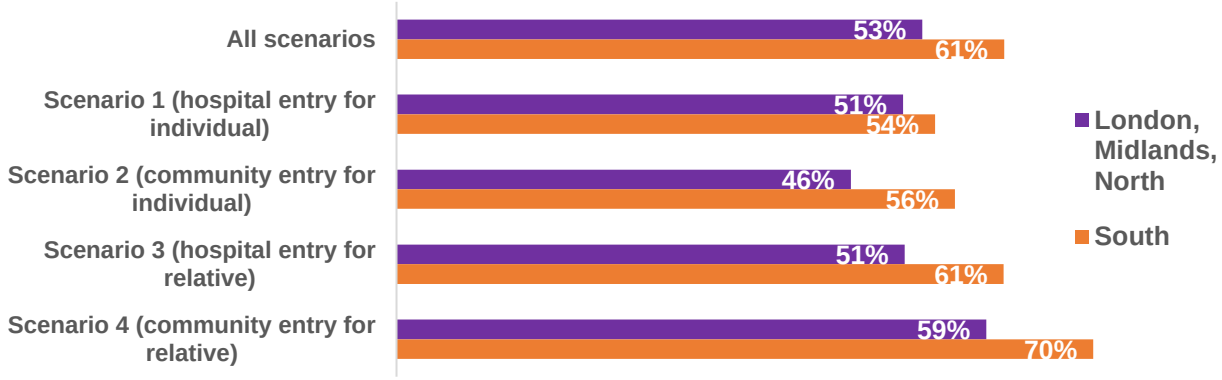
Figure 4.13: Preference share by region and type of offer



Base: London, Midlands, North (n=724) and South (n=551) regions eligible for DCE

Figure 4.14 shows how preference share differs by region and scenario. Because of low base sizes, in this analysis all regions apart from the South have been grouped. Participants from the South were more likely to take up S.18(3) than those in London, Midlands and North for most scenarios, with a 10-percentage point difference. The exception was the scenario of considering care for self when coming out of hospital, where the difference was less (London, Midlands, and North, 51%, and South, 54%). The sample sizes were too small to explore reasons for these regional differences.

Figure 4.14: Preference share by region and scenario



Base: London, Midlands, North (n=724 (all scenarios), 144 (scenario 1), 133 (scenario 2), 217 (scenario 3), 230 (scenario 4) and South (n=551 (all scenarios), 101 (scenario 1), 111 (scenario 2), 175 (scenario 3), 164 (scenario 4) eligible for DCE

4.8 Preference for specific offers by general likelihood of taking up S.18(3)

4.8.1 Preference by general likelihood

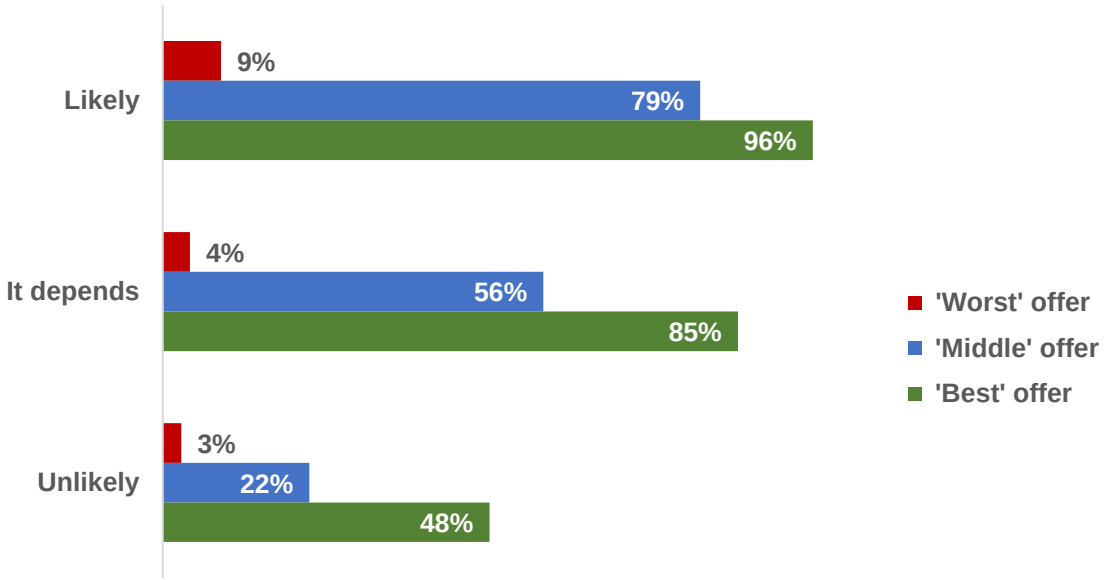
As described in section 3, participants were asked about their likelihood of taking up S.18(3) in a general question. This was asked when the policy had first been explained to them and then in a follow up question after they had taken part in the DCE. The DCE analysis has shown how important the details of the care home offer from the LA are in affecting preference. Here we explore how preferences for taking up the 'worst', 'best' and 'middle' offers in the DCE vary according to participants' generally expressed likelihood of taking up S.18(3). We have used the general likelihood question asked after the DCE when participants had been able to form more considered views.

The analysis shows that even among those who said they were generally likely to take up S.18(3), only 9% expressed a preference for taking up the 'worst' offer compared to 3% of those who said they were unlikely, or it would depend (4%). This suggests that when participants are expressing a general likelihood to take up S.18(3), they are not considering the worst offer.

Those who expressed a general likelihood of taking up S.18(3) were most likely to express a preference for taking up each of the offers, with 79% expressing a preference to take up the 'middle' offer, compared with 56% of those who said it would depend, and 22% of those who were unlikely. When considering the 'best' offer, 96% of those who were generally likely to take up S.18(3) expressed a preference for the offer, compared with 85% who said it depends and 48% who said they were unlikely to. It is notable that even among those who said they were unlikely to take up S.18(3), nearly half would express a preference for it when considering the best offer.

See Figure 4.15 for an overview of the analysis described above.

Figure 4.15: Preference share by general likelihood of taking up S.18(3)

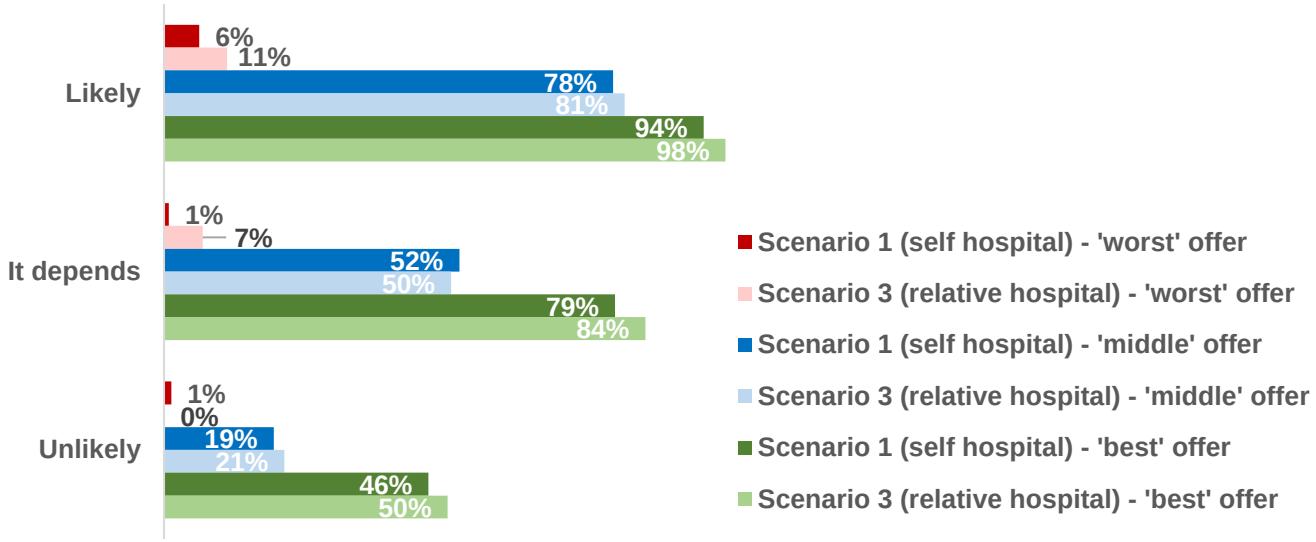


Base: Likely (n=570), it depends (n=341) and unlikely (n=326) eligible for DCE

4.8.2 Preference by general likelihood and scenario

Analysis was also carried out to explore how preferences varied by likelihood for the different scenarios (whether coming from hospital or the community) and whether considering arranging for oneself or a relative. Considering scenarios 1 and 3, when coming from hospital, whether arranging for oneself or a relative, even those who were generally likely to take up S.18(3) expressed a low preference for the 'worst' offer (6% for self and 11% for relative). For each scenario and offer, there was a similar preference for S.18(3) whether considering arranging care for oneself or a relative.

Figure 4.16: Preference share by general likelihood and scenario (from hospital)



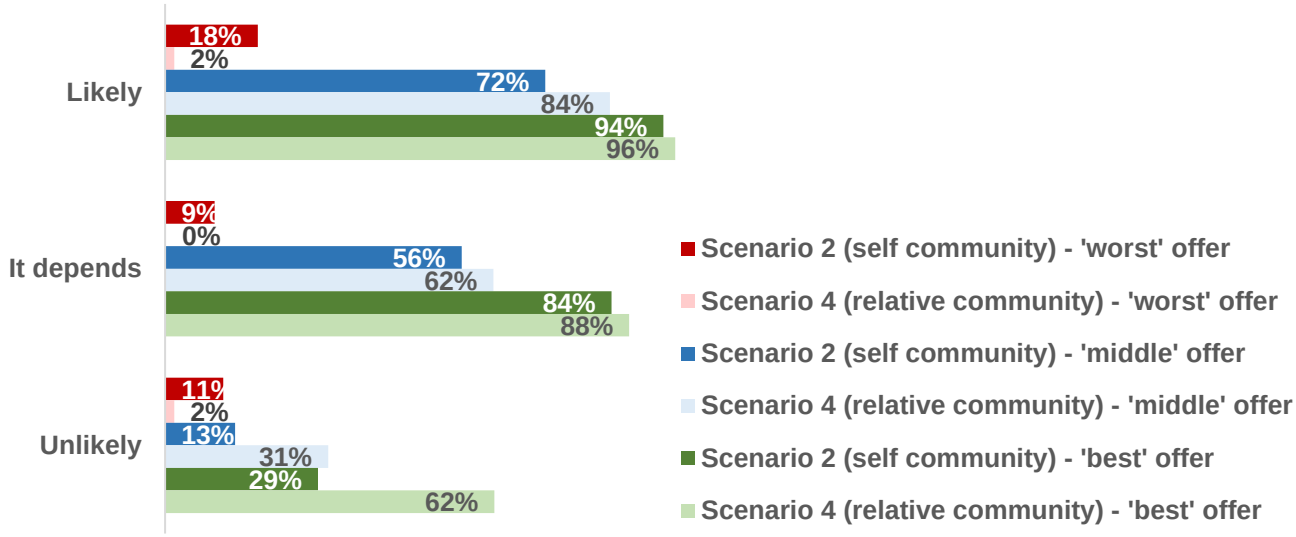
Base: Likely scenario 1 (n=107), Likely scenario 3 (n=188), it depends scenario 1 (n=49), it depends scenario 3 (n=98), unlikely scenario 1 (n=78), unlikely scenario 3 (n=96) (unweighted) eligible for DCE

When considering accessing a care home from the community (Figure 4.17), there was a greater disparity between the preferences of those considering care for self and those considering it for a relative. Among those who were generally likely to take it up when presented with the 'middle' offer, those considering care for a relative were more likely to prefer taking up S.18(3) (84%) than those considering care for themselves (72%). This difference decreased when considering the 'best' offer (those considering care for a relative, 96%, those considering care for themselves, 94%).

There was a similar pattern among those who were generally unlikely to take up S.18(3), with 31% of those who were considering care for a relative expressing a preference for the 'middle' offer, compared with 13% of those considering care for themselves. This pattern was equally pronounced for the 'best' offer (those considering care for a relative, 62%, those considering care for themselves, 29%).

In contrast, when considering the 'worst' offer, those arranging care for themselves and coming from the community were more likely than those arranging care for a relative to prefer taking it up (18% of those who were generally likely and 11% of those who were generally unlikely to take up for themselves, compared with 2% considering care for a relative).

Figure 4.17: Preference share by general likelihood and scenario (from community)



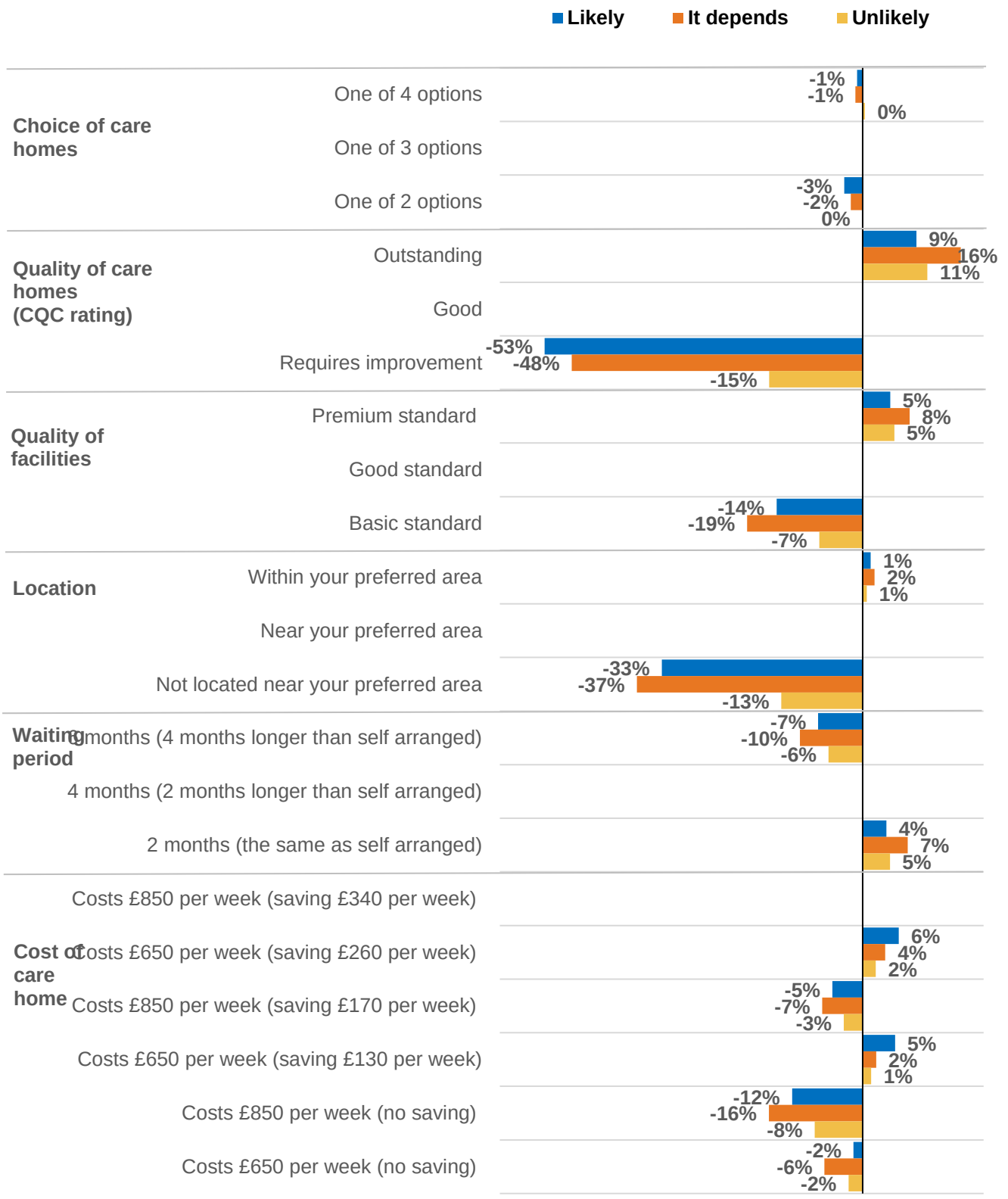
Base: Likely scenario 2 (n=100), Likely scenario 4 (n=175), it depends scenario 2 (n=73), it depends scenario 4 (n=121), unlikely scenario 2 (n=66), unlikely scenario 2 (n=86) (unweighted) eligible for DCE

4.8.3 Impact of care home offer by general likelihood

Analysis of how different levels of the attributes affect preference compared to the 'middle' offer shows that varying levels of attributes have a much greater impact on preference for those who expressed a general likelihood to take up S.18(3) than on those who were unlikely. For example, considering the care home quality, a 'requires improvement' rating reduced preference by 53 percentage points for those who were generally likely and only 15 percentage points for those who were generally unlikely. Not being located near the preferred area reduced preference by 33 percentage points for those who were generally likely, 37 for those who said it would depend, and 13 percentage points for those who were generally unlikely. A cost of £850 with no saving reduced preference by 12 percentage points for those who were likely, 15 for those who said it would depend, and 8 percentage points for those who were unlikely.

The impact of levels on preference shares was generally greater for those who expressed uncertainty about whether they would take up S.18(3) or not, than for those who said they were likely or unlikely. This suggests that the actual take up among the 47% who expressed a general preference for taking up S.18(3) will depend very much on what care they are offered. For those who indicated on the general question that they were unlikely to take up S.18(3), the particular care home offer matters less, and so regardless of the particular circumstances on needing care, they are unlikely to take it up.

Figure 4.18: Difference in preference share (percentage points) compared to 'middle' offer by general likelihood of taking up S.18(3)



Base: Likely (n=570), it depends (n=341), unlikely (n=326) (unweighted) eligible for DCE

5 Findings from the behavioural model

This section presents findings from the behavioural model questions asked in the survey, which presented participants with five different LA care home offers ranging from ‘very poor’ to ‘very good’. This includes exploration of how participant characteristics and attitudes may influence uptake for differing offers from the LA, building on the findings from sections 3 and 4. Some characteristics identified as important in relation to potential take up of S.18(3) could not be included in the DCE analysis and so their relationship with differing offers from the LA is explored here.

Behavioural model: key findings

Participants were presented with and asked to consider five behavioural models (‘very poor’ to ‘very good’) to understand how differences in care home offer might influence uptake (see below for more detail). Findings from the behavioural model analysis reinforce findings from the DCE which suggest uptake is predominantly influenced by the offer. The behavioural model analysis suggests that, overall, the better the care home offer from the LA, the more likely participants were to say they would take up S.18(3). For example, eight in ten (80%) of participants said they would be likely to take up S.18(3) for the 'very good' offer, compared with less than one in ten (9%) who said they would be likely to take up the 'very poor' offer.

The behavioural model response data was analysed to look for patterns of participant characteristics that could not be explored in the DCE. Analysis of the data found an association between trust in LA and likely uptake, with those with trust in their LA more likely to take up S.18(3) and those with distrust in their LA less likely.

Analysis was also carried out to understand behaviours around overall intention to take up S.18(3). The data show that nearly half of participants (49%) showed uncertainty about their intentions to take up S.18(3), with almost a quarter (23%) consistently saying they would take up S.18(3) when considering the policy generally or a middle offer. These findings also suggest intentions vary according to the specific care home offer.

Analysis was also carried out to understand likelihood of approaching the LA. It suggests that most participants would approach the LA in some way as they explore what care home options are available to them. This indicate that even if eventual take up of S.18(3) is low, most people will consider approaching the LA about the policy and the options.

5.1 The behavioural model

Participants were asked to consider a series of five behavioural models to understand how differences in care home offer might influence uptake of S.18(3). These were based on DHSC’s suggestion of what ‘poor’ and ‘good’ offers would look like before the research was carried out. The different behavioural models, ranging from ‘very poor’ to ‘very good’ are set out in Table 5.1. They were presented to participants in these combinations. It should be noted that these are different from the ‘middle’ offer of the DCE which was based on the middle level of the attributes and the ‘best’ and ‘worst’ offers from the DCE which are based on analysis of answers from all the various combinations of attributes and levels presented in the experiment and the preference shares. The labels of ‘very poor’ to ‘very good’ were not shown to participants and are just used for reference and for a shorthand to describe the models here.

Table 5.1: Behavioural models

Attributes	MODEL 1 (Very Poor)	MODEL 2 (Poor)	MODEL 3 (Neither Good Nor Poor)	MODEL 4 (Good)	MODEL 5 (Very Good)
Choice of care homes if the LA arranges the care	One of 2 options offered by the LA	One of 2 options offered by the LA	One of 3 options offered by the LA	One of 3 options offered by the LA	One of 4 options offered by the LA
Quality of care (CQC rating) if the LA arranges the care	Requires Improvement	Good	Good	Good	Outstanding
Quality of facilities if the LA arranges the care	Basic standard of facilities, room size and food	Basic standard of facilities, room size and food	Good standard of facilities, room size and food	Premium standard of facilities, room size and food	Premium standard of facilities, room size and food
Location if the LA arranges the care	Not located near your preferred area	Located near your preferred area	Located near your preferred area	Located within your preferred area	Located within your preferred area
Waiting period from contacting the LA for assistance to being placed in the long-term care home place*	6 months (4 months longer than self arranged)	6 months (4 months longer than self arranged)	4 months (2 months longer than self arranged)	4 months (2 months longer than self arranged)	2 months (the same as self arranged)
Cost of care home if the LA arranges the care (saving compared with arranging it yourself)	Costs £850 per week (no saving)	Costs £850 per week (saving £170 per week)	Costs £850 per week (saving £340 per week)	Costs £650 per week (saving £130 per week)	Costs £650 per week (saving £260 per week)

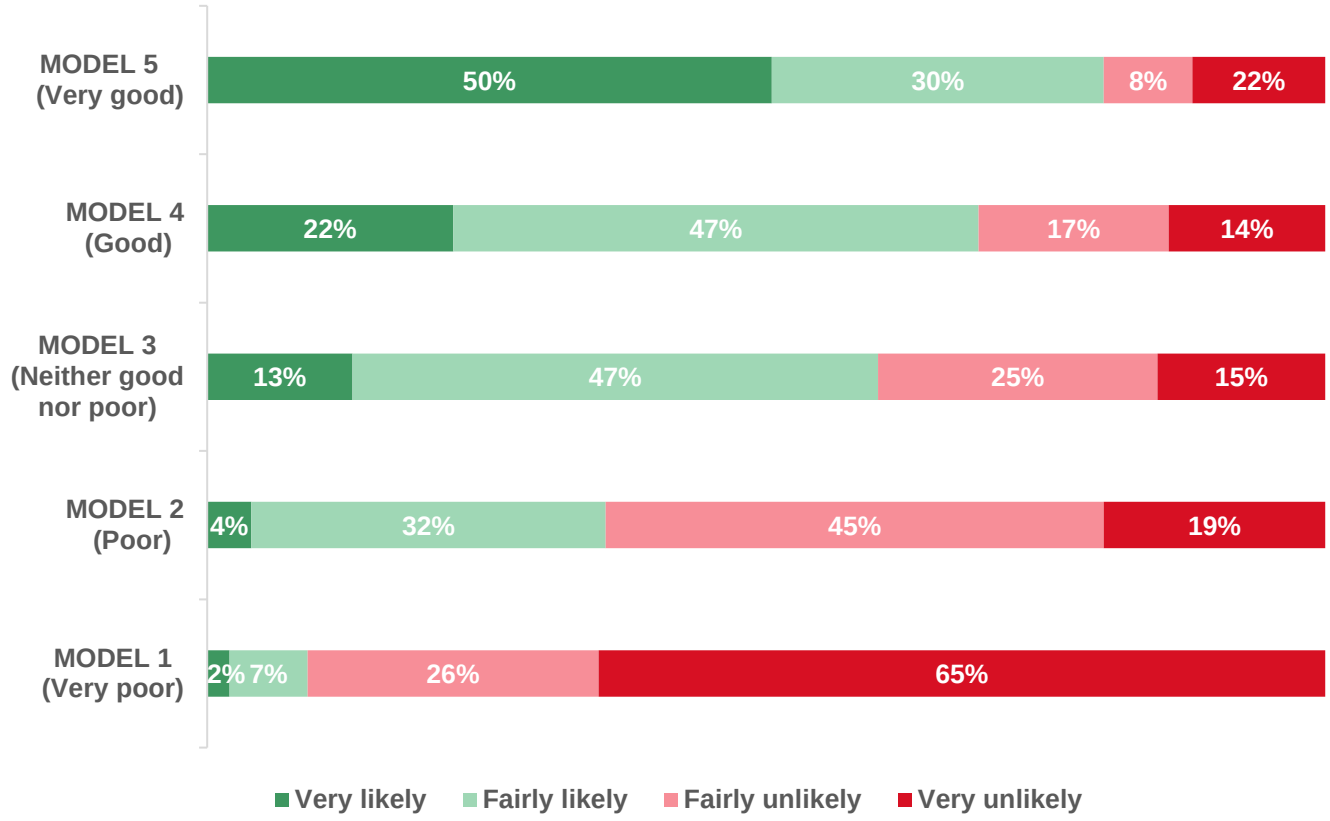
*(Note: The wait time for self-funders is approximately 2 months)

Participants were shown each behavioural model, one after another and asked to respond on a 4-point scale (from very likely to very unlikely) about how likely they would be to take up S.18(3), based on the offer. The findings suggest that the better the care home offer from the LA, the more likely participants were to say they would take up S.18(3). For example, only one in ten (9%) participants said they were likely to take up S.18(3) if the LA offered them a ‘very poor’ (Model 1) care home place and only 2% were very likely. In contrast, four out of five (80%) participants said they would take up S.18(3) if the LA offer was ‘very good’ (Model 5), including half (50%) of participants saying they would be very likely to take up S.18(3) if the offer from the LA was ‘very good’. Although the findings of the DCE show that participants may have taken heuristic ‘short cuts’, these findings show that participants were responding reasonably to these questions which followed the DCE (and which were presented in a random order), still paying attention to detail, resulting in participants expressing a higher likelihood of uptake, the better the offer.

The difference in participants saying they would likely take up S.18(3) between the two poorest care home offers (Model 1 and Model 2) was considerable. Over a third (36%) of participants said they would be likely to take up S.18(3) if the offer was ‘poor’ (Model 2), compared with one in nine (9%) saying they would take up S.18(3) if the offer was ‘very poor’ (Model 1). This difference might be explained by the difference in CQC ratings between the ‘very poor’ (requires improvement) and ‘poor’ (good) offers. A similar difference can also be seen between the ‘good’ offer (Model 4) with a good CQC rating, where over two thirds (69%) said they would take up S.18(3), and the ‘very good’ offer (Model 5) with an outstanding CQC rating, where four out of five (80%) said they would take up S.18(3). This aligns with findings from the DCE which showed that the attribute with the biggest effect on preference for S.18(3)

was CQC rating, with a requires improvement rating have a bigger negative impact than the positive impact of an outstanding CQC rating. Figure 5.1 shows a breakdown on a 4-point scale for each behavioural model.

Figure 5.1: Breakdown of uptake likelihood for each behavioural model



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

5.2 Behavioural model patterns

The behavioural model response data was analysed to look for patterns according to participant characteristics, focussing particularly on those which could not be explored in the DCE. Analysis of the data found a statistically significant association between trust in LA and likely uptake.

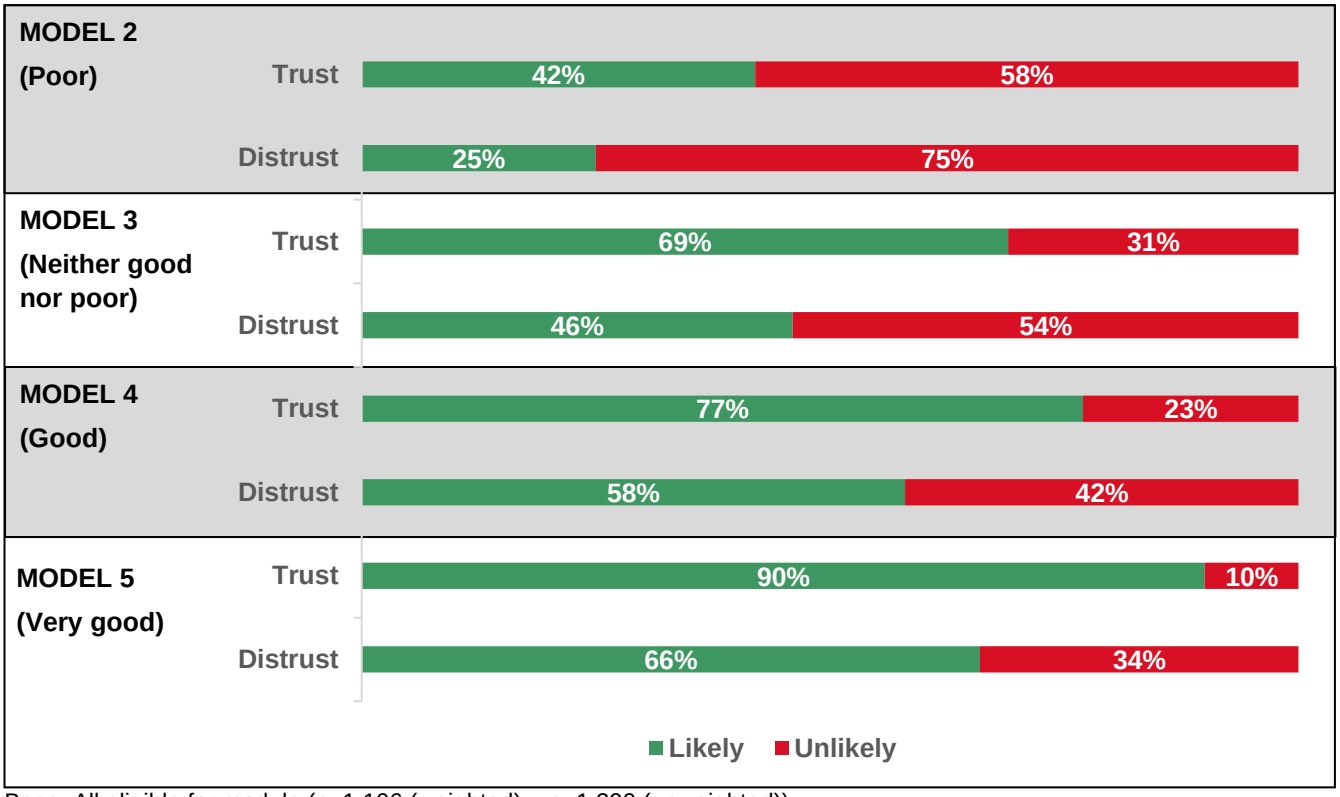
Excluding the poorest offer (Model 1 – not shown in Figure 5.2), trust in LA was found to be significantly related to the likelihood of taking up S.18(3). For example, looking at responses for the 'neither good nor poor' offer (Model 3), over two thirds (69%) of participants who reported trust in their LA said they would be likely to take up S.18(3), compared with less than half (46%) of participants who said they did not have trust in their LA.

Similarly, looking at uptake responses for the 'very good' offer (Model 5), almost a third (34%) of participants who said they did not have trust in their LA said they would be unlikely to take up S.18(3), compared with one in ten (10%) of participants who said they had trust in their LA. Differences by trust in the likelihood of taking up the 'very poor' offer (Model 1) might be influenced by the CQC rating of the care home being offered, as this offer was the only offer in which the care home was rated requires improvement by the CQC.

Figure 5.2 shows the associations between difference in uptake by trust and distrust in LA for behavioural models 2 to 5. Although for each model uptake was higher among those who trusted the LA,

both groups showed a consistent and reasonable pattern of increased likelihood of uptake, the better the offer from the LA.

Figure 5.2: Difference in uptake by trust and distrust in LA – for behavioural models 2-5



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

The analysis also explored whether other characteristics found to be associated with likelihood of taking up S.18(3) such as gender differences or previous experience with social care were associated with likelihood when the same specific offer from the LA was being considered. However, no statistically significant patterns were identified. This suggests that the decision to take up S.18(3) is more heavily influenced by the offer from the LA than by individual demographic characteristics or previous experience. It also suggests that some differences in likelihood of uptake found when participants were asked a general question may be related to differences in perceptions of what the LA would offer. Once this is made consistent, differences between participants in likely uptake disappear.

Findings from the open response question provide insight into how the trust or distrust in the LA influences the likelihood of asking the LA to take up S.18(3). Participants said they trusted the LA because they viewed the LA as having specific knowledge about social care and could offer more reliable standards of care.

> **"I would have more faith in the council offering accommodation which is safe and caring."**
> (age 63, asked about supporting someone else, Q1 take up of S.18(3) 'Very likely').

> **"The Local Authority should have a broad overview of the adult social care available locally"**
> (age 80, asked about self, Q1 take up of S.18(3) 'Likely').

Some participants based their view on past experiences with the LA that they found negative, whilst others had more general perceptions that LAs faced organisational challenges which might impact their ability to choose the right kind of care.

> **"From experience, communication with the local authority was unreliable; decision making was prolonged and inconsistent."**
> (age 68, asked about self, Q1 take up of S.18(3) 'Unlikely').

> **"The local authority are hugely understaffed and would therefore not have the necessary time to research the best and most appropriate care homes"**
> (age 74, asked about self, Q1 take up of S.18(3) 'Likely').

5.3 Overall likelihood of taking up S.18(3)

The survey asked participants about their likelihood of taking up S.18(3) in multiple different ways:

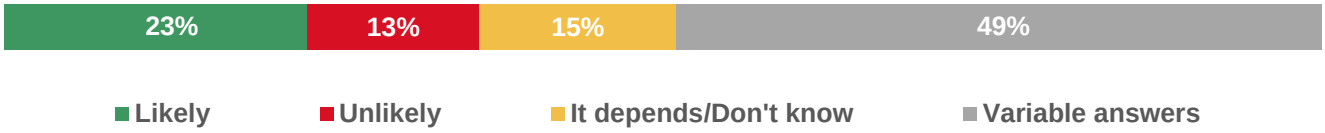
- initial overall view after being given information about the policy
- DCE with 12 different combinations of the care offer for each participant
- behavioural model with 5 standard combinations of the care offer shown to all participants (in differing orders)
- overall view after having seen more detail of what the care offer might look like
- views on whether they would approach the LA to enquire about S.18(3) (without necessarily taking it up)

The report so far has presented findings for each of these separately. Here we present some combined analysis to give an overall assessment of the potential uptake of the policy, considering both the initial approach to the LA and the decision to take it up.

The answers from the initial likelihood question and the final likelihood question were combined with the answers from the 'neither good nor poor' behavioural model offer. Participants were grouped according to whether they always said they were likely or very likely, always said unlikely or very unlikely, said depend (two overall questions only) or gave variable answers which indicated that their intentions are uncertain.

Using this combined derived variable, the data show that nearly half of participants (49%) varied their answers across the three questions, indicating the level of uncertainty among participants about their uptake intentions. Nearly a quarter of participants (23%) said they were likely to take up S.13(3) and this did not vary according to whether they were thinking about care for themselves or others. Over one in ten (13%) consistently reported they would be unlikely to take it up and 15% said it would depend. This is shown in Figure 5.3.

Figure 5.3: Combined answers from initial likelihood and final likelihood question with 'neither good nor poor' (Model 3) behavioural model offer



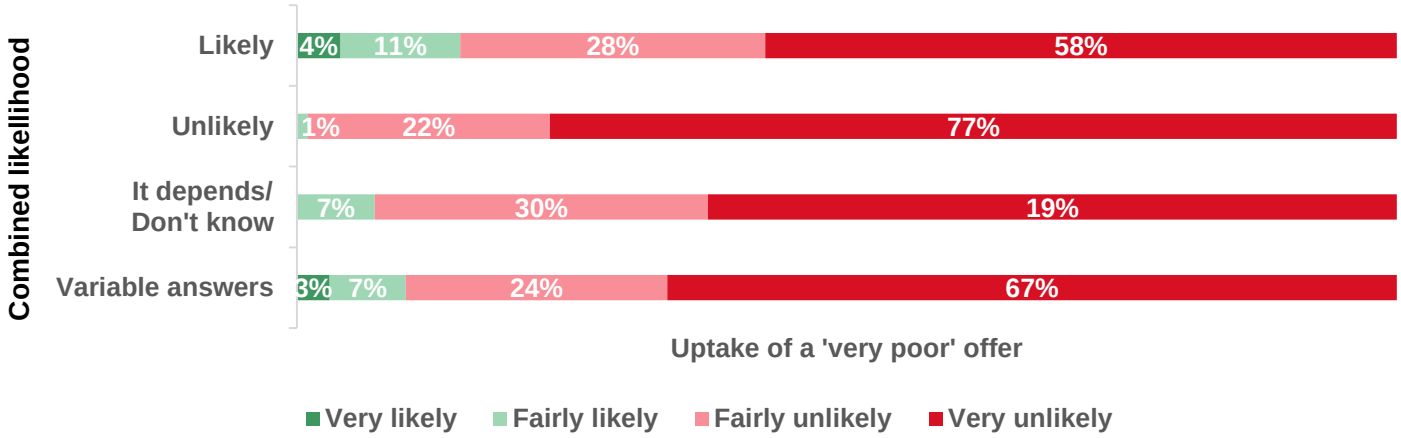
Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

The results of the behavioural model and DCE showed that the offer made by the LA affected likelihood of take up. Analysis was carried out to explore how the broad likelihood groups (in the derived variable described above and shown in Figure 5.3) responded when shown a specific 'very poor' or 'very good' offer in the behavioural model.

The data show that even among the groups which show an overall intention to be likely or unlikely to take up S.18(3) across several questions, intentions vary according to the offer, with 21% of those who are overall unlikely to take up S.18(3) reporting they are likely when the offer is 'very good' and with 85% of those who are overall likely to take it up reporting they are unlikely when the offer is 'very poor'. Among those saying that it depends or they don't know about uptake across the general questions, when presented with the 'very poor' offer 7% would be likely to take it up, and when presented with the 'very good' offer 70% would be likely to take it up. Similar patterns were found among those who gave variable answers to the general questions.

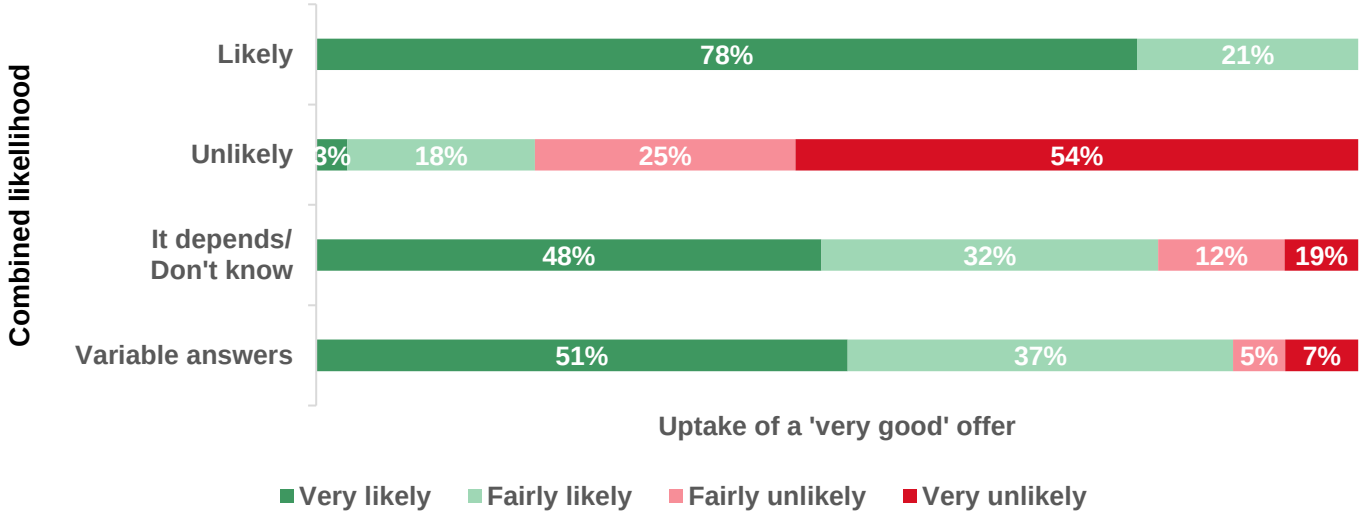
Figure 5.4 shows how broad likelihood groups responded to the 'very poor' offer and Figure 5.5 shows how broad likelihood groups responded to the 'very good' offer. Each bar represents a group in the combined variable for likelihood of taking up S.18(3). The categories on each bar show responses to the question about likelihood of taking up a specific offer shown in the behavioural model.

Figure 5.4: Likely uptake of a 'very poor' offer (Model 1 in behavioural model) by combined answers to likelihood of taking up S.18(3)



Base: Likely uptake of 'very good' (Model 5) behavioural model: Likely (n=255 (weighted) – n=262 (unweighted)); Unlikely (n=147 (weighted) – n=169 (unweighted)); It depends/ Don't know (n=164 (weighted) – n=209 (unweighted)); Variable answers (n=539 (weighted) – n=650 (unweighted)). N.B. Column percentage may not sum to 100% because of rounding

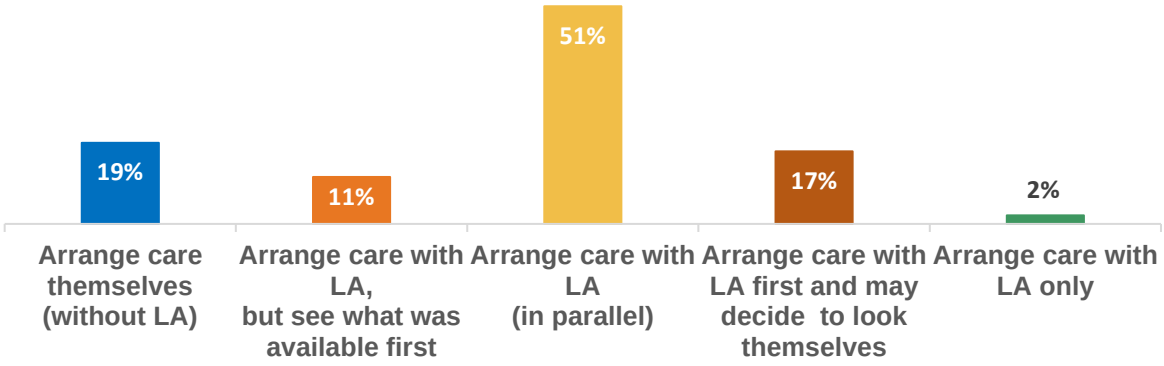
Figure 5.5: Likely uptake of a 'very good' offer (Model 5 in behavioural model) by combined answers to likelihood of taking up S.18(3)



Base: Likely uptake of 'very good' (Model 5) behavioural model: Likely (n=255 (weighted) – n=262 (unweighted)); Unlikely (n=147 (weighted) – n=169 (unweighted)); It depends/ Don't know (n=164 (weighted) – n=209 (unweighted)); Variable answers (n=539 (weighted) – n=650 (unweighted)). N.B. Column percentage may not sum to 100% because of rounding

We also explored how likelihood of approaching the LA to explore the option of S.18(3) varied according to the broad likelihood groups. See section 3.1.2 for the detailed results for the questions from which this measure about involvement of the LA has been derived. Overall, among those expressing a view, 80% would involve the LA in some way in exploring what the options would be in deciding whether to take up S.18(3), with half exploring the options themselves in parallel with the LA (51%) and 17% exploring what the LA could offer first before finding out themselves. This suggests that even if eventual take up of S.18(3) is lower, there will be considerable initial contact with the LA about the policy and the options with LAs operating as advice services, with the opportunity for them to influence uptake of S.18(3) by varying the offer. Figure 5.6 shows a breakdown of whether and how participants would involve the LA in arranging their care.

Figure 5.6: Whether and how participants would involve the LA in arranging care

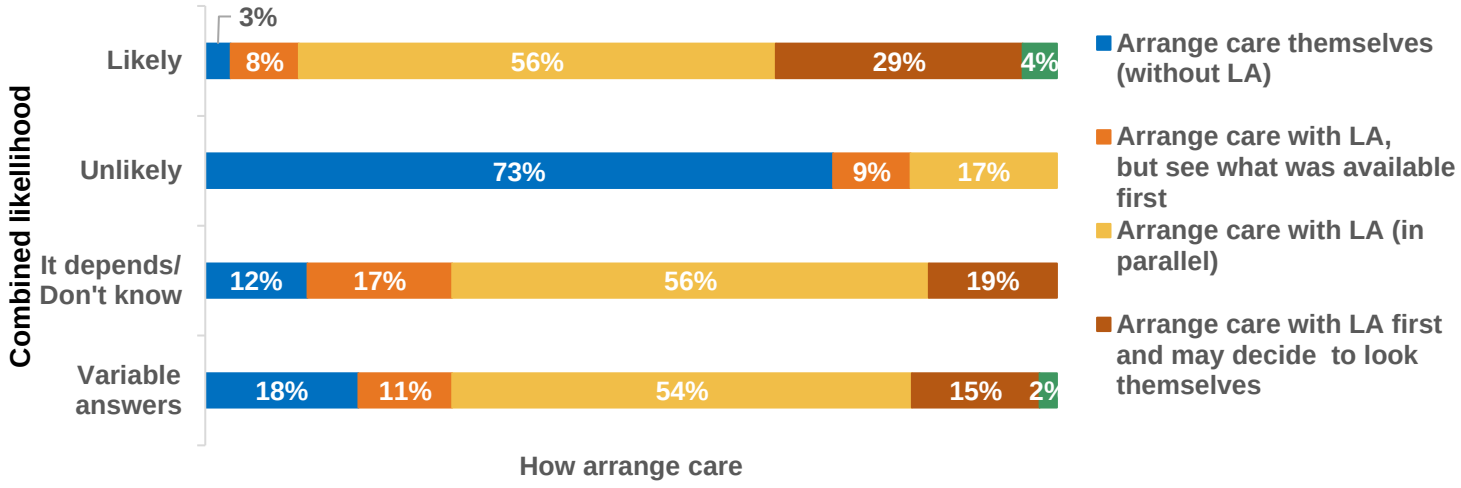


Base: All who expressed view on to approach LA (n=1,008 (weighted) – n=1,191 (Unweighted))

Even among those who are unlikely to take up S.18(3), over a quarter (27%) would involve the LA in some way in exploring the care options. Among those for whom the decision to take up S.18(3) would depend or they don't know, 88% would involve the LA in seeing what the options are. The scoping focus groups showed how important choice was to participants. The DCE showed that the number of care homes offered was not what mattered in determining preference for S.18(3) but it does appear that this desire for choice is seen in participants intending to explore all the options, even if they would not take up S.18(3) in the end.

Figure 5.7 shows whether and how participants would involve the LA in arranging care by combined answers to likelihood of taking up S.18(3) (derived variable shown in Figure 5.3). In Figure 5.7 each bar represents a group in the combined variable for likelihood of taking up S.18(3). The categories on each bar show responses to the combined questions about how they would involve the LA in arranging care.

Figure 5.7: Whether and how participants would involve the LA in arranging care by combined answers to likelihood of taking up S.18(3)



Base: All who expressed view on to approach LA (n=1,008 (weighted) – n=1,191 (Unweighted))

6 Wider findings

After completing the DCE and behavioural model questions, participants were asked a series of questions intended to explore their views, attitudes, experiences and behaviours towards issues relating to adult social care. The below section sets out the key findings. Each finding is outlined in the subsection heading and explored in more detail within the subsection.

Wider views, attitudes, experiences and behaviours: key findings

The survey asked participants questions intended to explore their views, attitudes, experiences and behaviours towards issues relating to adult social care. Participants were asked what concerns they had about the cost of adult social care. The data suggests affordability (76%), cost of adult social care (73%) and loss of home or other assets (68%) are of greatest concern to participants.

Participants were asked about which LA services they had been in contact with in the last five years. Over half (54%) of participants reported little use of local authority services, with the most commonly used LA service being birth, death or marriage registration (20%). Around one in ten (14%) participants reported having experience of using adult social care services.

Participants were asked to indicate the degree to which they trust or distrust their LA. Around half (52%) reported trusting their LA compared with under a third (29%) of participants who reported distrusting their LA. The most common reasons for distrusting the LA were perceptions that it was a poorly run (67%) or an underfunded organisation (50%). Some also had a general distrust for government organisations (32%).

Participants were asked about their personal experiences of using social care services, for themselves or in helping to arrange care on behalf of a friend or relative. Most (88%) participants reported little experience with adult social care services, with only one in five (18%) reporting experience in helping to arrange a care home place for a relative or friend.

Participants were asked about their expectation of leaving an inheritance, considering the value of any savings, property and other valuables. Findings suggest participants expect to leave an inheritance, with around a third (30%) expecting to leave £250,000 or more. However, one in five (22%) said they did not know how much they intended to leave behind.

Participants were also asked about their attitude to spending assets and savings to pay for a care home. Findings suggest most (58%) participants favoured protecting assets from care costs in order to leave behind more inheritance for their family.

Participants were asked about their plans for the future, such as in older age or retirement. Around half (48%) reported having done none of the listed things to plan for their future, suggesting there is a lack of planning for older age.

6.1 Affordability and cost of adult social care are of greatest concern for the public

Participants were asked what concerns they had about the cost of adult social care. The data suggests affordability and cost of adult social care are of greatest concern to participants. Three in ten (29%) participants reported that they were concerned about all the issues about the cost of care presented in the question. The percentages reported below include those who mentioned all the concerns as well as those who reported each specific concern. The results show a concern both for issues related to how care will be paid for and its value for money, as well as longer term concerns about impacts on assets and inheritances.

Affordability (month by month) was the most salient concern relating to the cost of adult social care, reported by over three quarters (76%) of participants. Sub-group analysis shows significant differences between younger and older age groups, with those in age groups 30 to 44 (55%), 45 to 54 (50%) and 55 to 64 (60%) being more likely to report affordability concerns compared with those in two oldest age groups, 65 to 74 (38%) and 75+ (40%). Those who said they would be likely to take up S.18(3) (53%) were also more likely to report a concern about the affordability of the cost of adult social care, compared with those who said they would be unlikely to take it up (38%).

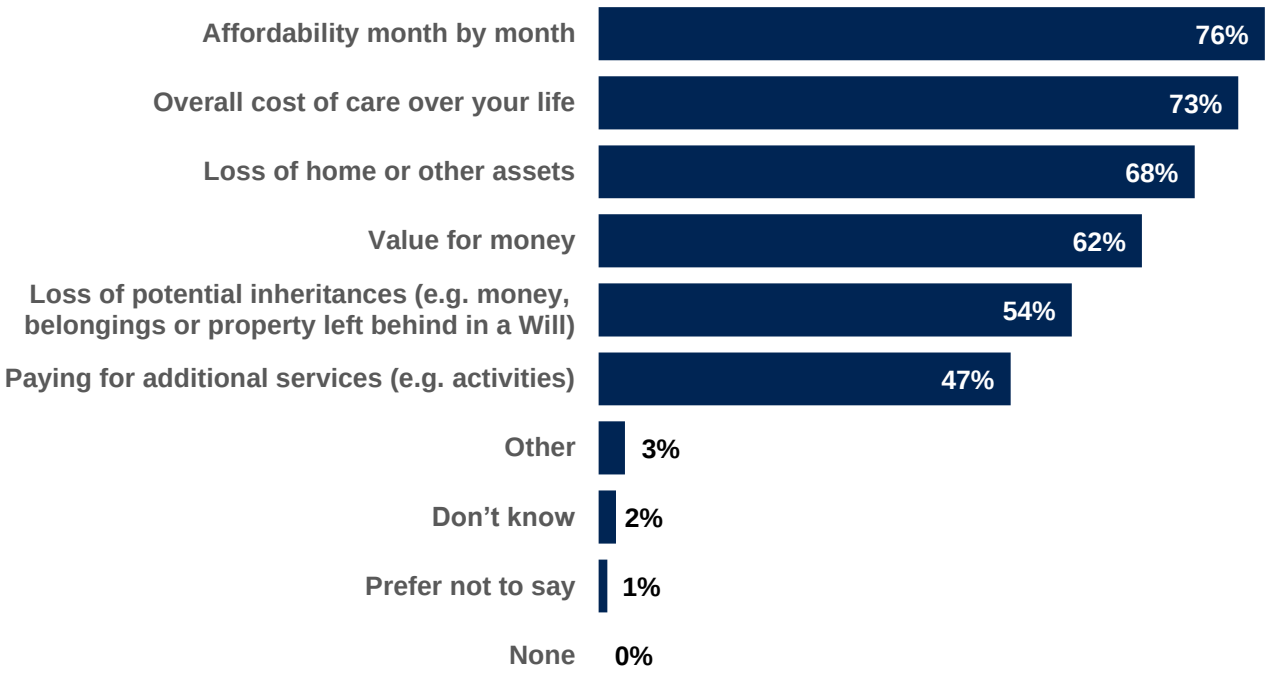
Overall cost of care over your life was the second most reported concern about the cost of adult social care, reported by three-quarters (73%) of participants. Loss of home or other assets was the third most reported concern about the cost of adult social care amongst two-thirds (68%) of participants.

A small number of participants selected 'other' (3%) in their responses and were asked to provide detail on this in their response. Thematic analysis of the open text responses suggests quality of care rather than the cost of care was the key concern for these participants, corroborating the results of the DCE which showed that the quality of care attribute had a greater impact on preferences than the cost attribute.

Participants were also asked to indicate which of the issues they were most concerned about. This showed that while affordability month by month was the primary concern (29% were most concerned about this), loss of home or other assets was the second most concerning issue (21% were most concerned about this), followed by the overall cost of care.

Figure 6.1 shows the list of response options provided to participants and the proportion of participants with different concerns.

Figure 6.1: Concerns about cost of adult social care



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

Participants were then grouped according to their primary concern (i.e. the issue which concerned them most), these were:

- the cost of care or value for money
- assets and inheritances

Analysis in section 3.2.3 showed that those most concerned about the cost of care or value for money were more likely to take up S.18(3) than those primarily concerned about assets and inheritances. When asked the first general question about uptake there was a difference according to whether they were arranging care for themselves or a relative, with those arranging care for a relative being initially more likely to say they would take it up if their primary concern was assets and inheritance.

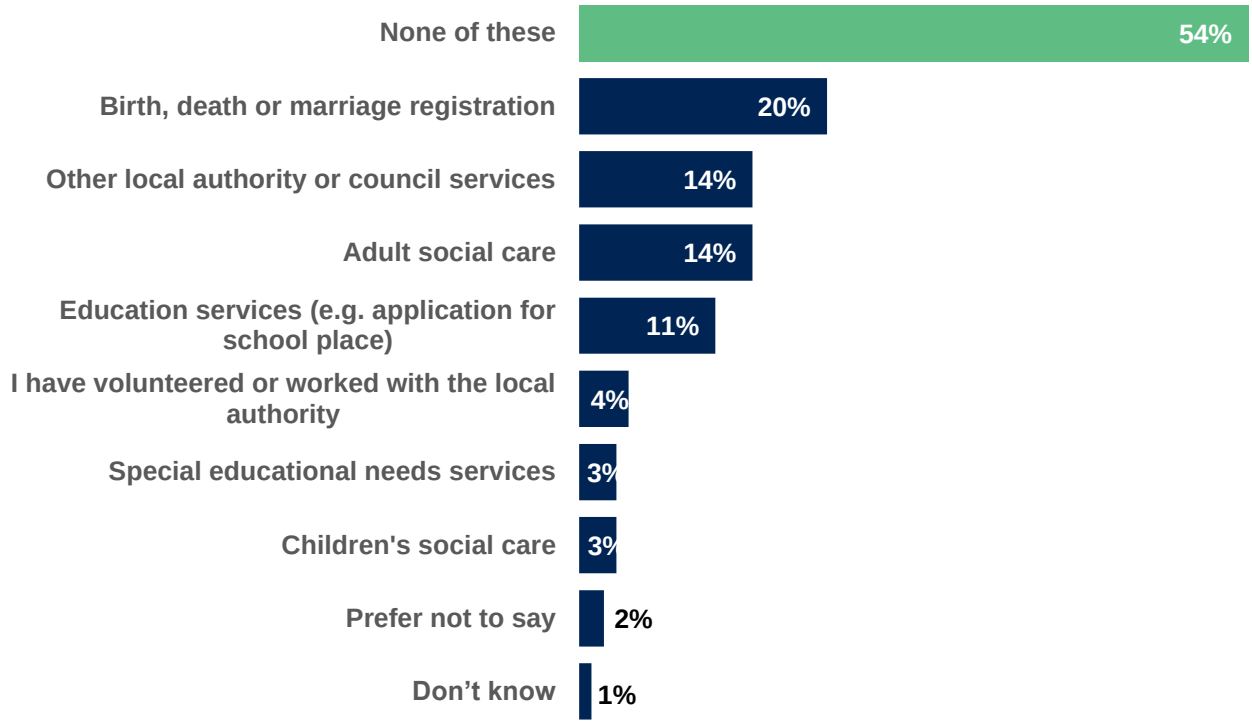
6.2 The majority of participants reported little use of local authority services

Participants were asked about which LA services they had contact within the last five years. The majority of participants reported little use of local authority services in that time period, with over half (54%) of participants reporting having no contact with LA in the last five years. Sub-group analysis shows significant differences between younger and older age groups in terms of contact with local authorities. Older age groups (55 to 64 (55%), 65 to 74 (66%) 75+ (63%)), were more likely to report having no contact with LA services in the last five years, compared with younger age groups (30 to 44 (37%), 45 to 54 (40%)).

Findings also highlighted other associations between certain sub-groups and contact with the LA with greater levels of contact among those in receipt of benefits and with prior experience of formal care. For example, those who do not receive benefits (57%) were more likely to report not having contact with LA services compared with those in receipt of benefits (40%). Similarly, those with no experience of formal care for themselves or others (65%) were more likely to report not having had contact with LA services compared with those who had experience of care (36%).

Around two in five (43%) participants reported having had contact with an LA service in the last five years. The most reported LA service participants were in touch with was birth, death or marriage registration (20%), followed by adult social care (14%) and other LA or council services (14%). Education services (11%) were the fourth most commonly reported service participants reported having had contact with. The list of services and proportion of participants having contact with each service is presented in Figure 6.2.

Figure 6.2: Contact with local authority services in the last five years



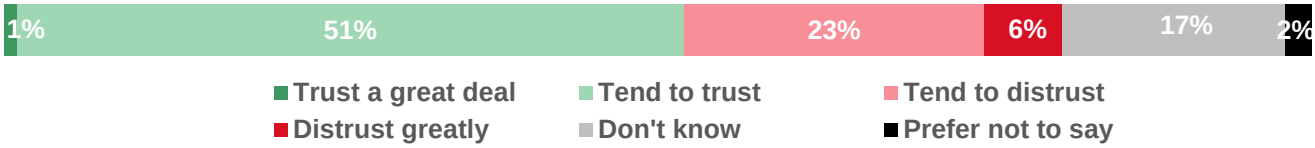
Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

6.3 About half reported trust in LA, however a sizeable minority reported distrust

Participants were asked to indicate the degree to which they trust or distrust their LA. Around half (52%) of participants reported trusting their LA. However, only 1% of participants reported having a great deal of trust in their LA. Under a third (29%) of participants reported distrusting their LA, with 6% saying they distrusted their LA greatly. Almost one in five (17%) responded 'don't know'.

There was an association between trust in the LA and previous contact, with those who had trust in the LA being less likely to have had no contact with the LA in the last five years (46%) than those who distrusted the LA (63%). However, looking specifically at contact with the LA in relation to adult social care services there was no association with trust in their LA. The scale of trust or distrust is presented in Figure 6.3.

Figure 6.3: General trust/distrust in local authority



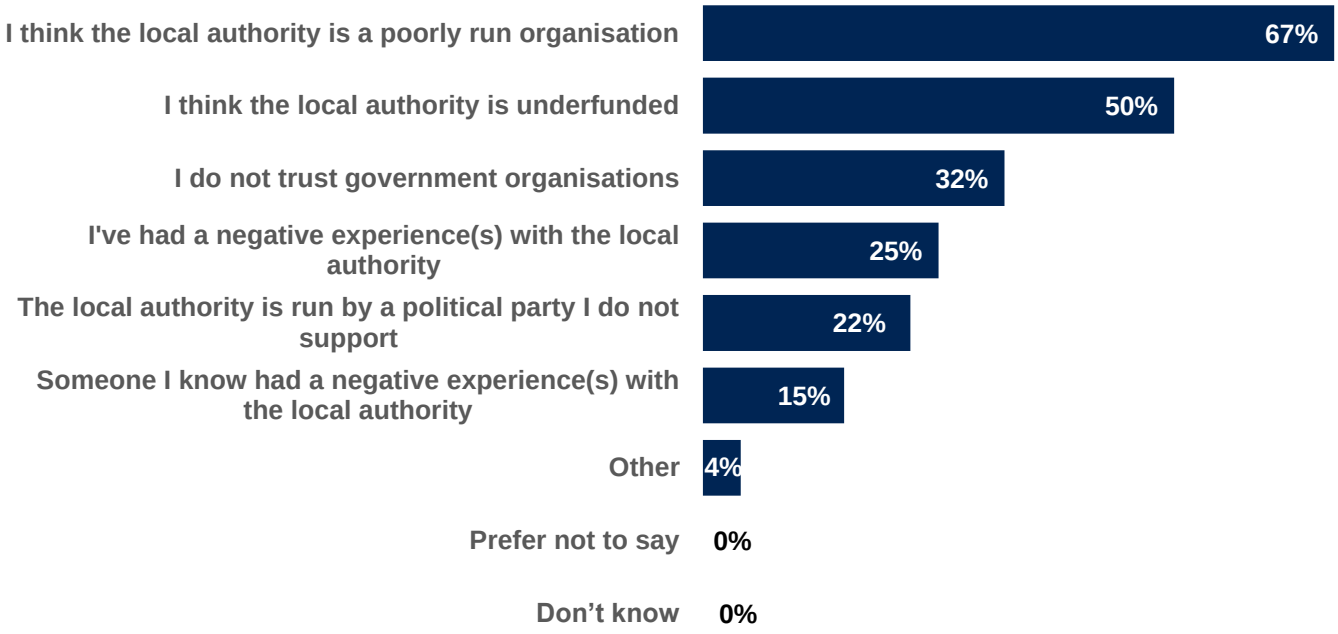
Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

Those participants who reported distrusting the local authority were asked a follow-up question to understand why they distrusted the LA. The main reasons for distrusting the LA related to perceptions of the organisation or government and political views, reflecting the fact that the majority of those who distrusted the LA had had no contact with the LA in the last five years, though some reported basing their distrust on experience.

Among those who distrust the LA, the most common reason for it was because the local authority was viewed to be a poorly run organisation (67%). The second most common reason was because participants viewed the LA to be underfunded (50%). Other reasons given included that participants did not trust government organisations (32%) or the LA being run by a political party they do not support (22%). Among those basing it on experience participants mentioned having a negative experience with the local authority (25%), or someone they know having a bad experience with the LA (15%).

The reasons for distrusting the local authority are presented in Figure 6.4.

Figure 6.4: Reasons for distrusting the LA



Base: All who reported distrust in local authority (n=322 (weighted), n=422 (unweighted))

The KnowledgePanel data includes data collected previously on trust in government which shows that levels of trust in their LA expressed in this module are higher than those expressed in government generally by this sample (38% trusted the government at all and about a quarter (26%) distrust the government greatly). This is consistent with data from the national Trust in Government Survey (2022) carried out by ONS which also showed higher levels of trust in local than central government.

6.4 Most participants have little experience with adult social care services

Participants were asked about their personal experiences of using social care services, for themselves or in helping to arrange care on behalf of a friend or relative. The following findings highlight participants' levels of experience (or the lack of it) with social care services and which services participants were most likely to have experience with:

- One in five (20%) participants reported experience of helping to arrange home care on behalf of a friend or relative.
- Around one in five (18%) of participants reported experience of helping to arrange residential or nursing care on behalf of a friend or relative.
- Almost nine in ten (88%) participants reported having accessed no adult social care services for themselves.
- Two-thirds (66%) reported having no experience of accessing adult social care services in helping to arrange care for a friend or relative.

Participants were also asked about their experience of visiting a care home in the last five years. Two-thirds (66%) of participants reported not having visited a friend or relative in a care home in the last five years, whilst around one in five (21%) reported visiting a friend or relative on occasion and over one in ten (12%) reported visiting a friend or relating once a week or more.

These findings suggest the majority of people may be inexperienced when arranging care for themselves or for a friend or relative. They also suggest that the majority of people have little experience of care homes and the experiences of those living in care homes. Section 3.2.1 showed that those having had experience of formal care for themselves or a relative are less likely to take up S.18(3).

6.5 There is an expectation to leave an inheritance

Participants were asked about their expectation of leaving an inheritance. They were asked to consider the value of any savings, property and other valuables that they or their spouse or partner own that they expect to leave as an inheritance. Almost two-thirds (60%) of participants reported that they expected to leave something as an inheritance. This included almost a third (30%) expecting to leave £250,000 or more and over one in ten (13%) expecting leave between £100,000 and £249,999. This reflects the eligible sample for the survey which was those who would be self-funders who have £100,000 assets, or who care for or would support someone with this level of assets (using housing wealth as a proxy).

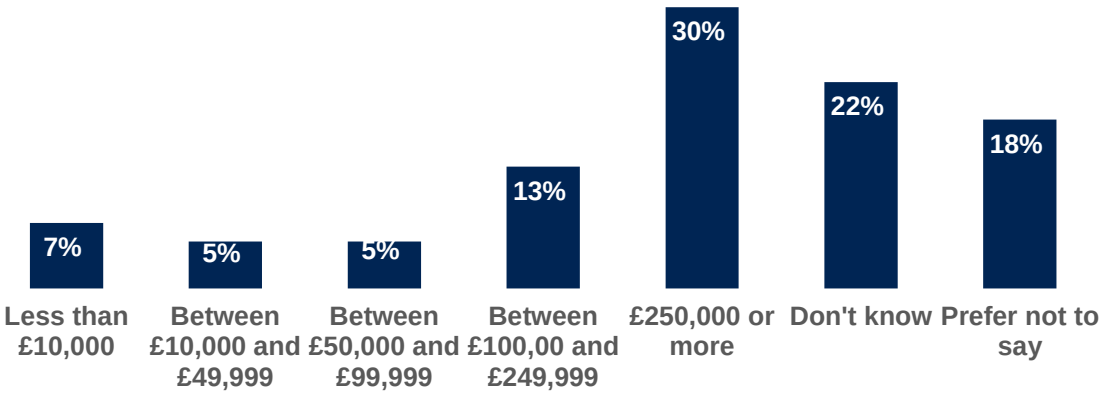
One in five (22%) reported not knowing whether they expect to leave something as an inheritance. Those reporting 'don't know' were more likely to be in the lower age groups (30 to 44 and 45 to 54) and may have not given as much thought to inheritance compared with those in later stages of life (55 to 64, 65 to 74 and 75+). It may also be that this group are less certain about what their eventual financial situation will be when they die because of the longer time horizon between now and when they may die.

Around one in five also reported 'prefer not to say'. This may reflect some participants' hesitancy to disclose financial information.

Among those aged 65 and over who were asked questions about care for themselves when considering the likelihood of taking up S.18(3), more than a quarter (27%) reported being likely to leave an inheritance of £250,000 or more, while among those aged 65+ thinking about care for someone else, almost half (49%) reported they were expecting to leave an inheritance of £250,000 or more.

A breakdown of the amount all participants expected to leave as an inheritance is shown in Figure 6.5.

Figure 6.5: Breakdown of amount expected to leave as an inheritance (£)



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

6.6 Participants favoured protecting assets from care costs

Participants were also asked about their attitude to spending assets and savings to pay for a care home. The data suggests most participants favoured protecting assets from care costs in order to leave behind more inheritance for their family.

One in five agreed that savings (22%) or housing assets (15%) should be used to pay for care if someone needs to access care, while a majority considered that savings should be protected for inheritance (58%). There were no significant differences in views between the group considering care for themselves and those considering care for others, and few demographic differences, apart from gender. Men were significantly more likely than women to disagree that savings should be spent on paying for care (57% for men and 48% for women) or to disagree that housing assets should be spent on care (67% and 58%) and more likely to think savings and property should be protected from care costs (63% and 54%). Men were also more likely than women to report being likely to take up S.18(3), which potentially saves money so their attitudes and intended behaviours appear to align.

There were also differences in attitudes according to trust in LA, with those with lower levels of trust being more concerned about preserving assets. Among those who reported that they trusted the LA, 29% agreed that savings should be spent on paying for care and 20% agreed the value of a person's house should be used for paying for care compared to 16% and 12% of those who distrusted the LA.

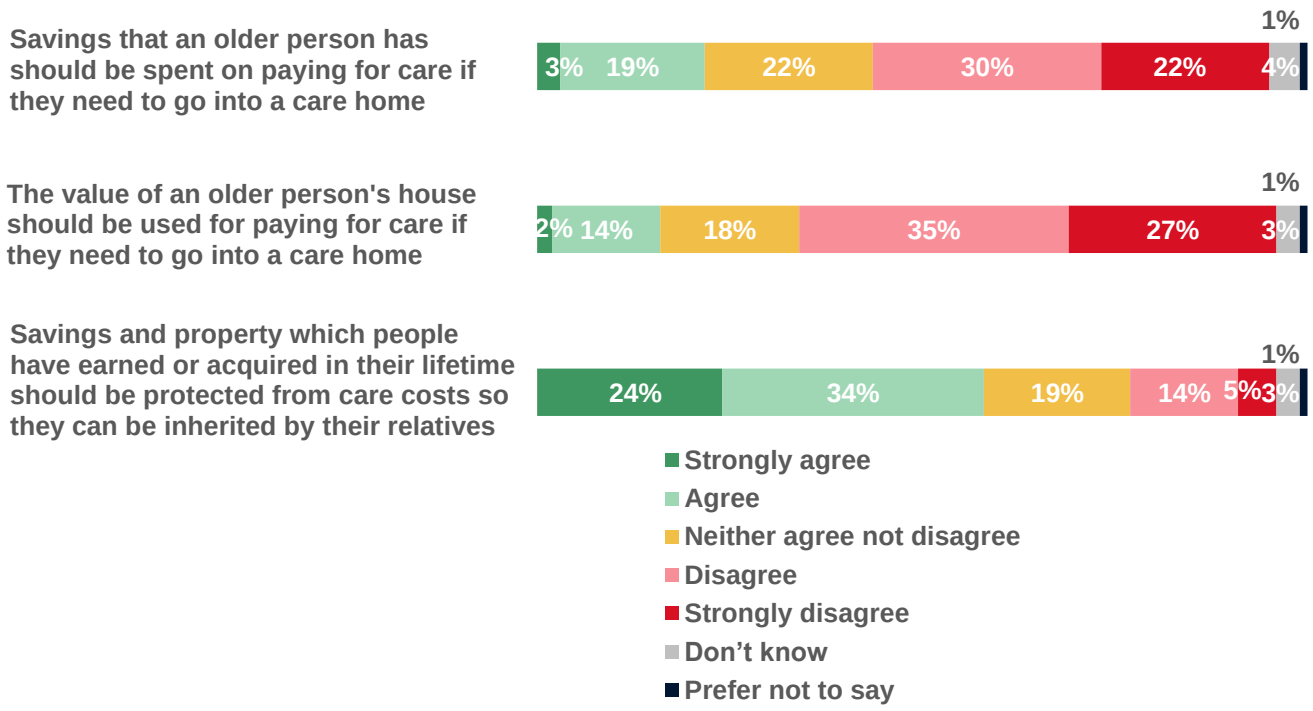
Those who trusted their LA were significantly less likely to agree that savings and property should be protected from care costs (54%) than those who distrusted the LA (66%).

At the same time, those who distrust the LA are less likely to report being likely to take up S.18(3) even though it would potentially result in cost savings which would help preserve their assets. Those who trust the LA being more willing to use assets to pay for care compared with those who distrust the LA aligns with findings from other research showing the positive effects of institutional trust on willingness to pay more taxes.[6]

Those who considered the person for whom the likelihood of uptake of S.18(3) questions were being answered to have a weak financial situation were significantly more likely to distrust the LA (37%) than those considering care for someone with a strong financial situation (23%). This suggests that those making decisions on behalf of people who may benefit most from the financial savings of S.18(3) could face barriers in taking up S.18(3) in the form of lower levels of trust in the LA. There were no statistically significant differences in trust in LA according to the annual household income of the participant or whether their primary concern about the cost of care was cost and value for money or impacts on assets and inheritances.

A breakdown of participant attitudes toward financial assets in older age are presented in Figure 6.6.

Figure 6.6: Attitudes towards financial assets in older age



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

Responses to the open text question highlight the general sentiment around attitudes towards financial assets in older age, where participants also expressed that assets should be protected from care costs.

[6] Habibov et al. (2018) Does Institutional Trust Increase Willingness to Pay More Taxes to Support the Welfare State?. Sociological Spectrum, Vol. 38

> **"The current older generation are the only ones who have paid National Insurance and other taxation all their lives and should be cared for in old age from these funds and not have everything they have worked for taken from them in their time of need."**
> (age 75, asked about self, Q1 take up of S.18(3) 'Unlikely').

Others had a different view, suggesting that those who have assets which could cover the cost of care in old age should use them for this.

> **"If people need care and have money, why do they think someone else should pay for it? Obviously if people don't have the money they will need the state to fully support them."**
> (age 38, asked about someone else, Q1 take of S.18(3) 'It depends').

6.7 Around half of participants had not made plans for older age

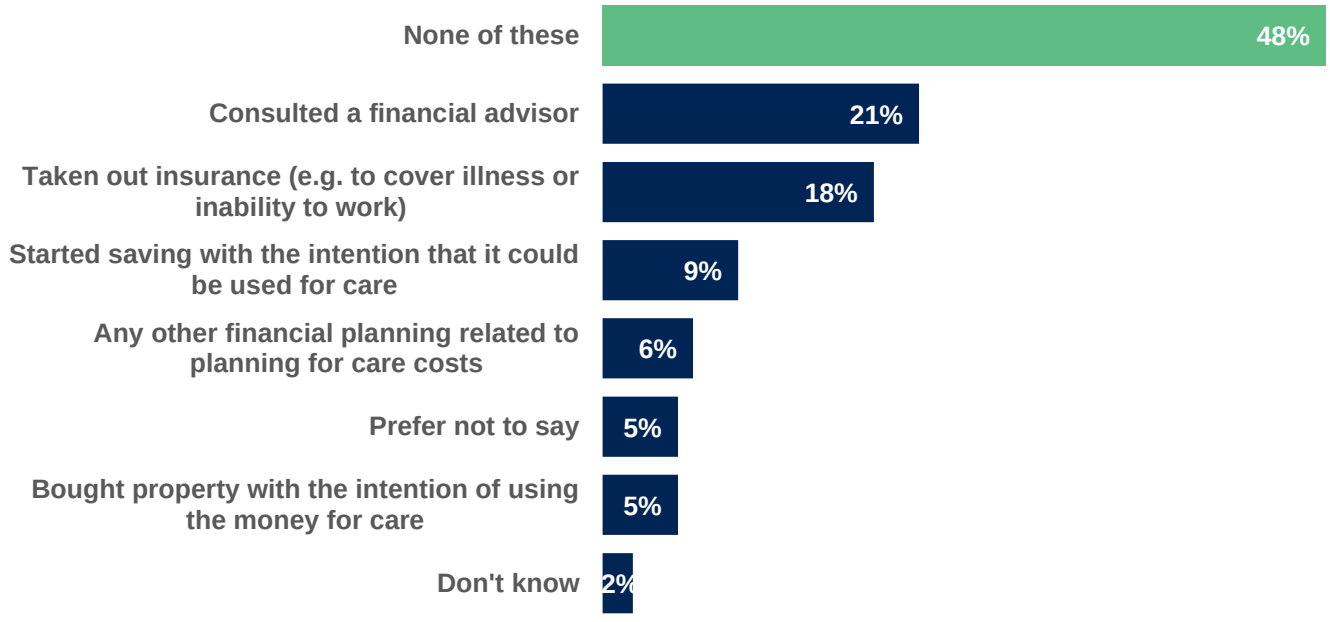
Participants were asked about their plans for the future, such as in older age or retirement. Data suggests there is a lack of planning for older age. Around half (48%) of participants reported having done none of the listed things to plan for their future. Those in the oldest age group (75+) (59%) were more likely to report having done none of the listed things to plan for their future, compared with other age groups (30 to 44 (48%), 45 to 54 (40%), 55 to 64 (41%), 65 to 74 (50%)).

Those in the lowest annual income group (up to £25,999) (55%) were also more likely to report having made none of the listed plans for their future, compared with those in other income groups (£26,000 up to £51,999 (46%), £52,000 up to £99,999 (44%) £100,000 and above (29%).

Around one in five (21%) participants reported consulting a financial advisor and nearly one in five (18%) also reported having taken out insurance (for example to cover illness or inability to work). Only one in ten (9%) reported having started saving with the intention that it could be used for care.

The proportion of participants who reported different plans for the future are detailed in Figure 6.7.

Figure 6.7: Planning for future older age or retirement



Base: All eligible for module (n=1,106 (weighted) – n=1,290 (unweighted))

7 Conclusions and implications

This section draws together the findings from across the report to set out the main conclusions and implications.

7.1 There is uncertainty about the uptake of S.18(3) which depends on the care offered

A primary purpose of this research was to produce an estimate of the likely uptake of S.18(3) in terms of the percentage of those who are very likely, very unlikely or for whom it depends on circumstances.

The scoping phase of this research and responses to survey questions show that for a self-funder there are two key stages in taking up S.18(3). The first is whether an individual or their relative considers it as an option and approaches the LA to find out what would be offered if they took up S.18(3). The second is whether they take up the offer of a care home place and go ahead and ask the LA to commission this on behalf of the person with care needs. An LA's offer in respect of given eligible needs should not differ according to whether the person is a self-funder via S.18(3) or LA-funded in whole or in part.

The research shows that there is uncertainty surrounding the uptake of S.18(3). After answering questions which enabled participants to understand how the offer of a care home might differ and the potential financial benefits of S.18(3), nearly half thought they would take it up (47%) but over a quarter still thought it depended (23%) or they did not know (4%).

When presented with the DCE and the behavioural model, preferences and intention to take up S.18(3) were closely related to what was being offered. The characteristics of the offer which most affected uptake were the quality of the care (CQC rating), whether the location is near their preferred area or not, the overall weekly costs and savings, and the quality of the facilities. Characteristics considered to be less good (for example requires improvement CQC rating) had a stronger negative impact on preference than those considered to be positive (for example outstanding CQC rating) when compared with the 'middle' offer of a good CQC rating. This may relate to a 'dread risk bias' when people focus on a worst-case scenario and weigh it more in their decisions.[7] It is also possible that requires improvement is easier to conceptualise than outstanding because of the focus on poor care in care homes and the risks it brings in the media. In the research, waiting time for a place had a weaker impact (and for someone looking for care for themselves and coming from the community, a longer wait was preferred), and the number of care homes to choose from had very little effect on uptake. Likely uptake reported by participants was much lower for an offer with a care home rated requires improvement, in a less desirable location, with basic facilities, for which the cost was higher and the savings less, than it was for an outstanding home with premium facilities in the preferred location with a lower cost and greater savings.

The response of 'it would depend' to the general question was not an indication of participants not understanding the policy or not being willing to state a preference, but reflected the fact that the specific care on offer through the S.18(3) route would affect whether or not potential self-funders would take it up. Even participants who had stated they would be likely or unlikely to take up S.18(3) generally adjusted their preference for taking up S.18(3) according to the offer, though the impact of the offer on

[7] Jagiello, R.D. and Hills, T.T. (2018) *Bad news has wings: dread risk mediates social amplification in risk communication*. Risk Analysis, Vol 38: 10. https://warwick.ac.uk/fac/sci/psych/people/thills/thills/2018jagiellohills.pdf

take up was greatest for those who indicated that overall it would depend. The 'worst' offer in the DCE had very low preference shares regardless of general likelihood of taking up S.18(3) with only 8% of those likely to take up S.18(3) saying they preferred to take up the 'worst' offer over not taking it up, compared to 3% of those who were unlikely. When considering the 'best' offer the uncalibrated preference share for those generally likely to take up S.18(3) was 96% compared with 48% for those who were generally unlikely to take up S.18(3) and 85% of those for whom it depends.

This conclusion that the decision depends on the care on offer is also supported by the finding that when asked about it directly, most participants (74%) said they would involve the LA in their decisions about care for themselves or their relative. Since their decision about whether to take up S.18(3) depends on the situation and what is offered, for most people a necessary step is finding out what the LA can offer. The scoping work found that choice was important. The survey has shown that choice is more about being aware of the full range of options, including S.18(3), rather than a specific number of care homes to choose from. It is possible that too many choices may result in ‘choice overload’ and that it is easier to make a decision about taking up S.18(3) from a smaller number of options. The aspect of choice that people value is instead ‘keeping their options open’.[8]

This means that levels of initial contact with LAs about S.18(3) could be high but the likelihood of taking it further and asking the LA to commission the care, depends very much on how the care offered by the LA differs from that which could be arranged as a self-funder for oneself.

7.2 Who is arranging the care and the circumstances affects uptake

Overall, the same factors and characteristics were important in determining participants’ preference, regardless of whose care was being considered and their route into a care home (from hospital or community). However, the characteristics of the offer had a bigger impact for participants making decisions for others, than those making decisions for themselves. This suggests that certain characteristics of the offer act as a counter to their overall preference for S.18(3), particularly the quality of care being requiring improvement and the location not being near their preferred area. It was also notable that for participants considering a move for themselves from their own home, a longer wait to be placed in the care home (6 months) was preferred over a shorter wait, whereas for all other groups a shorter wait was preferred.

7.3 Demographic characteristics have little impact but trust in LA is important

There were few demographic differences in likelihood of taking up S.18(3). Overall men were more likely to take up S.18(3) than women. Even when taking account of previous experience of care (which tends to reduce likelihood) men were more likely than women to take up S.18(3) when asked a general question about uptake. Looking at the results of DCE when specific care offers were being considered there was still a gender difference with men more likely to take up the ‘middle’ and ‘worst’ offers, though this was smaller than for the general question and there was no clear difference for the ‘best’ offer. Once participants were considering a consistent scenario and offer from the LA, gender differences in uptake were reduced, suggesting that men may have been assuming a better offer from the LA when considering the general question.

[8] Blasheck,T.L. and Noor, J. (2020) T*he Dark Side of Variety: An Economic Model of Choice Overload*. Behavioural Economics Vol 1.1 https://elischolar.library.yale.edu/cgi/viewcontent.cgi?article=1037&context=yurj

The findings also showed that CQC rating, location, quality of facilities, cost and savings of the offer had the greatest impact on the preference for or likelihood of taking up S.18(3), regardless of gender or other demographic characteristics.

The findings suggested a higher likelihood of S.18(3) uptake in the South compared to other regions. Sample sizes were not large enough to explore the reasons behind this.

As well as demographic differences, the research also explored how attitudes and experience were related to take up of S.18(3). Participants with higher levels of trust in their LA were more likely to take up S.18(3). Trust varied according to prior experience of formal social care, with those with formal care experience for themselves or others having lower levels of trust in their LA and also being less likely to take up S.18(3). When considering the general questions about taking up S.18(3) this may reflect differing assumptions about what the offer would be, with those with prior experience or less trust in the LA assuming a worse offer than those without previous experience of care or with higher levels of trust. However, analysis of the behavioural model questions which presented a consistent offer to participants showed that whether the offer was ‘poor’ or ‘very good’, those who trusted the LA were still more likely to take up S.18(3).

If levels of trust in the LA are consistent across LAs and only reflect variation between people within an LA then the level of trust would not matter too much in modelling likely uptake of S.18(3). The main reason given for distrusting the LA was the perception that the LA is a poorly run organisation, closely followed by concerns about the under-funding of the LA. Lack of trust did not appear to be based on experience as those with lower levels of trust generally had less contact with the LA. While these perceptions are likely to be held nationally, it is possible that these perceptions may vary between LAs. The sample for this survey was too small to explore whether trust varies between LAs. If it does, then this needs to be accounted for in DHSC’s uptake estimations because uptake may be higher in LAs where there are higher levels of trust among self-funders.

Generally low levels of prior contact with LAs mean that it might be beneficial to consider people’s lack of experience when deciding the level of information communicated about S.18(3). People may need factual and practical information owing to a lack of prior knowledge, as well as information to help overcome assumptions made about the trustworthiness of the LA which may be based on limited prior experience.

7.4 The impact of finances on uptake depends on who is making the decision

The survey included questions about the participant's own financial circumstances and their attitudes to finances in relation to care as well as some limited information about the financial circumstances of the person for whom decisions about S.18(3) were being considered.

There were limited differences in the likelihood of taking up S.18(3) according to participants’ financial status both in the cross-sectional analysis and the DCE. There is no evidence that those in a weaker financial situation are more likely to take it up. Analysis also showed that the impacts of attitudes about paying for care on likelihood of taking up S.18(3) differed according to whether the care was being arranged for oneself or another person. For example, among participants who thought savings should be spent on paying for care, those considering care for themselves were more likely to take up S.18(3) than those arranging for a relative, whereas among those who disagreed the savings should be spent on care the opposite was true. Similar patterns were found in relation to attitudes to using house value to pay for care and leaving an inheritance. This indicates that the same information communicated to those making decisions about their own care and those arranging care for others might have differing impacts on the

uptake of S.18(3). This suggests the need for tailored communication or an awareness of how the same messages may impact different groups.

Understanding the factors related to who is making the decision and their financial priorities could also be useful for LAs in predicting how likely someone making an initial inquiry about S.18(3) is to take it up. Screening questions about who is involved in the decision and their main concerns about the cost of care asked when people approach the LA could provide LAs with useful insights, helping them to understand demand for the policy.

7.5 In a behavioural framework, knowledge and beliefs about consequences influence uptake

The research has involved a behavioural approach to considering the likely uptake of S.18(3) and the factors which affect decisions. See section 2.4 for how the Theoretical Domains Framework, which aligns to COM-B was applied to the survey content. There are complex relationships between certain capability and motivational factors when considering uptake of 18(3), specifically between knowledge (capability) and beliefs about consequences (motivations).Those who are more informed from prior experience or those who have more information about the likely offer from the local authority may be less likely to take up S.18(3) if the information suggests the offer would be less good than that available if care was arranged themselves. Countering this, the research found that those who lacked trust in the LA tended to be more likely to have had no contact with the LA in the last five years, suggesting their lack of trust was based on assumptions rather than experience.

The survey did not include any questions specifically about the perceived quality of care and participants' views on this (generally across care homes or in specific settings). However, the importance of this attribute in the DCE (in which a 'requires improvement' rating on quality was the attribute and level with the greatest impact on preferences for S.18(3)) and the focus on quality in the open text answers suggests that concerns about quality and the impact of taking up S.18(3) on the quality of care received is important. This also comes under the domain of beliefs about consequences, suggesting that this domain which encompasses trust, concerns about quality and concerns about the costs of care is one of the most important domains influencing decisions about S.18(3).

Participants considering care for someone in a weaker perceived financial situation showed lower preference for taking up S.18(3) than those in a stronger financial situation, especially when considering care for someone else. Preference for S.18(3) (a middle offer) was greatest for those aged 65+ considering care for others, when their greatest concern about the cost of care was impacts on assets and inheritances. Since in most cases, relatives will have some input into the decisions and arrangements around entering a care home, considering their perspective is important in communicating information about the policy. Since the government and LAs have limited control over who reads different information materials and sources, both perspectives need to be considered in the preparation of any information about the policy, though where targeted communications are possible, tailoring them may be appropriate. This would potentially inform people of an alternative perspective to consider in their decision making. For those arranging care on behalf of someone else, it may be advantageous to communicate the importance of considering ability to pay for care, as well as impacts on assets and inheritances, to ensure that the relatives of those with lower levels of assets consider taking up S.18(3) to ensure the sustainability of remaining in a care home for as long as they need.

The research showed that the particular care offer in terms of quality of care and facilities, location, cost and savings, and time waiting for a place were more important than the characteristics of participants in influencing likely uptake. Once considering a consistent offer from the LA, differences in uptake between

groups were reduced, but levels of uptake varied greatly according to the offer. This suggests that the knowledge about the policy communicated needs not only to include general information about the policy, how it works and general benefits and impacts but also specific information about what the offer would look like in individual cases and circumstances. Even if general information is provided, participants still indicated a desire to contact the LA to find out the specific offer in their individual case before making a decision. The findings of the DCE suggested that the specific care offered is what ultimately will determine take up in terms of requests for LAs to go ahead and commission the care home place on their behalf. Providing information about the offer will enable people to have more informed beliefs and enable them to make the best decision about whether to take up S.18(3) in light of their own personal circumstances. This also suggests that if information about the offer is made available in a format which is accessible to all groups, the equalities impact of the policy will relate mainly to differences in the quality of the local authority offer and local care market, rather than how different groups understand the benefits and respond to the policy.

7.6 Implications for designing communications

Information about the policy will need to be disseminated to the public, care providers and organisations in the sector supporting them. Consideration of the context and the channel where messages might be consumed is important. Decisions about how to arrange care need to be made carefully and people will need time for deliberation on the policy being communicated to them. Careful consideration needs to be given about how to communicate about the policy because of relatively low existing levels of trust in LAs and the government. This could inform branding or which organisations have an active role in communication. Consideration of how to simplify messaging for a variety of languages and literacy levels will be important.

Taking up S.18(3) involves several steps and decision points. Most people expressed a preference for finding out what the LA could offer under the policy, which provides an opportunity to engage with many people about the policy at several points. Communications are likely to be needed at multiple stages:

- Prior to people contacting the LA, so they are aware of the policy and can decide whether to explore the options with the LA. This ideally should be provided by trusted organisations.
- When people initially contact the LA about S.18(3), including information about the general options and process.
- Following the initial contact with the LA, detailed information on what the offer would be from the LA in their particular situation would need to be provided.

Those who may take up S.18(3) come from very different levels of prior experience of formal care and contact with the council and varying levels of trust in the LA. The same information may have differing impacts on uptake depending particularly on prior assumptions and who is arranging the care (a relative or the person themselves). This research suggests that initial general communications about the policy could usefully address some of the assumptions people may have so that people are not making misplaced assumptions when deciding whether or not to approach the LA initially. The research also suggests that, once a specific request for support has been made, LAs will need to communicate detailed information to enable people to make a timely decision about whether to take up S.18(3). This means that having a clear plan for the hierarchy of communications is likely to be important. In order to avoid the risk of information overload, it is important that the most relevant information is shared at the right time.

Communications with LAs and care providers about the likely uptake need to emphasise the main factors which influence uptake. This research shows that the quality of the care home (in terms of CQC rating and facilities), location and cost and saving compared with self-arranged care are the factors which most affect uptake. Knowing what the care home offer is likely to be for people approaching the LA will be most important in assessing likely uptake locally and working out the resourcing and financial implications for LAs and care providers.

Although the offer is the main factor influencing uptake, personal circumstances, especially financial, also have a role. It could be valuable for communications to include case studies or example personal stories to show how the policy might apply in different situations.

7.7 Further research questions

In designing the communications plans for this policy and preparing LAs for its implementation it would be useful to gain further insight into the following issues, through further qualitative research or existing data sources as indicated:

- Exploring qualitative, emotional and personal views about the prospect of arranging social care, how different circumstances could impact decision making or judgement and the role of emotions such as fear and worry in decision making.
- Understanding more about the process by which people would approach the LA about S.18(3) and consider involving them in arranging care.
- Understanding more about the motivations for taking up S.18(3) in relation to financial concerns among people considering care for themselves and for relatives, and the reasons for these differences (qualitative follow up). Specifically on wealth, exploring whether concerns about care vs. saving assets for inheritance differ.
- Understanding more about people's interpretation of quality of care and the CQC ratings, as well as how their decisions about taking up S.18(3) are related to their general approach to risk and perceptions of risk, specifically related to 'requires improvement' ratings.
- Understanding the balance of input from people with care needs and their relatives in contact with LAs and care providers as this may affect modelling (consulting with LAs).
- Understanding the drivers influencing uptake intentions for people based within the community needing to access a care home place, compared with those needing a care home place being discharged from hospital (qualitative follow up).
- Understanding more about gender differences in uptake and the relationship to prior knowledge and assumptions (qualitative follow up).
- Understanding more about the reasons why certain groups appear to be more likely to take up a 'worst' offer and less likely to take up the 'best' offer (for example minority ethnic groups) even when their preference for a ‘middle’ offer is similar to other groups. Exploring whether this relates to a perceived lack of choice, greater concern about cost or less concern about quality of care or location.

- Understanding the reasons for regional difference and greater uptake in the South (existing data about regional differences in trust in local government, financial status and uptake of care services).
- Understanding more about what people understand by 'trust in their LA' and the drivers for this.
- Understanding how trust varies between LAs and whether there are differences between LAs which could affect uptake in different LAs or whether trust in LAs mainly varies within LAs. The modelling should also consider the effects of institutional trust on willingness to pay which may be relevant here. Other research carried out by ONS for wider research about trust in government generally shows five drivers that can influence levels of trust: integrity, responsiveness, reliability, openness and fairness (https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/trustingovernmentuk/2022). It is possible that information on these could be used to assess likely levels of trust in an LA.
- Understanding how to communicate the policy in terms of information required, timing and channels of communication, as this was not covered in the survey.

Our standards and accreditations

Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a "right first time" approach throughout our organisation.

ISO 20252

This is the international market research specific standard that supersedes BS 7911/MRQSA and incorporates IQCS (Interviewer Quality Control Scheme). It covers the five stages of a Market Research project. Ipsos was the first company in the world to gain this accreditation.

Market Research Society (MRS) Company Partnership

By being an MRS Company Partner, Ipsos endorses and supports the core MRS brand values of professionalism, research excellence and business effectiveness, and commits to comply with the MRS Code of Conduct throughout the organisation. We were the first company to sign up to the requirements and self-regulation of the MRS Code. More than 350 companies have followed our lead.

ISO 9001

This is the international general company standard with a focus on continual improvement through quality management systems. In 1994, we became one of the early adopters of the ISO 9001 business standard.

ISO 27001

This is the international standard for information security, designed to ensure the selection of adequate and proportionate security controls. Ipsos was the first research company in the UK to be awarded this in August 2008.

The UK General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA) 2018

Ipsos is required to comply with the UK GDPR and the UK DPA. It covers the processing of personal data and the protection of privacy.

HMG Cyber Essentials

This is a government-backed scheme and a key deliverable of the UK's National Cyber Security Programme. Ipsos was assessment-validated for Cyber Essentials certification in 2016. Cyber Essentials defines a set of controls which, when properly implemented, provide organisations with basic protection from the most prevalent forms of threat coming from the internet.

Fair Data

Ipsos is signed up as a "Fair Data" company, agreeing to adhere to 10 core principles. The principles support and complement other standards such as ISOs, and the requirements of Data Protection legislation.

For more information

3 Thomas More Square
London
E1W 1YW

t: +44 (0)20 3059 5000

www.ipsos.com/en-uk
http://twitter.com/IpsosUK

About Ipsos Public Affairs

Ipsos Public Affairs works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. Combined with our methods and communications expertise, this helps ensure that our research makes a difference for decision makers and communities.