

***Shifting Shapes: Report of Work Package 1 – National interviews, local
authority survey and secondary data analysis***

Catherine Needham, Emily Burn, Kelly Hall, Steve McKay, Catherine Mangan, Kerry Allen, Melanie
Henwood, Sarah Carr and Jon Glasby



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This is an interim report, presenting findings from the first phase of the research, and has not been peer-reviewed. The final report from the research projects will be peer-reviewed prior to publication.

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Key Findings

- **Definitions** of market shaping and personalisation are fluid and there is uncertainty about what good looks like.
- Local authority survey respondents and national stakeholder interviewees see **financial constraints** as the major challenge facing care services, inhibiting the impact of the Care Act.
- The care market within a locality is divided into **multiple sub-markets**, making market shaping a complex and fractured activity.
- Survey respondents are utilising preferred **provided frameworks and/or block contracts** to assure the stability of supply, which takes precedence over maximizing choice and diversity.
- National stakeholder interviewees feel local authorities could do more to **incentivise providers to innovate**. Local authority respondents see providers as resistant to change.
- Survey respondents gave some good examples of **local level integration with health**, e.g. growing numbers of joint market statements and good use of Integrated Personal Commissioning (IPC). However there was some scepticism that integration with health will improve social care provision, and anxiety that system level integration will make it harder to integrate around the person.
- **Rules** (eg. tenders, contracts, monitoring) and **relationships** (with providers and local communities) are two key variables in effective market shaping and personalisation.
- Four local authority types of market-shaping were identified depending on their configuration of rules and relationships with providers and people using services:
 - the **procuring** council (high rules, weak relationships)
 - the **commissioning** council (high rules, strong relationships)
 - the **open market** council (weak rules, weak relationships)
 - the **partnership** council (weak rules, strong relationships)
- If the Care Act envisages effective care markets that stimulate provider innovation and diversity in order to offer choice and control to all people using services then the **open market** and **partnership models** are two models which support that. The **procurement and commissioning models** are rule-driven and likely to limit scope for diversity and innovation.

Implications for Policy and Practice

Local authorities need further support to:

- Gather and **analyse data** on market demand and future projections, and use that to develop a strategy for effective care and support with communities and providers
- Shape **multiple markets** within one locality
- Design local rules in ways that **enhance diversity and choice** rather than reduce it, either on the open market council model or the partnership council model.
- Build **effective relationships** with providers to share risk and stimulate innovation

National government needs to address:

- The **adequacy of funding** in the social care system
- **Workforce supply**
- Approaches to **integration which support person-centred support**

Executive Summary

The [Care Act 2014](#) assigned local authorities in England the responsibility to ensure that there is a wide variety of good quality care services available for people who need them. Older people, people with disabilities, people using mental health services and people with caring responsibilities should all have access to information about what services are available locally. Those services should be person-centred and high quality. The *Shifting Shapes* research project focuses on two aspects of the Care Act which underpin high quality support: first, the duty placed on local authorities to shape local care markets; second, the requirement to support individual choice and control within the broader wellbeing duty, which is referred to by the term ‘personalisation’ in the [Care Act statutory guidance](#).

Data and Methods

This report presents empirical data on market shaping and personalisation from three different sources:

- National stakeholder interviews with 28 senior leaders of key national organisations and other opinion formers, in the care sector.
- An online survey of the 152 local authorities in England with primary social care responsibilities, focused on market information (e.g. number of providers on framework contracts), market-shaping activities undertaken, key challenges and future plans. A total of 27 local authorities completed the survey, an 18% response rate. The low response rate is recognised to be a limitation on the data. Findings are presented not as a way of generalising to the local authority experience but in order to develop theory and patterns that can be explored further in the local case study fieldwork which will follow.
- Secondary analysis of national datasets on care outcomes for people using state-funded services to explore the relationship between outcomes and other variables such as spending, workforce vacancies and direct payment levels.

The Context of Market Shaping

In the national stakeholder interviews and the local authority survey, three contextual factors were raised as influencing what was possible in relation to market shaping:

- (1) The complexity of local care markets:** Interviewees and survey respondents pointed out that no unified adult social care market operates even within a single locality. A key distinction is between markets for people funded by the local authority and for people funding their own care (usually referred to as self-funders). Differentiation within the market was also recognised to exist in relation to main groups of service users (e.g. older people,

working age people with physical or learning disabilities, people using mental health services) and types of provision (e.g. the domiciliary market and the residential care market).

There are also geographically distinct sub-markets within different parts of local authorities, and local authorities are typically influenced by the supply and demand within neighbouring localities. Understanding the scope of the care market is further limited by uncertainty about what constitutes a care provider. Non-registered services such as peer support groups and directly employed personal assistants can be providing activities which meet a care need but are not visible to the CQC and may not be part of what a local authority understands to be its care market.

- (2) Reduced public spending and rising demand** were interlinked in a set of comments about **austerity**. Local authorities were recognised by interviewees to be under pressure to deliver more for less, and austerity was seen as impacting on the attitudes and behaviour of commissioners and other local authority staff. Local authorities were criticised by some interviewees for short-termism and being more focused on saving money than on ensuring quality care, although the difficult trade-offs here were also recognised.

Nearly all (96%) respondents to the local authority survey were concerned about the sustainability of care providers in their locality in the current financial climate (with 41% being very concerned). Other issues were: the level of flexibility by providers (with 25% identifying that this is a challenge to a great extent) and the commissioning/procurement processes for small providers (22% identifying that this is a challenge to a great extent).

- (3) Workforce** issues, particularly the shortage of staff and difficulties relating to payment and contracts, were a key third contextual factor. Low pay in the care sector was referred to by stakeholder interviewees as a major problem, and this was seen to be further compounded by the domiciliary care workforce not being paid for travel time between appointments, often resulting in actual wages below minimum wage, as well as poor terms and conditions. Local authority respondents were asked to rank their concerns about the future of their local care market from 1 (not at all concerned) to 10 (extremely concerned). The biggest common concern for the future was around workforce shortages with an average score of 8.07 indicating a very high level of concern.

Market Shaping as a Mechanism

When asked about how market shaping should be done, the interviews and survey respondents focused on two key mechanisms:

- (1) Understand and manage demand:** Stakeholder interviewees felt that a central aim of market shaping was to understand the needs of the local population, which involves the analysis of a range of data to develop a strategic vision. However, some interviewees suggested that market shaping lacked conceptual clarity and that it was unclear what 'good' market shaping looked like.

There was scepticism among the national stakeholder interviewees about the extent to which local authorities were moving beyond commissioning to take on the broader aspects of market shaping (as envisaged by the Care Act). The multiple markets operating within social care were also suggested to affect the quality of relationships between local authorities and providers. Some interviewees also questioned the extent to which local authorities had the capacity and skills to undertake detailed data analysis.

Market position statements were recognised by interviewees as a potential channel to communicate the local authority's vision for social care. However, interviewees believed that market position statements, in their current form, did not facilitate this and did not supply the data required to support providers' service development. It was noted in particular that the data within the statements were often focussed on demographic projections rather than developing a vision as to how a holistic care system can respond to possible future demands.

In the survey, all responding local authorities had undertaken or were planning to carry out, an assessment of the local care market capacity. Over three quarters (77%) had already undertaken a partial assessment, whilst 19% had undertaken a detailed assessment. Survey respondents were more confident that local market capacity has been addressed sufficiently in domiciliary and residential care provision (with over 90% being very or fairly confident) than in other market segments (e.g user-led organisations or specialist community support services).

- (2) Working with providers to stimulate supply and meet demand:** Both interviewees and survey respondents were sceptical about the extent to which relationships between local authorities and providers were working well in order to meet this aim. A number of interviewees felt that local authority engagement of providers is tokenistic. The continued use of block contracts by many local authorities (particularly for older people) was seen by interviewees as limiting innovation through restricting the ability of providers who were not already agreed suppliers to deliver services. Outcomes-based commissioning was raised by several interviewees as a potential alternative to traditional contracting arrangements, but was felt to be hard to operationalise in practice.

Most local authorities surveyed (92%) have a preferred provider framework for adult social care. Respondents said that managing contracts was demanding and that there was often a lack of resource to support the commissioning of services and wider market shaping activity. Most survey respondents felt that providers needed to do more to lead on innovation.

Impact of the Care Act

Both interviewees and survey respondents indicated that at a local level the Care Act had had limited impact. Some interviewees reported that the legislation had helped to raise the profile of

market shaping and also signalled to local authorities their wider responsibilities. Despite this, interviewees felt that they had seen little actual change since the introduction of the legislation.

Some stakeholder interviewees expressed concern that local authorities are not held accountable for fulfilment of their market-shaping duties and that insufficient data is collected that could support such monitoring. The collection of such benchmarking and monitoring data was also suggested to be affected by the difficulties of defining market shaping and related activity. This led to some interviewees describing the legislation as a weak lever for change.

Outcomes of Market Shaping

Stakeholder interviewees found it difficult to predict the outcomes of market shaping and restated the differences in local contexts and markets within social care. It was noted that aspects of the care market were often beyond the control of local authorities and that external factors could have unforeseen consequences.

A valued potential outcome of market shaping was the ability for areas to understand their neighbouring care markets and collaborate in a way that refocuses work on the needs of their populations. Interviewees stressed the importance of trying to break down local and regional area boundaries to care market knowledge and provision which could inhibit service improvement.

Rather than linking market shaping directly to a set of outcomes, national stakeholders and survey respondents found it easier to identify what they saw as good practice. These insights into practice indicate that there is a set of intermediate outcomes which are a necessary first step to improving user-level outcomes. These are:

- diversification of the provider market;
- co-production of services and engagement;
- market stabilisation;
- more efficient working within local authority organisations

Personalisation

A key issue for stakeholder interviewees and survey respondents in relation to personalisation was the **range of definitions** associated with it which got in the way of a clear understanding as to whether or not it was being done well. Some definitions were more aspirational than others, with some defining it from a service aspect whilst others focused on the impact personalisation could have on people's lives and wellbeing. A widely used definition referenced making the shift from expecting people to fit in with services to designing services around people's lives.

Personalisation as a Mechanism

In the interviews and the survey, respondents identified the following mechanisms to achieve personalisation:

- the provision of information;
- personal budgets;
- provider diversity;
- local authority facilitation;
- integration across the system, including health services.

Provision of information: Half (52%) of survey respondents rated information about the different support options available as good, with the remaining 48% rating it as poor or fair (and none rating it very good). When asked about information for different user groups, under half (42%) were very or fairly confident that people using local authority funded care services have sufficient information to make a choice. There was less confidence that self-funders have sufficient information and advice with none being very confident and only 38% being fairly confident.

Personal budgets: Personal budgets were recognised to be one of the mechanisms through which personalisation can be achieved. When asked about personal budgets, over a third of survey respondents (39%) reported that most (over 75%) eligible people in their local authority access care via a personal budget. In contrast, nearly a third (30%) reported that only 1-25% of people in their local authority access a personal budget indicating significant differences across responding local authority areas. Most respondents felt that personal budgets were making people's choice and control in using services better (16% a lot better and 68% a bit better). Whilst 16% felt that personal budgets make no difference to choice and control, no respondents felt that they made things worse.

There was a recognised need for personal budgets to be met with wider cultural changes and an awareness that the market may not provide the services that individuals want to access, demonstrating the link between personalisation and market-shaping. Respondents felt that providers were doing little to adapt in response to personal budgets with over two thirds (67%) stating that providers were adapting their offer only to a small extent.

Provider diversity: Several interviewees talked about provider diversity as the key mechanism to achieve more person-centred support. For some, the market had not responded by providing personalised support and is limited to supporting people with their basic needs. Others suggested that the care market was binary; either block contracting or individual purchasing; both of which had limitations. There was felt to be a tension between the market diversity required by personalisation and the stability required as an effective market shaper.

Local authority facilitation: The key aspects which national stakeholder interviewees saw as shaping the effectiveness of personalisation were the systems and culture of local authorities. Overly bureaucratic systems were seen by many interviewees as a major barrier to personalisation, along with attitudes of commissioners, social workers and providers. Several interviewees spoke about the restrictions that councils had put on direct payments including pre-payment cards, which

encouraged people to stay within a narrow definition of what might support their care needs. Local authority procurement processes were seen as preventing the development of agile, flexible approaches needed for personalised approaches. Several interviewees commented that they believed commissioners did not have the required skills to commission personalised services and that they have focussed on creating efficiencies and defending the services and contracts that they have in place. A lack of ambition for support packages for older people in particular was highlighted.

Integration across the system: A further mechanism seen by interviewees as underpinning effective personalisation was the ability to deliver person-centred support across a range of services, particularly health and social care. Some good practice examples of local level integration were provided. There are now growing numbers of joint market statements that include both social care and health. Integrated Personal Commissioning (IPC) was cited by many participants as providing an opportunity to bring together health and social care services focused on the needs of the individual. However, both survey respondents and interviewees indicated that on a national scale, integration was rarely happening, and where it was happening it was not working very effectively. Responses emphasised the importance of patients being the active *'integrators of their own care'*, rather than seeing an inherent value of achieving joint services or organisations. Others reported variance in the extent to which health commissioners understand the personalisation agenda.

Overall 80% of survey respondents reported that they had effective local relationships with voluntary and community providers, independent sector providers, CCGs and other parts of their own local authority e.g. housing. Over three quarters (76%) also reported that they have effective co-operation with other local authorities. Just over two-thirds (69%) reported effective co-operation with NHS acute care providers, whilst less than half reported co-operation with primary care providers (48%) and only a quarter with NHS England specialised commissioning (27%).

A Typology of Market Shaping

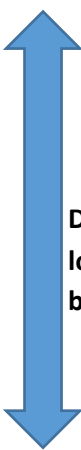

Whilst the survey response rate doesn't allow us to make generalisations about the wider local authority experience, we can use the data to develop theory on how market shaping and personalisation are operating, which can be tested in further phases of the project: Within the data it is possible to draw out two main sets of responses: one relating to the setting of **rules** around tendering, contracting and monitoring (which may be tightly set or relatively loose) and the other relating to **relationships** with providers (which may vary in the extent to which they are based on trust, transparency and partnership).

On the **rule** dimension, local authorities can be located on a spectrum between taking a rule-based approach to market shaping and personalisation or a more open and emergent approach: for example they can create barriers to market entry for providers and impose tight limits on how people spend their personal budgets; or they can be more flexible on these aspects to maximize diversity.

On the **relationship** dimension, the spectrum of local authority behaviours can span from creating close relationships with providers and people who use services (for example regular provider forums and collaborative forms of commissioning) to taking a less interventionist approach in which it is left to providers and consumers to develop bilateral relationships.

These are variables rather than binaries, such that many local authorities will not match these ideal types. However they do allow the development of a typology of market shaping practices which can be used when exploring how local authorities are fulfilling their Care Act duties in local case study work, as shown below.

Figure 1: Market Shaping Typology

<p><i>High</i></p>  <p>Degree to which local authority sets binding rules</p>	<p>Care providers are multiple and dispersed. Local authority sets binding rules. This can be described as a PROCUREMENT approach.</p>	<p>Local authority has a close relationship with a small in-group of providers, in which LA set binding rules. This can be described as a COMMISSIONING approach.</p>
	<p>Care providers are multiple and dispersed and compete with each other in open markets – accountable to customers as much as to commissioners. This can be described as an OPEN MARKET approach.</p>	<p>Local authority has a partnership relationship with a small in-group of providers, in which they work together to shape care system. This can be described as a PARTNERSHIP approach.</p>
<i>Low</i>	<p><i>Weak</i>  <i>Strong</i></p> <p>Strength of relationships between Local Authorities and providers</p>	

The typology shows four types of market shaping activity. If the aim of the Care Act is to create effective care markets that stimulate provider innovation and diversity in order to offer choice and control to all people using services then we can see the two low grid models as being most likely to do that. In the **open market** model, local authorities encourage maximum diversity of provider and encourage individuals and families to shop around to find the best fit for their care and support. In the **partnership model**, local authorities work closely with a smaller number of providers to ensure

that the range of support is innovative and supports choice and control, for example through collaborative forms of commissioning. The **procurement and commissioning models**, in contrast, are more rule-driven and likely to limit scope for diversity and innovation, inhibiting personalised support.

Developing a sample of local authorities

Having developed a theoretical typology of market shaping practices, the next phase of the research is to test the practical validity of the typology in eight case study local authorities. To develop the sampling frame for local authorities, data from the Adult Social Care Outcomes Framework (in particular, the Social Care Related Quality of Life (SCRQoL) measure) were compared against other variables to create a 'decision tree' regression which classified local authorities into eleven sets, based on which variables were most strongly linked to the SCRQoL. Eight case sites have been selected from this grouping, to give variance across the categories, but also to represent local authorities in relation to geographical spread; numbers of self-funders; political control and type of local authority.

Introduction

The [Care Act 2014](#) assigned local authorities in England the responsibility to ensure that there is a wide variety of good quality care services available for people who need them. Older people, people with disabilities, people using mental health services and people with caring responsibilities should all have access to information about what services are available locally. Those services should be person-centred and high quality. The *Shifting Shapes* research project focuses on two aspects of the Care Act which underpin high quality support: first, the duty placed on local authorities to shape local care markets; and second, the requirement to support individual choice and control within the broader wellbeing duty, which is referred to by the term ‘personalisation’ in the [Care Act statutory guidance](#).

This report brings together empirical data on these topics from national stakeholder interviews and a local authority survey, along with secondary data analysis. A typology of market-shaping is presented based on the configuration of rules and relationships within localities, along with a sampling strategy for the eight local authority case study sites that will be the focus for the next phase of the *Shifting Shapes* project.

Data is derived from:

- National stakeholder interviews with 28 senior leaders of key national organisations in the care sector (see Appendix 1 for the list of organisations).
- An online survey of local authorities in England with primary social care responsibilities, focused on market information (e.g. number of providers on framework contracts), market-shaping activities undertaken, key challenges and future plans.
- Secondary analysis of national datasets to give data on service user outcomes in relation to a range of variables including type of local authority; social care spend per head; market concentration; CQC rating; proportion of service users accessing a direct payment; and staff vacancy rates.

The report begins by setting out the programme theories which underpin market-shaping and personalisation, derived from an earlier synthesis of the literature. The synthesis took a realist approach, surfacing the programme theories that underpin market shaping and personalisation to inform a logic model which separates out the context, mechanism and outcome factors (Pawson *et al.*, 2005). Synthesis of the literature identified 64 relevant resources, most of which were policy documents or reports rather than peer reviewed academic studies. The full realist synthesis of the literature is available as a separate [report](#).

This report also takes a realist approach to understanding market shaping and personalisation. The questions which underpin a realist evaluation are: **What works, for whom, in what respects, to what extent, in what contexts, and how?** (Pawson *et al.*, 2005). To progress these questions it is important to understand more about the interventions themselves – what does it mean to say that local authorities are shaping the market and personalising care? We explore that question in the report. We also report on how far national stakeholders and local survey respondents see progress

as having been made on market shaping and personalisation since the Care Act. Together these inform the design of the local authority fieldwork in the next phase of the project, in which it will be possible to understand more about the ways in which the interventions become operationalised.

An aspect of realist evaluation is the ‘what works *for whom*’ question. Care markets are known to serve particular communities poorly (Needham and Carr, 2015). We have commissioned separate studies within the project on self-funders and on people using mental health services. These will be available in summer 2018.

It is important to emphasise that this report gives the perspective of national stakeholders and local authorities, as well as reporting on aggregate outcome data from existing surveys. We have not spoken directly to service providers or to people who use services, although we did interview representative bodies for both groups. These perspectives will be gathered directly in the next phase of the project when we move into local case sites. The absence of these perspectives means that we focus here particularly on the activities that local authorities are undertaking in relation to the Care Act.

Methodology

Details of the methods used in the different phases of the research are given below. Ethical approval for the project was granted by the NHS Research Ethics Committee (17/LO/1729). The Association of Directors of Adult Social Services (ADASS) also gave approval for the research (RG17-05).

National Stakeholder Interviews

The aim of interviewing national stakeholders was to explore perceptions of the Care Act from the perspective of those with a broad oversight of the social care sector. As such, senior individuals were selected from key national organisations in the care policy sector. They were invited to participate in semi-structured interviews including those representing people who access social care services, and those who were able to comment on the wider relationships between providers and commissioners of social care services. Interviews were conducted by a member of the research team over the telephone or face to face. With consent, they were audio recorded and transcribed. The interview topic guide was derived from the research questions for the overall study, and structured around the two key project elements: market-shaping and personalisation. A copy of the topic guide is given in Appendix 2.

Overall, 28 interviews with national stakeholders were completed and transcriptions were coded by the research team using the QSR-NVivo 11 software package. An initial coding frame was developed drawing on the context, mechanism, and outcome schematic that was used to structure the realist literature review. Sub-themes were then developed by the research team through processes of inductive coding (Attride-Stirling, 2001). To enhance inter-coder reliability, comparisons were made between each team member’s coding and discussions took place on interpretations of the codes and refinements were made to the final coding frame. In reporting the interview data below, each interview has been numbered to identify the range of perspectives that were captured within the interviews, whilst also preserving anonymity. Quotations from the transcripts are used to illustrate the key themes uncovered within the analysis.

Survey of Local Authorities

A survey of local authorities was undertaken to gather market information (e.g. number of providers in each local authority area, the number on framework contracts), understand market-shaping activities, identify key challenges and future plans. Survey questions were derived from the Association for the Directors of Adult Social Services (ADASS) national survey of local authorities (2017) and the research questions for the project, and were checked with the Department of Health and Social Care and with ADASS. The survey was set up online using Qualtrics software (see www.qualtrics.com) and was piloted with two local authorities. The pilot tested the online software and led to refinement of the survey questions and structure to aid clarity and ease of completion. All 152 local authorities with primary social care responsibilities were then invited to take part via the ADASS monthly commissioning bulletin, which goes out to social care commissioners by email.

The survey was open from June to September 2017. A total of 27 local authorities completed the survey, an 18% response rate. This is a low response rate, and may indicate survey fatigue on the part of local authorities. Steps were taken to increase the response rate, including keeping the survey open for a month longer than initially planned, and reminder emails sent by ADASS. The low response rate is recognised to be a limitation on the data. It may be that respondents came from those local authorities most engaged with market shaping, or that they are atypical in other ways. As respondents were anonymised we cannot compare responding councils with non-responding ones to identify any systematic bias in the responding population. We present the findings here not as a way of generalising to the local authority experience but in order to develop theory and patterns that can be explored further in local case study analysis.

The survey was analysed in both Qualtrics and Excel using descriptive statistics and primary frequency counts. Analysis was based on the evaluation questions and programme theories drawing on the Context Mechanism Outcome (CMO) model elicited in the *Shifting Shapes* realist review. The survey used mostly closed questions, although survey respondents were also given the opportunity to add free text comments, generating qualitative data which was added to NVivo, coded and analysed alongside the national stakeholder interviews.

Secondary Data Analysis

In addition to the completion of national interviews, analysis of available secondary data was also undertaken. The central aim of this was to better understand variables within the care market that had the most influence on care outcomes for people using services. This provided a sampling strategy for the selection of the eight case study sites on which future fieldwork related to the *Shifting Shapes* project will be based. As these case studies intend to consider how local authorities have responded to the market shaping duty as detailed within the Care Act, and to consider the effects of this on people's perceptions of the care that they receive, this requires a sample which is mixed in terms of demography, type of local authority and care outcomes.

Data from the Adult Social Care Survey (in particular, the Social Care Related Quality of Life score) was compared against other variables to create a 'decision tree' regression which grouped local authorities into eleven groups. The Adult Social Care Related Quality of Life (SCRQoL) measure is a composite measure derived from responses to the Adult Social Care Survey which cover the

following domains: control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation (Department of Health, 2017a, p. 10-11). Although it only covers people who are funded by the local authority, it provides an outcome score which can be used to better understand the relationship between a range of independent variables and care outcomes (the dependent variable). Associations between the structure of the social care market and the SCRQoL measure were also considered. Further detail on the data sources and the statistical techniques used can be found in the appendices.

Section 1: A Logic Model for Market Shaping and Personalisation

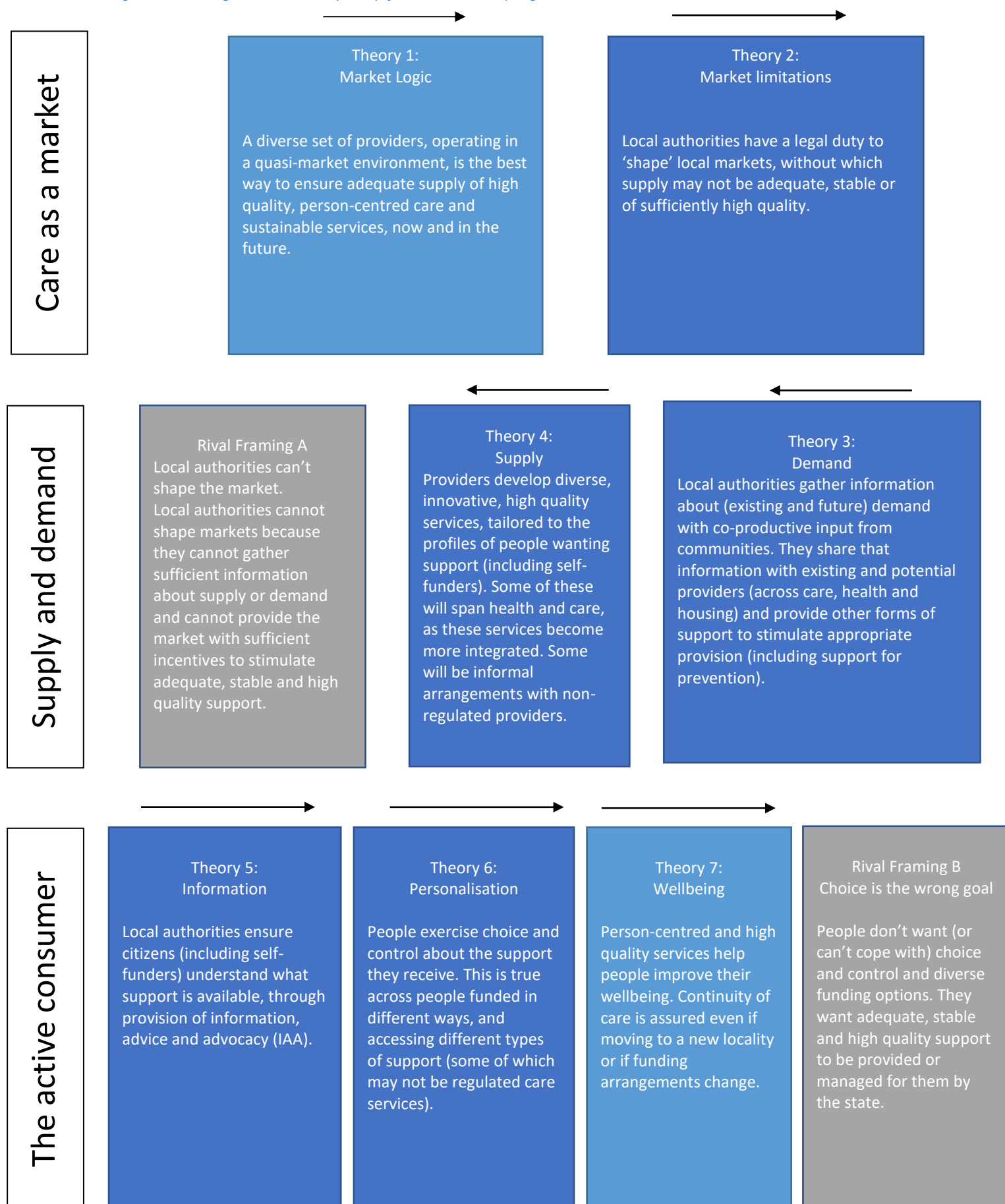
The first phase of the research was a realist synthesis of the literature, which identified the programme theories underpinning market shaping and personalisation, and the resultant logic model. We summarise this here to provide a starting point for the new empirical material that follows.

The questions for the literature synthesis were:

1. What are the intended outcomes of care market shaping and personalisation by local authorities?
2. What are the mechanisms by which it is believed that local authorities' market shaping and personalisation practices will achieve those outcomes?
3. What are the contexts which determine whether or not the different mechanisms produce the intended outcomes?

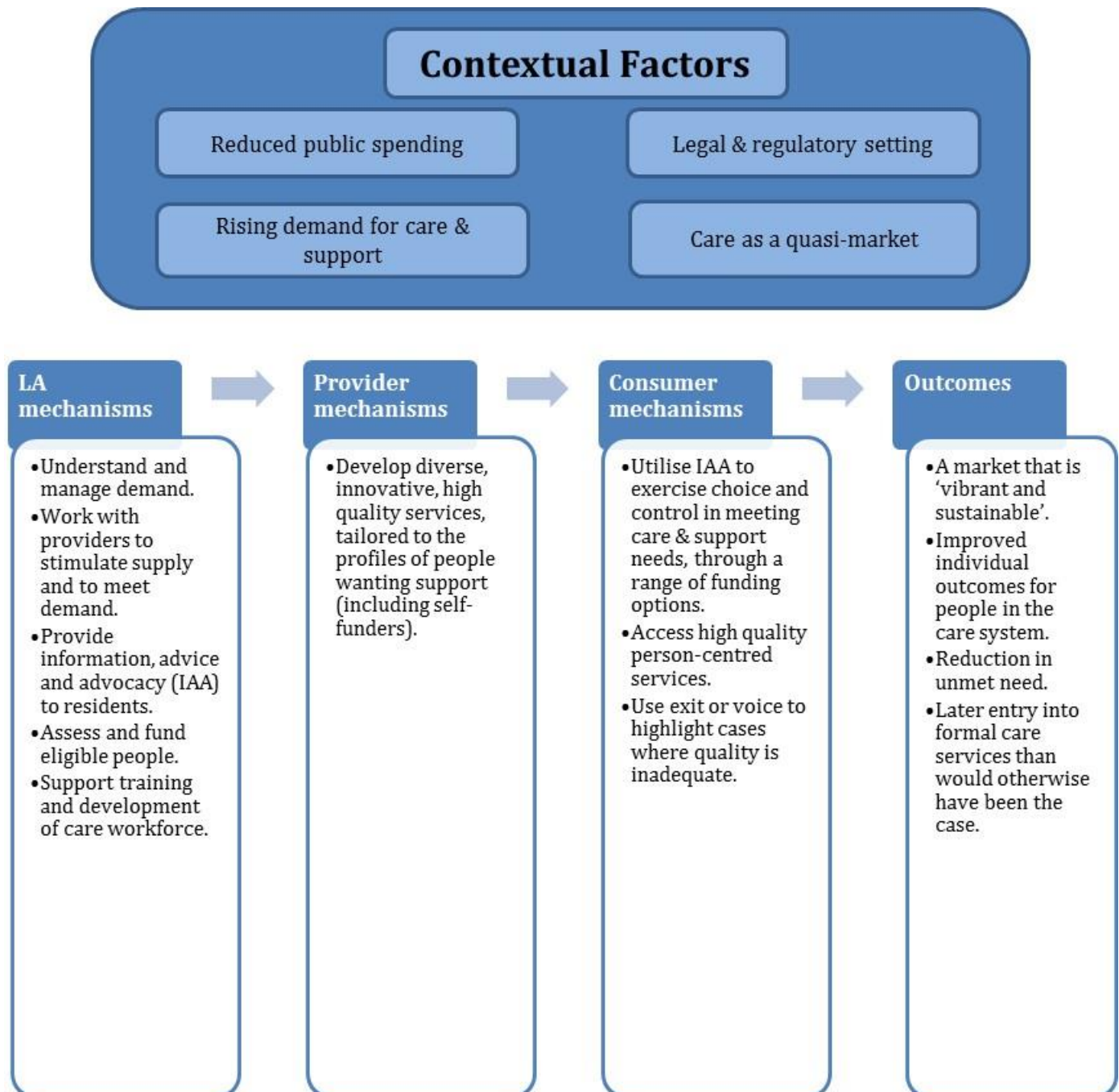
Literature searching and refinement identified 64 relevant resources, most of which were policy documents or reports ('grey literature') rather than peer reviewed academic studies ('research'). Applying the three questions to the literature led to the identification of the programme theories that underpin market shaping and personalisation, as well as a set of rival framings. The programme theories are shown in Figure 2 below. More details on the development of these elements is presented in the separate project output: *Market Shaping and Personalisation in Social Care: A Realist Synthesis of the Literature* (available on request).

Figure 2: A Programme Theory Map for Market Shaping and Personalisation



Having explored and refined the programme theories through the literature synthesis, the relationship between context, mechanism and outcomes was set out as a logic model. Mechanisms are separated into the activities undertaken by local authorities, by providers, and by people using care services. The model provides a structure for the empirical testing of programme theories.

Figure 3: Logic Model – Care Market Shaping and Personalisation



The realist synthesis of the literature drew attention to the different conditions which are required for the theory to be coherent, and the extent to which those conditions and their underlying assumptions are currently operating in and shaping English care services. Existing literature highlighted vulnerabilities and limitations within the logic model because of the restricted scope for the theory to work as proposed in a context of rising demand; continued austerity and constraints on public spending; insufficient staffing; weak consumer power; and poor flows of information. In the sections that follow we consider what our interview and survey data indicate about how local authorities are approaching their market shaping and personalisation-related duties.

Section 2: Market Shaping

Market shaping can be understood as an overarching term for the range of ways in which local authorities influence the behaviour of providers and people needing care and support within their localities.

This section looks first at the contextual factors which influence market shaping, before going on to explore the mechanisms through which local authorities undertake their market shaping duties, and the expected outcomes.

The Context of Market Shaping

The logic model identified four relevant contextual factors for market shaping:

1. Public spending on care;
2. Demand for care and support;
3. the legal and regulatory setting, including the workforce; and
4. care as a quasi-market

In the national stakeholder interviews and the local authority survey, each of these contextual factors was raised as a factor influencing what was possible in relation to market shaping. **Care as a quasi-market** was a key starting point, with particular focus on the complexities of local care markets. **Reduced public spending and rising demand** were interlinked in a set of comments about **austerity**. The **workforce** issue, particularly the shortage of staff and difficulties relating to payment and contracts, were a key third issue. These aspects are looked at in turn.

The Complexity of the Care Market

The logic model shown on p.18 above assumes that a care market is consistently defined and identifiable to the key people involved in it. One way to define the care market is through the number of providers operating within it. National CQC data records the number of registered providers, which can be broken down by locality, type of service and size (CQC, 2017). Our local authority survey asked respondents for the number of providers within their localities. As shown in Figure 4, nearly half of respondents (43%) had more than 200 social care providers in their care market, with 19% of those having more than 300. A quarter (27%) had 100 or fewer providers.

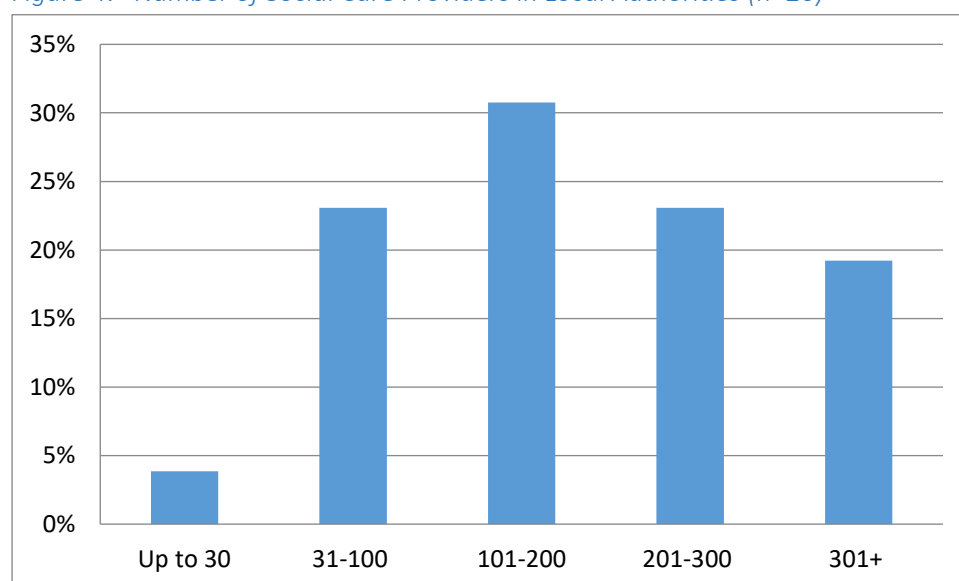
Some of this variance will be due to demographic differences in the size of local authorities, but it is also likely that local authorities are making different strategic choices in relation to the size of their care market. A National Audit Office (NAO) report on *Personalised Commissioning in Adult Social Care* noted:

...some authorities are reducing the number of providers they contract with, to achieve economies of scale, and, in areas where providers are struggling to recruit care workers, to limit the destabilising effect on the care market of workers moving frequently between providers (2016, p. 9).

In contrast,

One authority we visited had an advanced system that supported front-line staff in identifying services from more than 700 varied options available in the local area (NAO, 2016, p. 43).

Figure 4: Number of Social Care Providers in Local Authorities (n=26)



Q. Can you indicate how many providers are in your care market?

One respondent to the survey of local authorities reflected on the difficulty of keeping track of the number of domiciliary care providers:

This is a bit of guesswork... there are homecare providers setting up all the time and looking for work which we currently can't offer because we have a 15-strong framework contract.

Survey Respondent 13

A stakeholder interviewee similarly highlighted the lack of reliable data in relation to home care:

It is difficult for [us] to check what's happening to hours provided in home care...You can do it for CQC bed data but there is not corresponding data for home care. **Interview 13**

Understanding the scope of the care market is also limited by uncertainty at the boundaries about what constitutes a care provider. Non-registered services such as peer support groups and directly employed personal assistants can be providing activities which meet a care need but are not visible to the CQC and may not be part of what a local authority understands to be its care market (Needham and Carr, 2015; Needham et al., 2017).

Stakeholder interviewees' understanding of the market within social care frequently foregrounded the complexity and fragmentation of provision, pointing out that no unified adult social care market operates even within a single locality. A key distinction made by interviewees was between the market for people funded by the local authority and for the people paying for their own care (usually referred to as self-funders). As one interviewee put it:

Clearly in the social care field we've got sort of two different markets to talk about. So you know we have got the self-funding market and the one that the local authority has more immediate control over its market shaping roles. Interview 21

It is estimated that around 41% of care home places (Competition and Markets Authority (CMA), 2017, p.7), and around 35% of domiciliary care services (LaingBuisson, 2017) are self-funded by private individuals. However accurate data is difficult to collect as many self-funders may not be visible to public bodies.¹ Interviewees highlighted the different trajectories of markets for self-funders versus those oriented to local authority-funded people, which made it misleading to talk about the care market in general:

Now the self-funding market I think has changed quite significantly in the last few years partly because of increasing challenges around eligibility for people who might be previously needing local authority support at some level but partly as well because you know, there's been a kind of growth in that self-funding market. Interview 21

According to another interviewee, talking about the care home sector:

The new capacity coming into sector is predominantly biased towards self-funder beds. The beds exiting the system is the local authority provision.... The pace of exit in local authority provider supply is accelerating. Interview 13

This point, about increased investment in self-funder provision and withdrawal of local authority funded supply was also affirmed in the Competition and Markets Authority (CMA) report on the care home market, published in December 2017 (CMA, 2017, p. 38).

One interviewee questioned the extent to which local authorities can influence the market for self-funders.

There is a fundamental question about to what extent a local authority can actively influence a market and no doubt authorities can, either by their action or inaction have a bearing on their local market. The ability to which that will make a difference I think will depend significantly on the balance between what the authority itself purchases for its citizens compared to what private individuals are purchasing... Interview 5

¹ Further discussion of the self-funder context and available data will be published in the next *Shifting Shapes* publication (Henwood *et al.* (forthcoming)).

In the stakeholder interviews, differentiation within the market was also recognised to exist in relation to main group of users (e.g. older people, working age people with disabilities, people using mental health services) and types of provision (e.g. the domiciliary market and the residential care market). As one survey respondent put it:

*You've got submarkets in different areas. You've got submarkets even within service types. The catchment for a care home won't be more than five miles so within a local authority you've got more sub markets. **Interview 13***

A further complexity, raised by survey respondents, was that care markets within one local authority overlapped with and were influenced by the care market in neighbouring boroughs. This might affect the workforce for example:

*Difficulty with older people's domiciliary care providers recruiting when hourly rates are more generous on the border. **Survey Respondent 12***

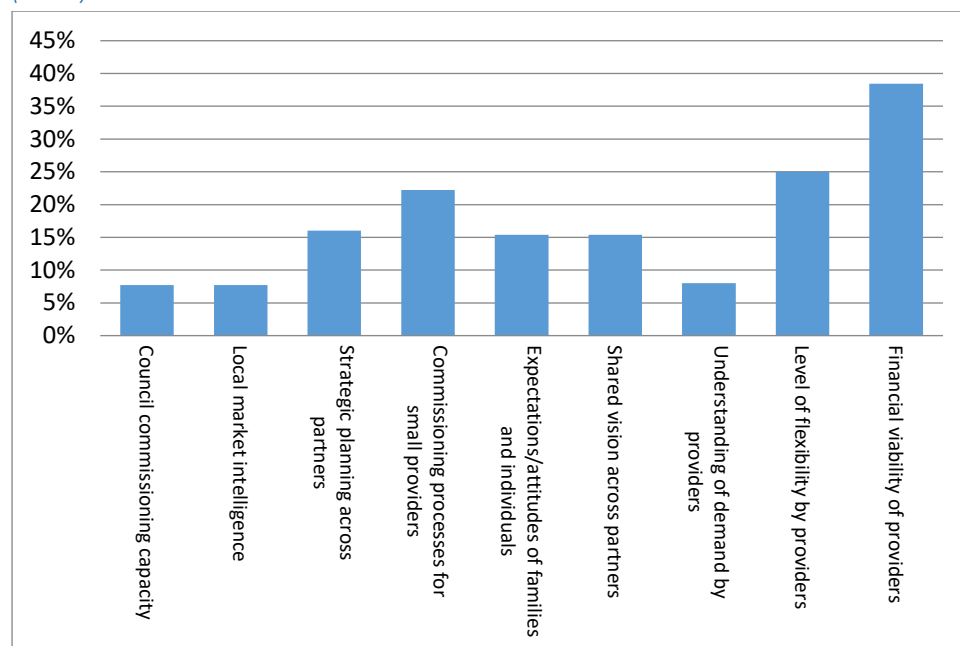
There may also be a reliance on neighbouring services to meet deficiencies in the local care market, as one survey respondent noted:

*There are currently no nursing or residential care providers within our boundaries. **Survey Respondent 16***

Challenges Facing Local Authorities

Local authority survey respondents were asked about the challenges that they face in market shaping. The areas that currently pose the most significant challenges to responding local authorities were the financial viability of care providers (with 38% of respondents identifying that this is a challenge to a great extent), the level of flexibility by providers (25% identifying that this is a challenge to a great extent) and the commissioning/procurement processes for small providers (22% identifying that this is a challenge to a great extent).

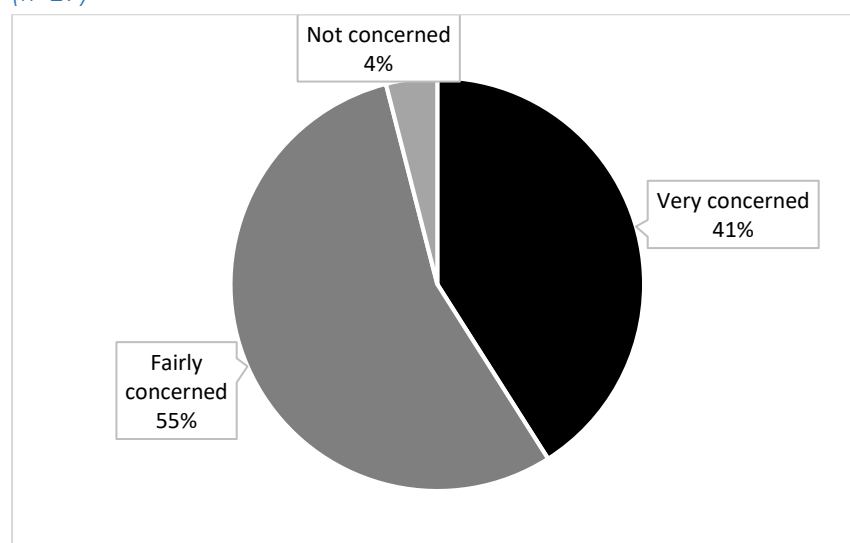
Figure 5: Issues Identified by Local Authorities to be a Challenge. Response Category: to a Great Extent (n=27)



Q. In your opinion, to what extent do the following pose a challenge to your council in shaping the care market?

Nearly all (96%) respondents were concerned about the sustainability of care providers in their locality in the current financial climate (with 41% being very concerned). Qualitative comments from survey respondents indicate that two other key challenges faced by local authorities in market shaping are: workforce issues including the recruitment and retention of care staff; and budget and resource cuts as well as a general under-resourcing of care.

Figure 6: Level of Concern about the Sustainability of Care Providers in the Current Financial Climate (n=27)

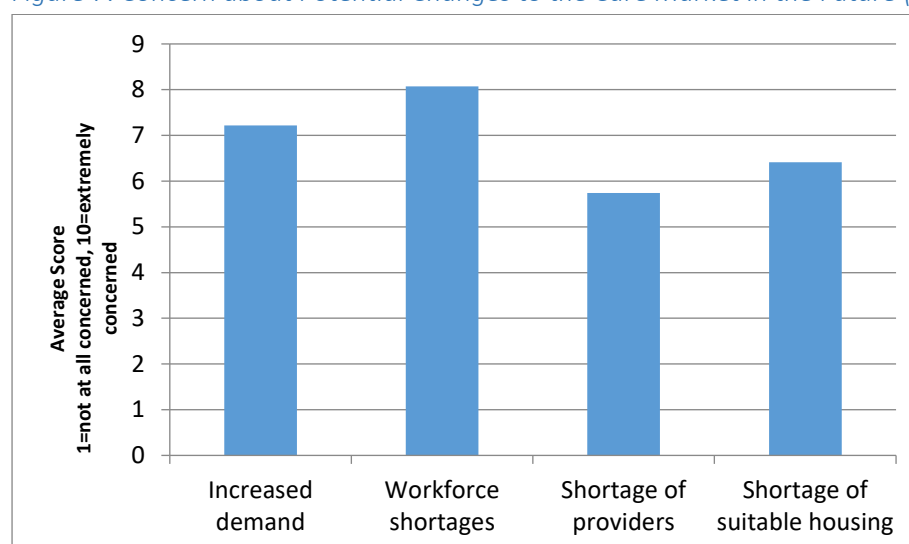


Q. Recent national evidence suggests that providers dependent on local authority funding are facing financial difficulty. How concerned are you about the sustainability of care providers in your locality in the current financial climate?

Survey respondents were more concerned about the viability of local authority funded services in their area than they were for self-funded services, as would be expected given that they have direct responsibility for arranging this provision. One respondent went on to comment that as self-funders are generally paying more, services are more financially sustainable. However, respondents also recognised that the two categories should not be seen as binaries: self-funders can themselves run out of money to pay for their care and some people funded by the local authority make a financial contribution via top-ups.

Survey respondents were also asked to rank their concerns about the future of their local care market from 1 (not at all concerned) to 10 (extremely concerned). The biggest common concern for the future (as also indicated above) was around workforce shortages with an average score of 8.07 indicating a very high level of concern. Respondents were somewhat less concerned about a shortage of providers with an average score of 5.74.

Figure 7: Concern about Potential Changes to the Care Market in the Future (average score) (n=27)



Q. Below are some potential changes to the local care market in the future. For each please state how concerned you are about this.

When invited to provide further information on their answers to this question, respondents highlighted a number of concerns:

*It is not so much the shortage of providers that is the challenge, but a shortage of effective leadership and a need for more hands-on staff. **Survey Respondent 23***

*Quality and performance of providers who are failing, resulting in high management of contracts officers. **Survey Respondent 26***

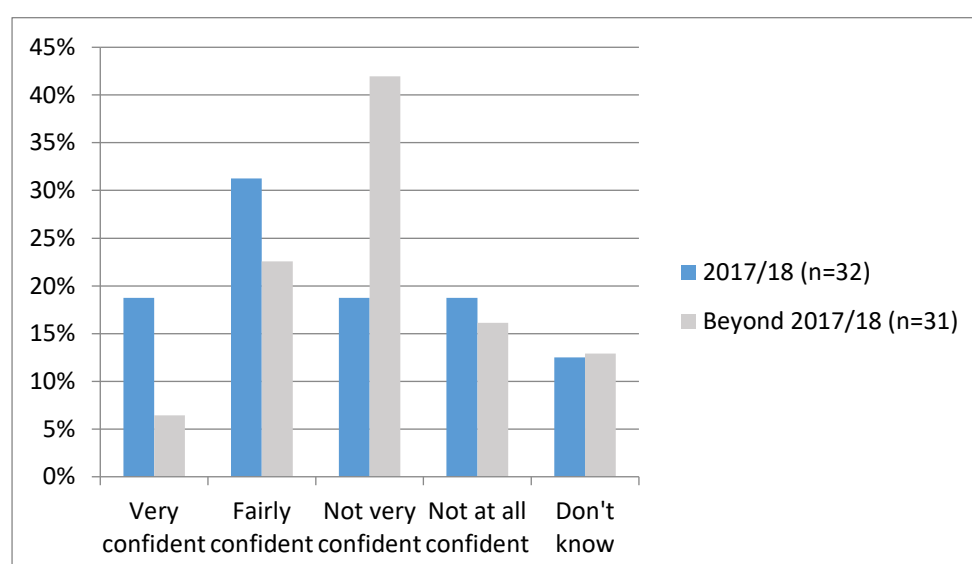
*The pace of market change and confidence by people to demand different things for their care and support needs. Take up of Direct Payment. Risk Management. Lack of preventative approaches taken up by the wider population. **Survey Respondent 20***

*It's not only the increase in demand but the added complexity some individuals have which need specialist support. Where these numbers are low it is even more difficult to find a provider to meet the needs of these individuals. With reference to those with nursing needs we are seeing increased frailty and complexity of some of the cases as we would expect as we are getting better at supporting people at home. **Survey Respondent 9***

The Financial Context

When asked about whether local authorities have sufficient money in their budget for meeting Care Act duties, half (50%) of survey respondents were very or fairly confident that they has sufficient for the current 2017/18 year. However, they were less confident in future years with only 29% being very or fairly confident.

Figure 8: Level of Confidence that there is Sufficient Money in Local Authority Budget to Meet Care Act Duties



Q. In your opinion, how confident is your council that there is sufficient money within its budget for meeting the Care Act duties?

One respondent to the local authority national survey identified the following difficulties in terms of there being enough budget to respond to the Care Act duties.

*Challenging times, decreasing budgets; increasing demand particularly for complex support eg. young people coming out of specialist education and older people with challenging dementia conditions. **Survey Respondent 21***

In the national stakeholder interviews, the social care market was widely perceived to be struggling with both increasing demand and significant funding cuts. Local authorities were recognised by interviewees to be under pressure to deliver more for less, and austerity was seen as impacting on the attitudes and behaviour of commissioners and other local authority staff. Local authorities were

criticised by some interviewees for being short-termist and more focused on saving money than on ensuring quality care, although the difficult trade-offs here were also recognised:

Local authorit[ies are in] an incredibly difficult situation. They've had money stripped out of them like there's no tomorrow, need is rising and costs are rising and so if you've got the kind of balance between am I paying for today in terms of putting together this package for this lady who needs to be discharged from hospital or whatever it may be, or am I paying for ensuring that tomorrow is in a better place... Interview 3

Interviewees were divided about whether austerity was constraining innovation or was creating a 'burning platform' which made change inevitable. As one put it:

All the cuts that have happened to local authority funding you know have a significant impact. I know there are those who would argue that kind of necessity is the mother of invention and it's forced people to think differently.... Interview 16

More common was the perception that austerity was stifling effective market shaping. As one said:

Austerity it like kills hope so people start just feeling a bit hopeless about it, it kills the flexibility that local authorities have to risk more innovative practices... Interview 17

For another, it made local authorities less able to undertake the culture change that is needed, with commissioners getting 'stuck into a pattern of commissioning' (**Interview 11**).

Funding cuts were seen by some to have entrenched a reliance on block contracting arrangements that prioritise large care providers over smaller and more innovative services, in addition to continued use by local authorities of the 'time and task' model of care and 15 minute care visits.

The perceived consequences of austerity included a decline in the number of third sector providers, which has been further exacerbated by a reduction in their access to grant funding:

People across the charity and the private sector are looking again at contracts, looking again at risk, looking at whether they will continue to contract to provide public services or services locally for the price and are still stepping out of the market. Interview 9

And some of that's come through all the grant funding that's been removed for a lot of these organisations that were doing a lot of good work locally. Interview 20

Workforce Shortages

Responding to such increasing demand may be hampered by workforce aspects, an issue cited as a significant concern for stakeholder interviewees and survey respondents alike. Concern regarding the sustainability of the social care workforce has also been reported by the National Audit Office (2018). In our research, low pay in the care sector was referred to as a major problem, and this was seen to be further compounded by the domiciliary care workforce not being paid for travel time between appointments, often resulting in actual wages below minimum wage, as well as poor terms

and conditions. Recruitment was noted to be affected by geographic variation in that social care workers in rural areas often have longer travel times which can reduce wages, impact on the duration of care visits, or leave providers having to cut costs elsewhere:

*Local authorities ... will pay on visit and that doesn't incorporate for example travel time and that is particularly challenging when you're working in larger counties and in very kind of like rural areas, you know you might be, you might be able to eek that out in the high density areas... **Interview 23***

One interviewee argued that staff recruitment challenges are likely to be exacerbated by the uncertainties of Brexit:

*We simply won't have enough people to provide the care and we're already seeing that in terms of debate around EU citizens that are currently living and working in this country and what happens to them post-Brexit, so I think it's 6 to 12% of the workforce but say in some parts of say London it's up to 50% of the care workforce is non-UK... **Interview 25***

Difficulties surrounding workforce recruitment and retention were also noted by survey respondents:

*Workforce - competing with retail and tourism, so even where providers are paying more the National Living Wage recruitment and retention is a major issue. Rural issues are another challenge- we already pay differential rates for super rural packages, (based on providers' submitted rates) but it is difficult to find providers who will travel to very remote areas. Particularly difficult for some specialist needs. **Survey Respondent 14***

*Recruitment - attracting people to the care sector / stigma of certain roles. Managing staff resources within flexible contract arrangements Providers ability/willingness to release staff for training. Providers unwilling to deliver smaller packages of support as not cost effective. **Survey Respondent 3***

How are Markets being Shaped?

Having considered the **contextual** factors which influence their care markets and scope for market shaping, this section looks at the **mechanisms** that local authorities are using in relation to market shaping.

The Care Act requires local authorities to move from influencing the care market solely through their commissioning activities to a more proactive role where, with providers and people who use services, they shape, facilitate and support the care market (including for self-funders) (IPC, 2015). As Statutory Guidance for the Care Act notes:

The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support. (Department of Health, 2017a, para 4.2).

The logic model derived from our literature synthesis identified five activities which local authorities should undertake to shape their markets:

- understand and manage demand;
- work with providers to stimulate supply and to meet demand;
- provide information, advice and advocacy to residents;
- assess and fund eligible people; and
- support training and development of the workforce.

When asked about market shaping, the interviewees and survey respondents focused on the first two of these aspects.

Understanding and Managing Demand

National interviewees felt that a central aim of market shaping was to understand the needs of the local population, which involves the analysis of a range of data to develop a strategic vision:

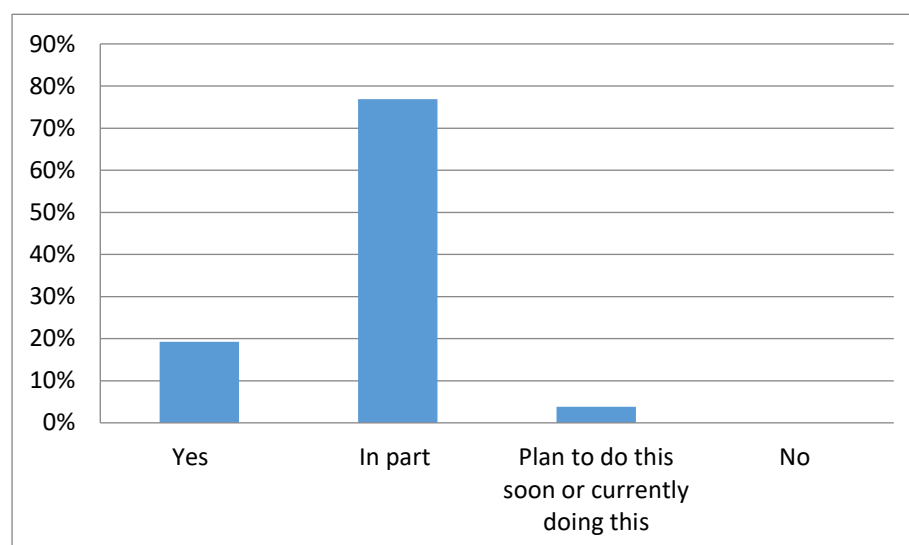
*Good market shaping would look to the horizon and not necessarily think about what we currently have but think about some of the unfolding agendas that citizens want and then think strategically about how do you send really clear signals that you will commission that sort of paradigm, shifting from where we are to where we need to be. **Interview 26***

However, some of the national stakeholder interviewees suggested that market shaping lacked conceptual clarity and that it was unclear as to what 'good' market shaping looked like. As one put it:

*And so they [local authorities] are talking about market shaping, well what is market shaping? Is it just about making sure you have enough beds at the price you could afford or is it actually about shaping the market to improve the sort of care that's being offered to people and the variety of care offers there can be? And they seemed to have no interest in any of that at all. So my own experience is it's not really happening. **Interview 6***

In the survey, all responding local authorities had or were planning to carry out an assessment of the local care market capacity. Over three quarters (77%) had already undertaken a partial assessment, whilst 19% had undertaken a detailed assessment.

Figure 9: Has the Council Carried out a Detailed Assessment of Local Care Market Capacity? (n=26)



Q. In your opinion, has your council carried out a detailed assessment of local care market capacity?

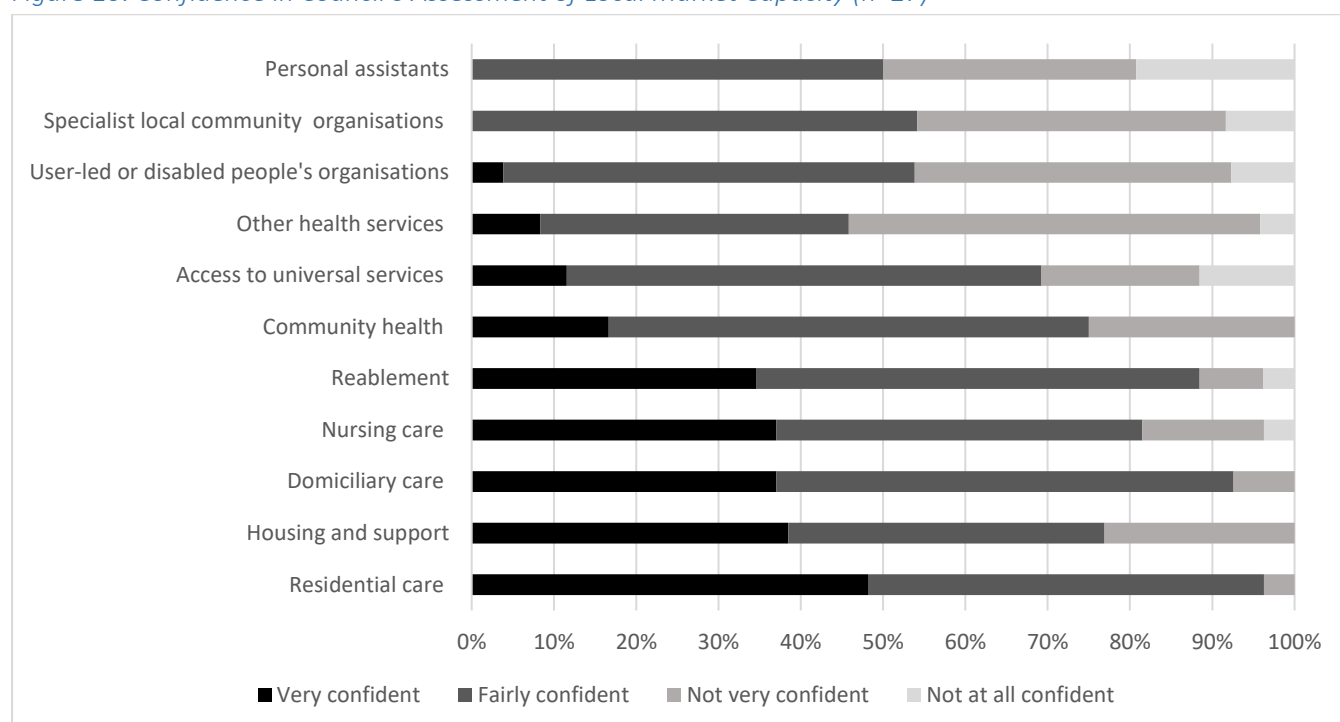
When invited to provide further information on their assessment of local market capacity, survey respondents highlighted the effects of the context in which they are operating, in particular the difficulty of generating data on self-funders' access to the domiciliary care market, along with responding to the increasing demand for services for older people.

Very difficult to get an understanding of private purchase in the domiciliary care market.

Survey Respondent 6

Survey respondents were, however, more confident that local market capacity has been sufficiently addressed in domiciliary and residential care provision (with over 90% being very or fairly confident) than in other areas. Market capacity is least likely to be addressed in relation to user-led or disabled people's organisations (46% not confident), specialist local community organisations (46% not confident), personal assistants (50% not confident) and other health services (54% not confident). Open-ended survey responses also indicate that less is known about market capacity for unregulated services and self-funders.

Figure 10: Confidence in Council's Assessment of Local Market Capacity (n=27)



Q. How confident are you that your council's assessment of local market capacity sufficiently addresses the following aspects of care provision?

The capacity within local authorities was highlighted by survey respondents:

*Capacity and capability of commissioners and models of commissioning. I see gaps in the ability to analyse and understand the market, and a lack of support from national tools in terms of actions that can be taken. Peer reviews I have undertaken suggest a lack of focus on action even where there is analysis. Research undertaken in London suggests that we spend a lot of time 'commissioning', but providers keep providing what they want to provide. We need functional models of commissioning that respond to this. In [this local authority] we are moving to a model that brings together the core commissioning functions around sub-markets to ensure that we have more effective transition between analysis, design and procurement, and implementation and management of the market. **Survey Respondent 1***

*Implications of prices and influence on market by market shaping of other neighbouring authorities **Survey Respondent 12***

Understanding the needs of the population was seen by interviewees to be facilitated by the analysis and dissemination of data and information. Market position statements were suggested by interviewees to offer a channel to communicate the local authority's vision for social care; however, interviewees suggested that market position statements, in their current form, did not facilitate this. They were found by several interviewees not to supply the data required to support providers' service development:

When local authorities and care markets were looking at market position statements...they were looking at their commissioning bundle and putting that out largely. Very few looked at

market position statements to look at the market as a whole for everybody within the locality to look at the operation of the market, the split of self-funder to publicly funded. And I think that really was an enormous missed opportunity. Interview 9

It was noted in particular that the data within the statements were often focussed on demographic projections rather than developing a vision as to how a holistic care system can respond to possible future demands.

Again, reflecting the complexity of the social care market, it was highlighted that this data analysis also needed to consider self-funders and that such information should be available to providers to inform their strategic planning and to stimulate the provision of services – a point also made strongly in the CMA (2017) report on the care home market. This can also include work to support the development of the capacity of social care providers. Capacity building was seen to be something that was directly related to the voluntary sector and the ability of these providers to develop links with the local community in order to unlock assets that support the provision of social care:

The other thing I would say about market shaping is it isn't all about commissioning and delivering it's about enabling as well... if you think you need certain sort of community capacity or voluntary sector capacity or even things that people can access themselves but through sort of self-funding, sometimes those things don't happen by chance because someone doesn't know there's a need they don't look to meet it. Interview 19

There was scepticism among the stakeholder interviewees about the extent to which local authorities were moving beyond commissioning to take on the broader aspects of market shaping:

I'm not sure councils are being that proactive in finding out what's happening to their self-funding populations... Interview 15

The multiple markets operating within social care were also suggested to affect the quality of relationships between local authorities and providers. A number of interviews showed there was often a lack of understanding between different stakeholders:

It's not a dynamic market ... I had a conversation with somebody from a local authority two or three years ago where they said, you know, 'we don't control the market'. They looked absolutely shocked when I said 'you are the blinkin' market!' Interview 1

One of the stakeholder interviewees also suggested that short-termism was an issue:

There is a disconnect between procurement and commissioning. If you look at the price being paid in relation to care types relative to the cost of care – on the one hand local authorities are driving down the price to below the fair cost of care. You have a short term win but in the long term you will drive out supply and investment in your market. Interview 13

Some interviewees also questioned the extent to which some local authorities had the capacity to undertake detailed data analysis, a point affirmed by the CMA analysis of care home markets (CMA,

2017). One interviewee suggested that such capacity may reside within public health teams and that robust analysis could be facilitated by joined-up working across the local authority.

Working with Providers to Stimulate Supply and Meet Demand

The logic model draws attention to the importance of good relationships between local authorities and providers if market shaping is to lead to improved outcomes for people. Where those relationships worked well, the logic model anticipated that providers would respond by:

- Developing diverse, innovative, high quality services, tailored to the profiles of people wanting support (including self-funders).

In the survey responses from local authorities it was clear that there was a variance with regards to levels of trust and transparency in their relationships with providers. Comments from survey respondents included:

Some providers operate legalistically and threaten judicial review of decisions.....making it difficult to be as open and transparent in all occasions. It causes the council to take low risk approaches inhibiting innovation **Survey Respondent 6**

Being a small local authority we have a fairly restricted buying and negotiating power - the location of the city also has an impact given travel costs etc. which when combined to the small size of the market has a greater impact on providers. **Survey Respondent 16**

Stakeholder interviewees questioned the ability of local authorities to develop relationships with providers who target self-funders and have relative autonomy in terms of service provision. The move away from the Care Act's cap on spending for self-funders was seen as key here, as that would have required local authorities to work much more closely with self-funders to track their care spend and assets, and therefore to have a better understanding of their market choices.

Some interviewees also noted that commercial confidentiality could limit transparency and prevent local authorities from appreciating the financial position of providers, consequently reducing their ability to ensure the sustainability of social care provision. This was also referenced by a respondent to the local authority survey:

Financial viability can be difficult to assess. Some providers are very open about the pressures they face whilst others are not, making it difficult at times to ensure on-going stability. **Survey Respondent 3**

Provider Frameworks and Contracts

Most local authorities surveyed (92%) already have a preferred provider framework for adult social care, with the remaining 8% having no plans to develop one. Responses to the survey of local authorities indicated diversity in the way in which preferred provider frameworks have been used, in particular framework arrangements often varied in terms of the care market in question:

*We are a small local authority - our market engagement exercise clearly informed us that providers were only interested in being a sole provider of domiciliary care. **Survey Respondent 16***

*We use a variety of approaches - large county and diverse geographies, so we do have Frameworks in some areas but an open provider list in others to maximise market opportunities. In very rural areas market interest in frameworks has been limited. **Survey Respondent 14***

*Only in certain care groups/types: OP domiciliary care in particular, crisis intervention, and floating support. **Survey Respondent 13***

*Preferred framework for Complex needs; MH and disabilities. For OP we have a zone/guarantee approach. **Survey Respondent 12***

*We have separate frameworks for care homes, dom care and day activities. **Survey Respondent 9***

*Varies according to care sector... **Survey Respondent 6***

*We have a number of different framework arrangements for different service modalities, rather than for adult care as a whole. E.g. domiciliary care; supported living etc. **Survey Respondent 4***

Other survey respondents explained how their provider framework was being developed further:

*Our procurement model for home care includes a prime provider model (n=12). In the previous 12 months this has begun to show marked benefits over the previous spot contracting arrangement. **Survey Respondent 15***

*We are changing from a long list of 50+ providers, first come first served - to up to 6 zonal lead providers. **Survey Respondent 8***

*We have zoned areas so providers can concentrate on manageable amounts of work. We have undertaken a systems thinking programme and are about to retender our framework to put providers more in control of commissioning. **Survey Respondent 7***

One survey respondent suggested that the domiciliary care market had a distinctive set of issues that required careful management:

*We need to do more work on the domiciliary care framework to manage the fragility of this particular market and the low barriers to entry, which have been perceived historically as a way to increase supply, but not in a managed way. **Survey Respondent 1***

Another respondent commented on how a lead provider model was developed with the NHS Trust:

Personal care: lead provider model including in one area a model with an NHS Trust operating a subsidiary company as the lead provider. This is working operationally very well.

Survey Respondent 6

Within the survey, local authorities were also invited to share examples of their current or planned market shaping activities. Responses included examples of contract management processes, provider engagement, and the intention to support the development of different models of service delivery:

We now utilise a mixture of joint block contracts (health and care) and spot arrangements to recognise supply issues within a procurement framework. In home care this has served us well and will be extended to residential care services by April 2018 on a 3 year negotiating cycle. A strategic market organisation has meant we have a strong, collective voice from market providers. **Survey Respondent 15**

We hold co-production events which involve both the contracted market and wider market from the independent and voluntary sector. This includes user led organisations. Service users current and potential are invited to participate in co-production events. We ensure that independent advocacy is available to service users who may find it difficult to have their views heard. The purpose of these events is to increase opportunities to gather views on the design of services and identify gaps in service provision, seek value for money options and explore innovative ideas. We involve elected members in the review of the quality of services and keep them updated on the outcomes of resolving issues. **Survey Respondent 10**

Outcomes-based commissioning was raised by several interviewees as a potential alternative to traditional contracting arrangements, but was felt to be hard to work with in practice. As one interviewee put it:

There is lots of talk about outcomes based commissioning but from a practical point of view no one has worked out how to do it effectively. **Interview 13**

Another interviewee said that there had been mixed reports as to how well outcomes based commissioning was working. In particular, it was suggested that as a concept it was more embedded within services for people with a learning disability than for services provided to older people:

...because somebody with a learning disability the chances are they've got - they're going to have a 24 hour or much more frequent support because there'll be often safety issues about people being on their own, so that then gives you the opportunity... to say 'right, what are we going to do with this time'. Whereas for an older person because they can usually be safely left for long periods of time and only really need help with personal care, there isn't that opportunity of a big block of time. **Interview 18**

It was suggested by a number of interviewees that some local authorities maintained block contracts which limited innovation through restricting the ability of providers who were not already agreed suppliers to deliver services. Survey respondents also suggested that managing contracts was demanding and that there was often a lack of resource to support the commissioning of services and wider market shaping activity. This was seen by some interviewees as providing a rationale for the maintenance of block contracts, particularly in home and residential care for older people. It was viewed to favour larger providers and inhibit greater co-production of services with small community-based providers and citizens.

Interviewees highlighted a range of concerns with block contracting:

Domiciliary care providers are handing back contracts and, you know, in some areas some of them [are] cherry picking...In some areas really good providers [are] really challenged, you know, stressed workers...a lot of challenges in that model... We haven't just boiled everything down into something that works really well, you know, we've boiled everything down into something that really doesn't work. Interview 1

The money is tied up in block contracts still. And obviously money for double funding is tight. ...The commissioning capacity is a huge issue. So, because commissioning teams themselves have been cut, the capacity and head space for doing new things isn't there, particularly innovative new things. Interview 2

I think there's something missing in relation to market shaping, because I think what councils have done, and certainly what the system seems to be demonstrating at the moment, is that we still have a real sort of – an emphasis on block contracts and block commissioning. Interview 11

The other thing that we've found is that block contracting of day services is hampering the use of innovative ways of using your direct payments... I think it's they're absolutely paranoid that the market will fail and block contracting gives them some control over that. Interview 20

It does make sense to know that you've got a certain amount of income coming in because that's paid, block contracts get paid whether or not you have the bed filled. Interview 6

Several interviewees suggested that local authorities do not appreciate providers' costs, and profit margins, when delivering quality services. Local authorities were seen to dominate these relationships and were suggested to not take providers' business needs into account when developing and implementing contracts:

My sort of overarching comment about market shaping is it's rather one-sided, so the idea is the local authority shapes the market, but when a provider has an idea around innovation and they want to try something new, the local authority is often not interested. So it's a very one way relationship. Interview 18

It was also indicated by a number of interviewees that local authority engagement of providers can be tokenistic in that providers are asked to feed into the development of the local authorities' approach to social care but without meaningful co-production. Contracts issued by local authorities can increase uncertainty for providers. For example, commissioned providers are sometimes expected to meet the additional costs incurred through the introduction of the living wage and the application of the national minimum wage to sleep-in shifts, often without additional financing from local authorities. The implications of such financial constraints placed on providers were also believed by interviewees to affect the recruitment and retention of the social care workforce and this was frequently seen to affect the delivery of sustainable care. For instance, it was remarked that the offer of higher wages in a neighbouring local authority can impact on the recruitment of domiciliary care staff.

In contrast, a survey respondent commented that they felt that providers were not innovative and needed to be 'taken on a journey':

*We need real change from traditional markets rather than necessarily extra capacity. This should include day/employment opportunities NOT day care and this means changing provider models and taking them on a journey. **Survey Respondent 25***

One respondent to the local authority survey referenced the different interpretations as to what was seen to be an acceptable level of profit from providers:

*We believe we have the evidence to prove that we are paying fair prices, which reflect costs. In doing this work though we have very different view on acceptable level of profit is (particularly return on land value, which is significant in London) and efficiency of services (for example, we have one domiciliary care agency who felt that it was fine to charge a high hourly rate because their overheads were high as they were based in [an affluent area]. **Survey Respondent 1***

Additionally, interviewees spoke about the importance of the relationships between the local authority and people who use services. They referred particularly to a need for local authorities to better listen to people and communities when it comes to the delivery of social care:

*I think it's the relationships. I think it is the relinquishing of power or the transference of power. Local authorities have to recognise that whilst they might know an awful lot in general, they don't actually know an awful lot in particular, but communities do and people do, individuals do. **Interview 20***

The importance of effective relationships – between local authorities and providers, and between local authorities and local communities – was a recurring theme in the data. It was clear that most interviewees and survey respondents felt that the quality of these relationships was very variable, impeding the development of effective market shaping.

Impact of the Care Act

National interviewees and local authority survey respondents indicated that at the local level the Care Act had had limited impact. Some interviewees said that the legislation had helped to raise the profile of market shaping and also signified to local authorities their wider responsibilities. Despite this, interviewees noted that they had seen little actual change since the introduction of the legislation, although this varied by local authority:

*I think in the best instances this has led to a true attempt at co-production where commissioners, citizens and service providers work together to try and ensure that there is the range of provision in whatever format that is...I think in the worst examples people are kind of just given a bit of a tokenistic nod to it and are more I would say trying to control the market. **Interview 16***

This then raises the question as to the extent to which the Care Act has enacted change, or whether there is continuity in local authority commissioning, and related market shaping activity:

*...I think probably if you were good at that kind of thing before the Care Act you're probably you know still good at that kind of thing and if you weren't does the Act make a difference? Because what people understand by shaping the market and how much they feel able to do so I suppose sort of depends on what, what the capability and capacity is in the local area... **Interview 19***

Reflecting on the impact of the Care Act, some national interviewees observed that local authorities are not held accountable for fulfilment of their market-shaping duties and that insufficient data is collected that could support such monitoring. The collection of such benchmarking and monitoring data was also suggested to be affected by the difficulties of defining market shaping and related activity. This led some interviewees describing the legislation as a weak lever for change. One interviewee said:

*The Care Act has made no difference at all, apart from if you're a person who uses services or a carer that knows about it, you can try and use it as a beating stick and say 'look, it's against the Care Act'. More often than not they'll say 'well take us to judicial review' **Interview 20***

Respondents to the survey were also asked whether there was more that the Department of Health and Social Care could be doing to support them to deliver the goals of the Care Act. Comments included:

Sharing Best Practice

*I was responsible for the completion of the Care Act Stocktakes. I still think these would be useful, for example, if there was an area of low Care Act compliance, there could be a resource toolkit attached to support LAs who are struggling with a particular aspect. **Survey Respondent 26***

Sharing innovative practice **Survey Respondent 24**

More sharing of best practice. **Survey Respondent 20**

Funding in Adult Social Care

Address the long term funding issues in Adult Social Care. **Survey Respondent 22**

Better and earlier access to information about funding opportunities. **Survey Respondent 18**

Ensure the Green Paper provides a sustainable and long term financial underpinning. **Survey Respondent 15**

A more honest narrative on the impact of local authority budget cuts, and associated changes like cuts to Personal Independence Payment. **Survey Respondent 13**

National approach to joint funding of packages between NHS and local authority. **Survey Respondent 12**

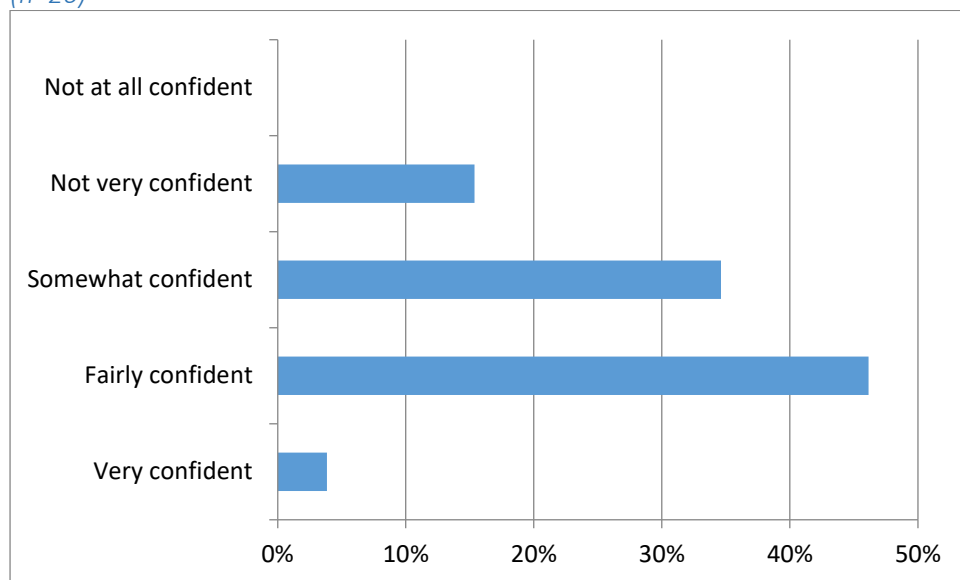
Increase the level of health funding to assist local authorities with demand management and increasing in preventative services. **Survey Respondent 10**

Within the survey, local authorities were asked about the information and guidance they had received on market shaping including specific guidance or toolkits. They reported that the most helpful guidance was the LGA/ADASS/DH Commissioning for Better Outcomes (2014) guidance with 88% finding it very or fairly helpful. Around two third of local authorities found TLAP's *Commissioning for Market Diversity* (2015) guidance helpful (68%) and the Institute of Public Care Market Shaping Toolkit (2015) helpful (64%). Alternatively, 44% found TLAP/NDTI's 'Be Bold' (2012) guidance helpful. Other helpful toolkits/guidance mentioned in qualitative comments include Joint Strategic Needs Assessments (JSNA) and Laing Buisson data, and the Cordis Bright Social Care Market Sustainability Toolkit (Department of Health *et al.*, 2015).

Market Shaping and Outcomes

When asked about levels of confidence that the local care market reflects and meets the needs of the local population, half (50%) of respondents were 'very' or 'fairly confident'.

Figure 11: Confidence that the Local Care Market Reflects and Meets the Needs of the Population (n=26)



Q. How confident are you that the local care and support market reflects and meets the needs of the local authority population demographic?

In the literature synthesis, a number of outcomes of effective market shaping were identified:

- A market that is vibrant and sustainable.
- Improved outcomes for people in the care system.
- Reduction in unmet need.
- Later entry into formal care services than would otherwise have been the case.

When asked about outcomes, stakeholder interviewees found it difficult to predict the outcomes of market shaping and drew attention to differences in local contexts and markets within social care. There was a general consensus that aspects of the care market were often beyond the control of local authorities and strategies to shape markets or external factors could have unforeseen – and unintended – consequences.

A valued potential outcome of market shaping was the ability for areas to understand their neighbouring care markets and collaborate in a way that refocuses work on the needs of their populations. Interviewees stressed the importance of trying to break down local and regional area boundaries to care market knowledge and provision which could inhibit service improvement.

Rather than linking market shaping directly to a set of outcomes, national stakeholders found it easier to identify what they saw as good practice, with examples shown below in Table 1.

Table 1: Market Shaping and Personalisation Practice Examples Identified by National Stakeholders

Good practice
<p>Supporting the inclusion of micro enterprises, co-operatives and mutual providers in social care</p> <p><i>Example: [supporting] about 170 tiny home care providers... that's a real piece of market shaping that's, you know, potentially changing the face of home care in that very rural area, which is quite resistant to big agencies, because of the rurality. You know, that, that kind of work is very relevant.</i></p> <p>Interview 2</p>
<p>Developing ways to co-produce services with voluntary sector providers and citizens</p> <p><i>Example: [developing] a framework for co-commissioning with the voluntary sector, not just with providers...And there's a way of enlisting citizens and people who use services as partners.</i></p> <p>Interview 2</p>
<p>Developing sensitive measures to prevent market/provider failure</p> <p><i>Example: the local authority had the most incredibly long checklist to assess whether their local providers were in trouble, they were looking for all sorts of sensitive signs, way deeper than what do we know about the balance sheet, which they couldn't find out directly anyway.</i></p> <p>Interview 4</p>
<p>Market shaping across all departments within local authorities</p> <p><i>Example: [J]oining up all of the local authority services. So for example bringing the planning departments into the market shaping process, so that when we do go and talk to the planners about planning permission on a piece of land, they actually already know the context for it... Another department to have on board is the department that deals with economic development.... if someone wants to invest ten million in a new care home and create a hundred new jobs you know, we welcome that.</i></p> <p>Interview 12</p>

These insights into practice indicate that there is a set of market shaping outcomes which are valued by local stakeholders, and which are an intermediate step to individual and system-wide outcomes:

- diversification of the provider market;
- co-production of services and engagement;
- market stabilisation; and
- more joined-up working within local authority organisations.

Conclusion

The discussion above highlights diversity in the ways in which local authorities are undertaking market shaping, some of which is shaped by differential contexts in relation to affluence and levels of demand. The setting up of the formal rules of commissioning was a key aspect of local authority activity. Block contracts remain an important part of local authority approaches to commissioning, along with preferred provider frameworks, although some spoke of the need for a more diverse market. The second key aspect was the relationships that were developed with local providers. Getting those relationships right was seen as crucial to effective market shaping. However the interviewees and survey respondents highlighted barriers to those relationships, with low trust relationships being seen as more common than effective partnerships. The extent to which the rules and relationships set by local authorities can be modelled as a typology of market shaping behaviours is explored in Section 4 below.

Section 3: Personalisation

The literature synthesis identified personalisation as one of the programme theories which led to an effective care market and good care outcomes. The theory underpinning personalisation was stated as:

People exercise choice and control about the support they receive. This is true across people funded in different ways, and accessing different types of support (some of which may not be regulated care services).

Defining Personalisation

A key issue for national interviewees and local authority survey respondents in relation to personalisation was the **range of definitions** associated with it which got in the way of a clear understanding as to whether or not it was being done well. Terms often used included choice, control, and a focus on the individual. Some definitions were more aspirational than others, with some defining it from a service aspect whilst others focused on the impact personalisation could have on people's lives and wellbeing. A common definition encompassed a shift from expecting people to fit in with services to designing services around people's needs:

*Personalisation has always been about ensuring that services fit around the needs of the individual rather than the needs of the individual having to fit around what services are available. **Interview 15***

While some interviewees defined personalisation as a whole systems change that could achieve well-being for people, set firmly within their family and community context beyond the care system, others saw it in more limited terms as the mechanism by which people who need support can achieve their aspirations in life. Some referenced personalisation in terms of professionals and individuals pooling expertise to identify the best approach to support:

*That it is about a relationship of equals so it's not professional knows best. Professional knows best about certain things, individual knows best about certain things and if we work together we'll find the best solution. **Interview 7***

*It's co-production so it's shared care, it's a shared understanding of what's best for the individual as the individual sees it... **Interview 25***

Several interviewees sounded a note of caution about the term personalisation. Some talked about the importance of recognising that personalisation is something that was dependent on available resources, whilst others referred to attitudes rather than the mechanisms that have been put in place to enable it:

It's important to be clear that personal budgets are one particular delivery mechanism for personalisation. But they're only one actually. And so for people in residential care for

example, personalisation is very much about attitudes and qualities of the staff... Interview 15

Furthermore, some interviewees suggested that the term was being used as jargon or had become devalued and used to describe an approach that was no longer adhering to the original principles of personalisation:

The origin of it was either forgotten or never understood, so it just became individualised care, the bit about what do you want day to day and you as an individual, that was captured by older people's services, but the origin of who has the power and who's running the service didn't feature. Interview 18

I don't like the term, I don't like the jargon and I think it's just become utterly devalued as a term because everybody has jumped on that band wagon and pretending they're doing it. Interview 6

Others suggested that the language of personalisation and co-production had been corrupted to hide the fact that people were being expected to do more for themselves:

We have created a language to talk about doing more yourself. Yes, in disability terms we would all like to do more for ourselves, but the actual links with experience we need people to enable us or facilitate us doing more for ourselves... Interview 7

Linked to this, some interviewees felt that it was time to go back to fundamental principles to recapture the original meaning of personalisation which focuses on putting the power with the individual. There was a sense that this had been lost:

There's no point in insisting that someone is washed every couple of days if actually they only used to wash once a week previously thank you very much and they prefer to do something else... and I use that because there is a letting go of control that needs to happen in personalisation and the recognition that different people have different standards around things, but I think I think conceptually a lot of people haven't got their head around [that]. Interview 27

Mechanisms to Support Personalisation

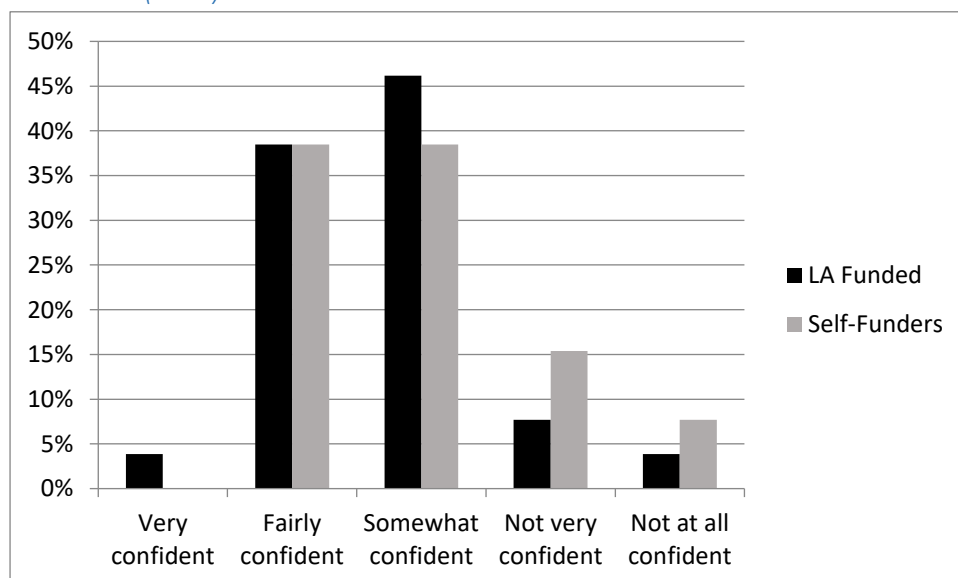
The interviews and survey provided an opportunity to explore what national stakeholders and survey respondents saw as being key mechanisms for achieving personalised services. In the interviews and the survey, people identified the following mechanisms which are discussed in turn below:

- the provision of information;
- personal budgets;
- provider diversity;
- local authority monitoring; and
- integration across the system, including health services.

The Provision of Information

Half (52%) survey respondents felt that information about the different support options available is good (with the remaining 48% rating it fair or poor). When asked about information for different user groups, less than half (42%) were very or fairly confident that people using local authority funded care services have sufficient information to make a choice. Over a tenth (12%) were not at all or not very confident. There was less confidence that self-funders have sufficient information and advice with none being very confident and only 38% being fairly confident. Nearly a quarter (23%) were not at all or not very confident.

Figure 12: Confidence that Local Authority Funded and Self-Funded Users have Sufficient Information and Advice (n=26)



Q.How confident are you that people using local authority funded care services have sufficient information and advice when making a choice of care service?

Q.How confident are you that self-funders have sufficient information and advice when making a choice of care services?

As noted by a survey respondent:

*For older people services we are constantly trying to meet demand rather than improving choice and control although there are elements already there. Mental health is our main weak area and we are taking steps to address this. **Survey Respondent 7***

A further enabler was seen to be the provision of information which several interviewees said was vital to help people understand what their options might be and how they could exercise choice and control:

*Because if you've only ever thought of you know the future for Mum is in a care home well you're going to look at how can I find the best care homes, whereas if there was the opportunity to sit down and think through a whole range of different options then often people can and do come up with you know alternative arrangements... **Interview 24***

One respondent to the survey of local authorities indicated their work to support the provision of information and guidance:

*We have a dedicated online directory of services...which can be accessed by all. This includes CQC ratings of provider services. We are also developing a new portal for all citizens and carers to self-assess and this will bring about tailored information and advice in response to the questions they answer. This will better promote local universal services and will equally help self-funders and those who need support with state funded care. **Survey Respondent 26***

In addition to a lack of services being seen as a barrier inhibiting personalisation, interviewees also suggested that there can be a lack of information for people as to the options available to them:

*I think you know local authorities do need to think about how they provide that information and advice and the culture of how that is delivered because they haven't got a vested interest to encourage people to you know apply or take up services that they may be entitled to either. **Interview 23***

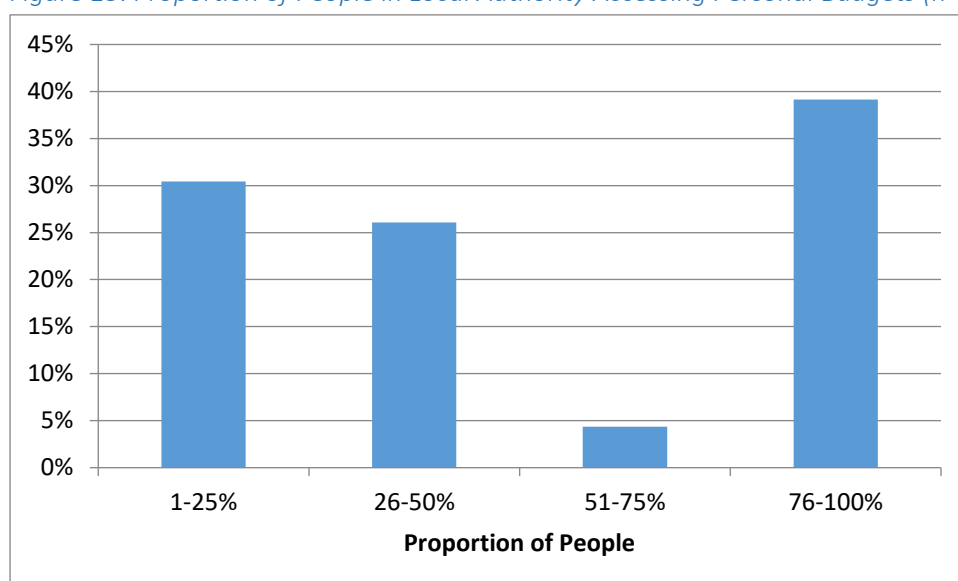
The lack of information was particularly problematic when people are trying to make a decision at a difficult time in their lives.

*This woman said to me 'I am 92, I'm suffering from severe arthritis and I've got a stroke'... I defy anybody to be assertive and demanding when you're in that position people are trying to be assertive consumers at the worst point in their life when a lot of their capacities, a lot of their energies are focused on other things. **Interview 26***

Personal Budgets

Personal budgets were recognised to be one of the mechanisms through which personalisation can be achieved. When asked about personal budgets, over a third of survey respondents (39%) reported that most (over 75%) eligible people in their local authority access care via a personal budget. On the other hand, nearly a third (30%) reported that only 1-25% of people in their local authority access a personal budget indicating significant differences across local authority areas. This compares to a national figure (2016/17) of 89% of people accessing self-directed support, defined either a direct payment, part direct payment or a local authority managed personal budget (Department of Health, 2017b; NHS Digital, 2017).

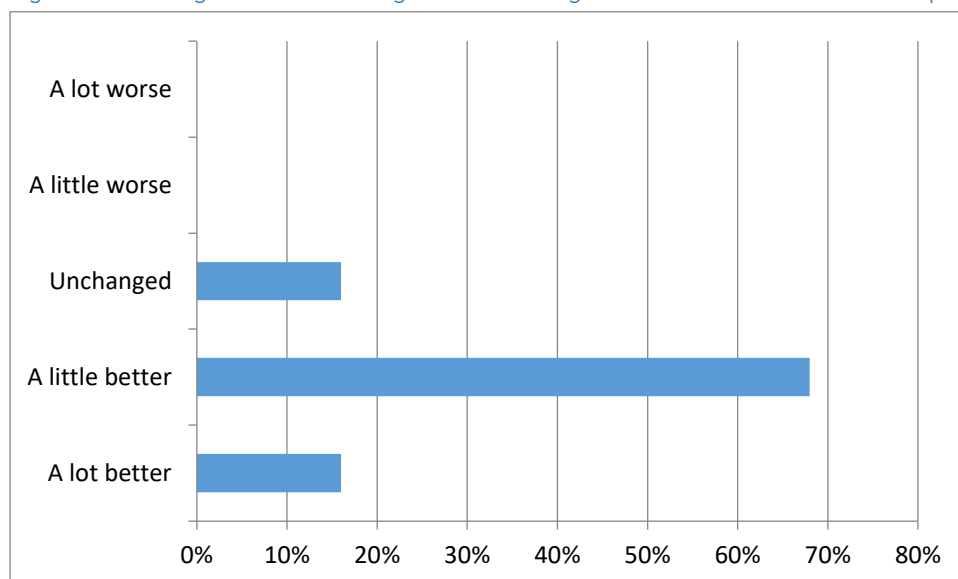
Figure 13: Proportion of People in Local Authority Accessing Personal Budgets (n=23)



Q. Approximately what proportion of eligible people in your local authority access care funding via a personal budget?

Most respondents felt that personal budgets were making people's choice and control in using services better (16% a lot better and 68% a bit better). Whilst 16% felt that personal budgets make no difference to choice and control, no respondents felt that they made things worse.

Figure 14: Changes Personal Budgets are Making to User's Choice and Control (n=25)



Q. What changes do you believe that access to personal budgets is making to people's choice and control in using care services? Are things...

Survey respondents offered mixed opinions when they were invited to provide further information on their opinion as to the changes that personal budgets have on provider activity people's choice and control. There was a recognised need for personal budgets to be met with wider cultural changes and an awareness that the market may not provide the services that individuals want to access, demonstrating the link between personalisation and market-shaping:

*Choice and control and personalisation is about a cultural shift and it has to happen across all part of the organisation. I think the continued focus on this means that at all levels and in all parts of the organisation we do not slip back to doing to people. However, there are also issues about expectations which we have always managed in this agenda. Personalisation does not mean anything you want. It means tailoring what we can provide to ensure it meets your individual needs, and that we work with you and listen to you, providing high quality customer care. **Survey Respondent 1***

*I remain sceptical that a PB makes any meaningful difference to most people...it clearly does in some areas....but for many there isn't the choice or innovation in providers to give individuals a genuine choice and control in their support needs **Survey Respondent 6***

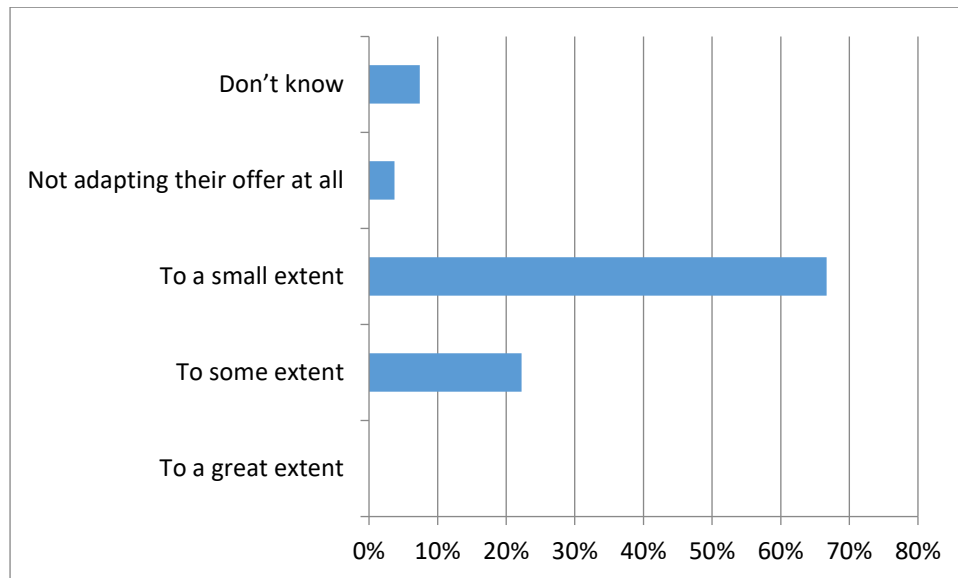
*Generally positive, but the model of a personal assistant potentially compromises the improvements, where the employer relationship is confusing and onerous. **Survey Respondent 13***

Some interviewees said that the perceived complexity of the systems that have been set up around direct payments were preventing people from making full use of them. As one put it:

*It's not just managing the finances, it's sourcing all the – you know, it's kind of the classic oh personalisation you want choice and control, oh there you go, over to you..... trying to organise all the shifts and get people in...I've known people who don't want to [be] bothered with the finances and the paperwork. **Interview 9***

Respondents felt that providers were doing little to adapt in response to personal budgets with over two thirds (67%) stating that providers were adapting their offer only to a small extent.

Figure 15: The Extent to which Providers are Adapting as a Result of Personal Budgets (n=27)



Q. In your opinion, to what extent are care providers adapting their offer as a result of personal budgets?

One respondent to the survey indicated that there can be a disconnect between what commissioners want from service delivery and what is delivered. This was attributed to the lack of joint working to co-design services with providers.

*I think there is a disconnect between what commissioners request and what is provided in some case because we don't co-design services with providers (to deliver the buy in to a different model) and are not robust in our contract management. So I think there will be commissioners who deliver this, there will be providers who deliver it irrespective of commissioners, and there will be cases where it doesn't happen even where the intention is for it to happen. **Survey Respondent 1***

Several interviewees suggested that a creative approach is needed to enable genuine personalisation and reflected that austerity had forced local authorities to think differently and more creatively about the kind of support that could be offered:

I think there have been some efforts in the light of austerity to have a different think about the role of social worker.... some of them kind of go well it is kind of interesting that we're forced now to have no money and therefore we have to think about care and support in a

*radically different way. They're almost forced into the position that people with disabilities in families naturally pursue if you give them control. **Interview 17***

*In times of austerity, I don't think that naturally leads to the removal of personalisation. In many ways, I think that that should manifest in a more rapid take up of the personalisation, because it's, it's much better to have a conversation with somebody to say we need to reduce your package of care from £1000 to £800. So how are we going to make this work? You know, what things can we do together, in order to shape a package of care that's still meeting the needs in an effective way? I struggle with the notion that lack of money leads to decision making to take personalised care out of the equation. **Interview 11***

Provider Diversity

Several interviewees talked about provider diversity as the key mechanism to achieve more person-centred support. For some, the market had not responded by providing personalised support and is limited to supporting people with their basic needs:

*The market is more shaped if you want someone to come into your house and you need to get on the toilet and have something to eat, that's great. But if you've got any bigger aspirations than that there's not that much that the market is out there to do it. **Interview 7***

Others suggested that the care market was binary; either block contracting or individual purchasing; both of which had limitations. There was a suggestion that there needed to be something in between:

*Now, I think what's needed is neither of those things. Because actually at one site this sort of approach doesn't work, and leading people to do it on an individual basis probably doesn't work in the long run either. So, what we need to get to, is the opportunity for people to access the same rates that are maybe through a block contract, but do that with their personal budget. **Interview 11***

Some interviewees suggested creativity could be facilitated through alternative, non-mainstreamed and non-council led approaches that were delivering effective personalisation approaches, such as Community Catalysts, Community Circles, Local Area Coordination and Shared Lives (for a summary of these see Shared Lives, 2017). However, all said that these were small scale and only operating in a handful of areas:

*Community catalystslooks to me to be a really impressive way of both recruiting people from within communities to provide capacity where the market has failed creating a supply of carers who can negotiate in a very personalised way with people on how is care is delivered. So really positive but a very much minority sport! **Interview 22***

Another interviewee suggested that there was a tension between the market diversity required by personalisation and the stability required as an effective market shaper:

There is a trade-off between choice and market stability. To have a flourishing market then trust needs to exist, uncertainty needs to be managed and the economics need to work. The challenge of having choice is it cuts through one of the opportunities that would otherwise be available to deal with these challenges. Block contracting would be one way to deal with the challenges – encourage investments, and help with the economics...There is a tension between the two strategies of market-shaping and personalisation, choice and control.

Interview 13

Local Authority Facilitation

The key aspects which stakeholder interviewees saw as shaping the effectiveness of personalisation were the systems and culture of local authorities. Overly bureaucratic systems were seen by many interviewees as a major barrier to personalisation. Several interviewees spoke about the restrictions that councils had put on the systems supporting direct payments including pre-payment cards, which encouraged people to stay within a narrow definition of what might support their care needs. Local authority procurement processes were seen as preventing agile, flexible approaches needed for personalised approaches. As one interviewee put it:

In an era of personalisation and a regulated sector there should be no such thing as a preferred provider list and there should be no such thing as a local authority saying 'you can't use this service, you can't use that service' because it's regulated. Nobody can tell me I can't use an airline because I have confidence in the regulator and the regulator is there to say it's a safe service, so why are local authorities putting themselves between the aspirations of the customer and the provider **Interview 26**

One interviewee reflected on a personal experience of delays in altering packages of care:

To get something different you really have to fight for it with commissioners, I mean [my son] he goes to a day service for 3 days a week, and that went up by £18 a week, it had to go to panel. Every little change, micro change, which is definitely against the Care Act. **Interview 20**

Many interviewees felt that the main barrier to personalisation was the attitudes of commissioners, providers and social workers with some interviewees suggesting that this was the result of risk-adverse approaches and a desire for local authorities to maintain control. Such attitudes were suggested to negatively affect relationships with providers:

When the Care Act was first initiated, the move was towards personal direct payments. And then suddenly it metamorphosed into personal budgets because hey presto the people who were in control of those were the people who'd been in control of the care plans before.... So everything in the system militated against the power and control going to the individual and it tried to claw it back for the power in the local authority or it re-asserted the power of professionals over people. **Interview 26**

Several interviewees spoke about the personalisation agenda being focused on people with learning disabilities rather than older people. A lack of ambition for support packages for older people in particular was highlighted.

*So I pulled out some care plans and what was very interesting, there were some younger people's care plans and they were talking about making sure they engage with leisure activities, making sure that they maintain family and personal relationships. I found one person who was being taken in a taxi 20 miles every fortnight to spend the afternoon with his sister. Have you ever seen that on a care plan for an older person with dementia? Because I never have... So the personalisation agenda tends to focus on a very few people and it forgets the vast majority. So there's this paucity of ambition in relation to the equalities agenda which then translates itself into older people getting in effect bog size one size fits all services...I saw an older person's care plan and it said 'get them up, get them washed, get them dressed and do it in 30 minutes'. **Interview 26***

Some interviewees commented that they believed commissioners did not have the required skills to commission personalised services and that they have focussed on creating efficiencies and defending the services and contracts that they have in place, which as discussed above was suggested to limit innovation and creativity:

*We're trying to introduce personal budgets in wheelchair services. And the commissioner said, in challenging me... he said well, the problem if I give people choice and control over wheelchair provision, is that nobody in my area will want to purchase their wheelchair from the contracts that I have in place. And my response was well why is the commissioner – are you commissioning things that you know people don't want? **Interview 11***

One interviewee suggested that personalisation had been introduced so quickly the system was not able to change to support it:

*Suddenly [personalisation] was flavour of the day, but you hadn't worked through the processes at a commissioner level.... You could realise that people were declaring victory before the basic mechanisms of control had shifted. **Interview 17***

Integration across the System

A further mechanism seen as underpinning effective personalisation was the ability to deliver person-centred support across a range of services, particularly health and social care. As one interviewee put it:

*We're doing lots of work around whole area approaches. It feels really important because we feel that it's always going to strike at something which is kind of innovative and personal centred and community based into a system which is quite legally focused. And actually, only really works if you, if you're up for transforming the whole system. **Interview 2***

Some good practice examples of local level integration were provided, for example:

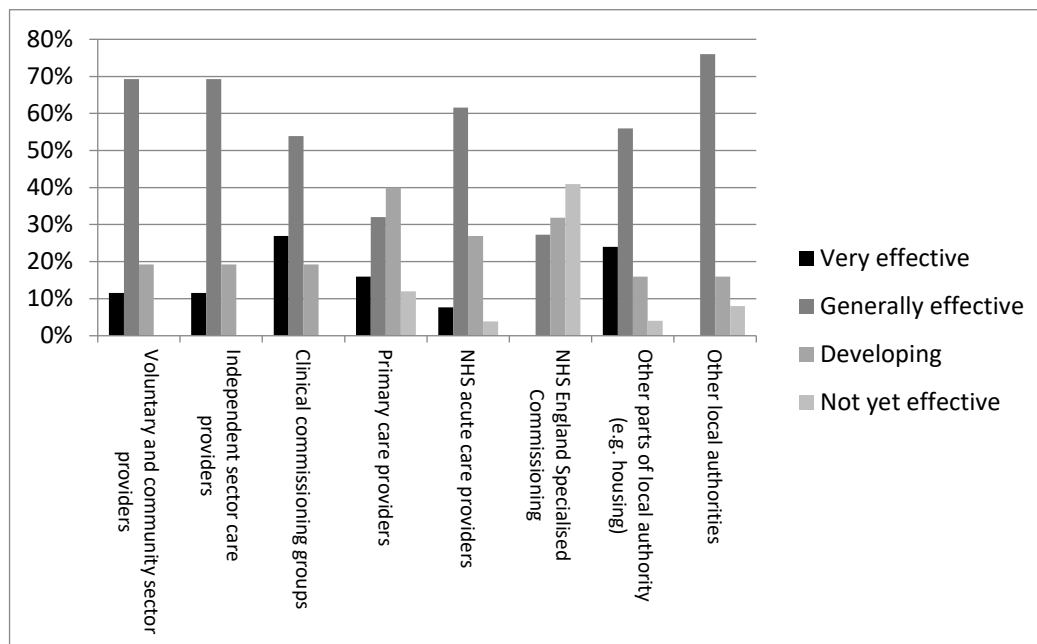
*There are some really good disruptors out there... who are doing some quite ground-breaking pieces of work looking at health creation rather than sort of an NHS sickness system looking at a wellness system. And they advocate all the kind of things that we've all been talking about, a life not a service, keep people out of the NHS, that's actually the way to do it really, to support wellbeing. **Interview 20***

In the survey, local authorities were asked about their co-operation with a range of different organisations. Figure 16 shows that overall 80% of survey respondents reported that they had effective relationships with voluntary and community providers, independent sector providers, CCGs and other parts of their own local authority e.g. housing. Over three quarters (76%) also reported that they have effective co-operation with other local authorities. Just over two-thirds (69%) reported effective co-operation with NHS acute care providers. Around half reported co-operation with primary care providers (48%) and a quarter with NHS England specialised commissioning (27%). This indicates that whilst responding local authorities often work closely with voluntary, community and independent providers, they are less likely to report effective co-operation with health services and commissioners.

When invited to provide examples of innovative partnership working, one respondent suggested that such working should not be conceived as innovation but rather about identifying what will facilitate organisations working together.

*I am not sure this is about innovation, I think it is about delivering joined up commissioning and doing the detail. For example, we have co-designed and implemented a rehab and re-ablement service with the CCG and the NHS provider... The approach was not particularly innovative, it was implementing good practice that we might individually deliver, but across 3 organisations. We are now dealing with all the cultural issues and the different approaches to contracts and contract management to do the detail which means that this service can work effectively. In other words, I think this is about detail and rigour as much as innovation. **Survey Respondent 1***

Figure 16: Effectiveness of Integration and Co-Operation between Local Authority and Other Organisations (n=26)



Q. The Care Act 2014 requires greater integration and co-operation between organisations. How effective is your authority's co-operation with the following organisations?

National stakeholder interviews felt that progress on integration with health was slow. Different organisational cultures of health and social care was cited by respondents as one of the key reasons for a lack of progress. This has created deeply embedded health and social care 'silos'. Further, the integration of health and social care was not unanimously viewed as a valuable outcome by national stakeholders. Responses emphasised the importance of patients being the active '*integrators of their own care*' (Interview 16), along the lines of personalisation, rather than only relying on joint services or organisations. There was a sense from some interviewees that integration between health and social care could actually prevent personalisation if there is an emphasis on integration at an organisational level, rather than focusing on individual outcomes:

I think some of the integration initiatives potentially could work against personalisation, particularly the ones that are very large scale and focused on organisations rather than individuals. Interview 15

One interviewee viewed the bio-medical culture within health as a threat to the values of social care services and organisations, stressing the importance of an outcomes-led approach:

I think we need to be really clear about what the outcomes are that we're expecting integration to deliver ... I think people are talking about it who don't really understand the system. My fear around integration is that the NHS culture is so strong it will just suck up and subsume social care, so anything around lifestyle or family or that bigger picture will be lost. Interview 18

Others reported variance in the extent to which health commissioners understand the personalisation agenda:

*I'm having some fantastic health driven conversations, particularly in some of the IPC [Integrated Personal Commissioning] sites, where it seems to me that health are pushing a strong values-based choice agenda. And I'm also having some conversations [elsewhere] where I think that health wouldn't know choice and control if they fell over it. **Interview 1***

Others countered these critiques with the argument that it is 'early days' for integration and that whilst there is geographical variation in practice, there are now growing numbers of joint market statements that include both social care and health. Again, Integrated Personal Commissioning (IPC) was cited as providing an opportunity to bring together health and social care services focused on the needs of the individual:

*We get health, social care and other parties working together. That gives clinicians, front line staff, permission to do the things that actually they were trained to do anyway... And what we find with IPC, is it enables people to break stuff and put it back together again in a different way. **Interview 11***

Respondents to the survey of local authorities highlighted ways in which they felt that the integration agenda could progress more effectively.

*Ensuring more resources are allocated to social care. Increased focus on early intervention / prevention. Assist the NHS to understand the impact/consequences of the Care Act more deeply. **Survey Respondent 19***

*Additional funding for identified areas of development; more understanding and ownership of health partners; choice and control; information and advice; market shaping and relationships; workforce development; new accredited job roles; governance and decision making processes streamlining. **Survey Respondent 21***

*Ensure alignment of policies e.g. welfare reform and housing delivery. **Survey Respondent 17***

*Ensuring that NHS indicators are aligned with LA indicators to present a more integrated approach to commissioning. Less reporting and surveys e.g. repetitive surveys were sent during implementation. Educating NHS organisations about the Act and their responsibilities under it. Especially with mental health trusts and other providers. **Survey Respondent 16***

*To recognise that the Care Act is more than hospital discharge, important though that is. **Survey Respondent 8***

The IBCF [Improved Better Care Fund] monies will help significantly, but additional templates and monitoring do not. I understand the need for impact, hence the focus on Delayed Transfer of Care, but the additional bureaucracy that goes with that is problematic. We have to solve the top down (NHS) vs bottom up (dilemma) and the issue about different modus

operandi and cultures across health and social care as it is draining and undermines progress if people are not squarely focused on local people, and local challenges and working together. Survey Respondent 1

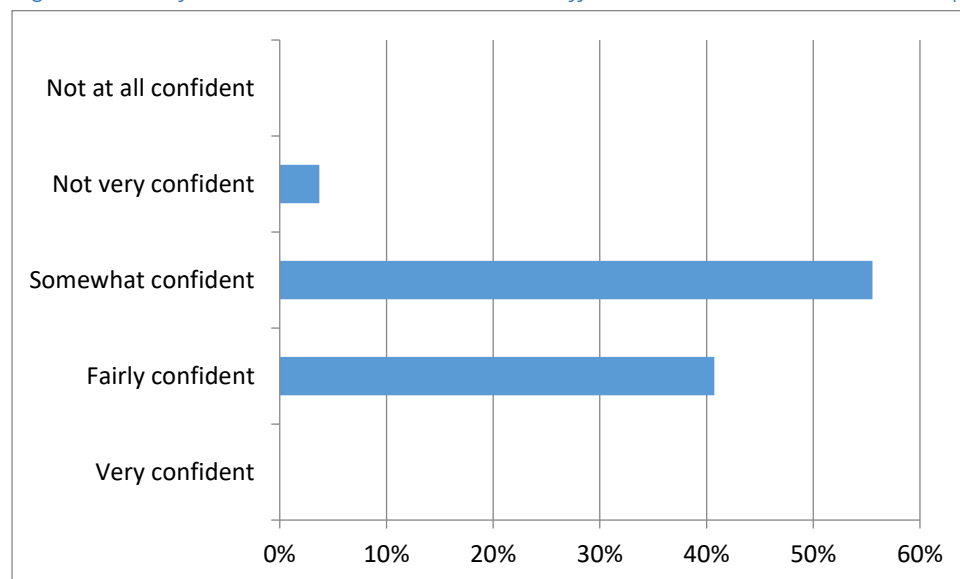
These comments indicate the complexity of the integration agenda and the limited impact it is having so far for people who use health and care services.

Outcomes

The survey of local authorities also asked respondents to consider the extent to which they were confident that they could achieve key outcomes relating to personalisation. These questions were focused on perceptions of the extent to which they can offer choice and control, along with the extent to which there is continuity of care when an individual moves across local authority boundaries.

When asked about the level of confidence that care providers are able to provide services that offer choice and control to people using them, no local authority respondents were very confident. However 41% were 'fairly confident' and 56% were 'somewhat confident'.

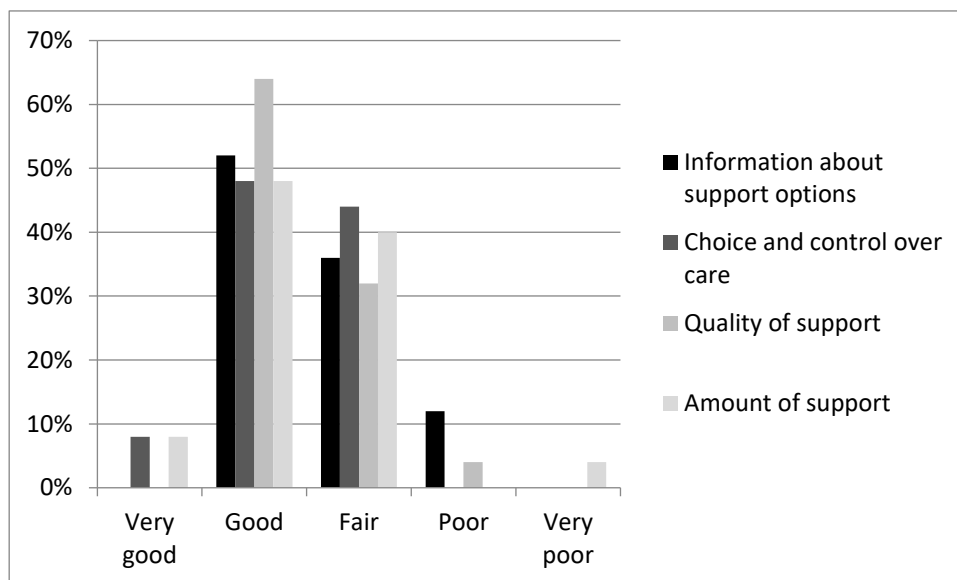
Figure 17: Confidence that Care Providers can Offer Choice and Control to Users (n=27)



Q. How confident are you that care providers are able to provide services that offer choice and control to people using them?

Survey respondents rated quality of support highly with nearly two thirds (64%) rating it as good, although none rated it as very good and 4% rated it as poor. The amount of support people receive, as well as their choice and control over the nature of that support, were rated quite highly, with 56% of respondents rating it as 'good' or 'very good' for both domains. A very small number (4%) rated the amount of support as 'very poor' and 4% rated choice and control as 'poor'. Information about support options was felt by most respondents to be good (52%) or fair (36%).

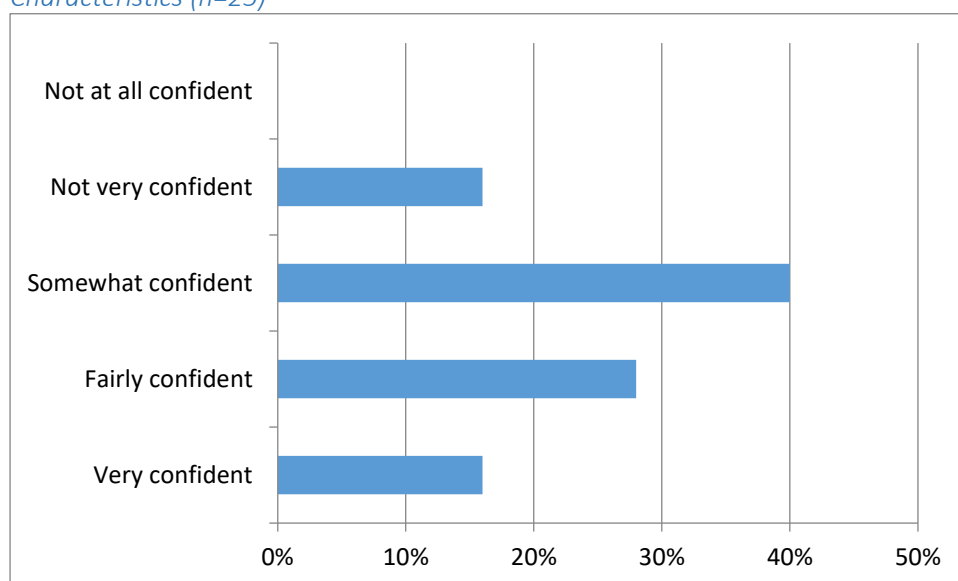
Figure 18: Experience of People Using Services (n=25)



Q. In your opinion, how good is the experience of people using services in the following aspects:

Fewer than half (44%) were 'very' or 'fairly confident' that the local care and support market is accessible to and provides for those with protected characteristics under the Equality Act 2010. Further, 16% were 'not very confident', as shown in Figure 19 below:

Figure 19: Confidence that Care Market is Accessible and Provides for those with Protected Characteristics (n=25)

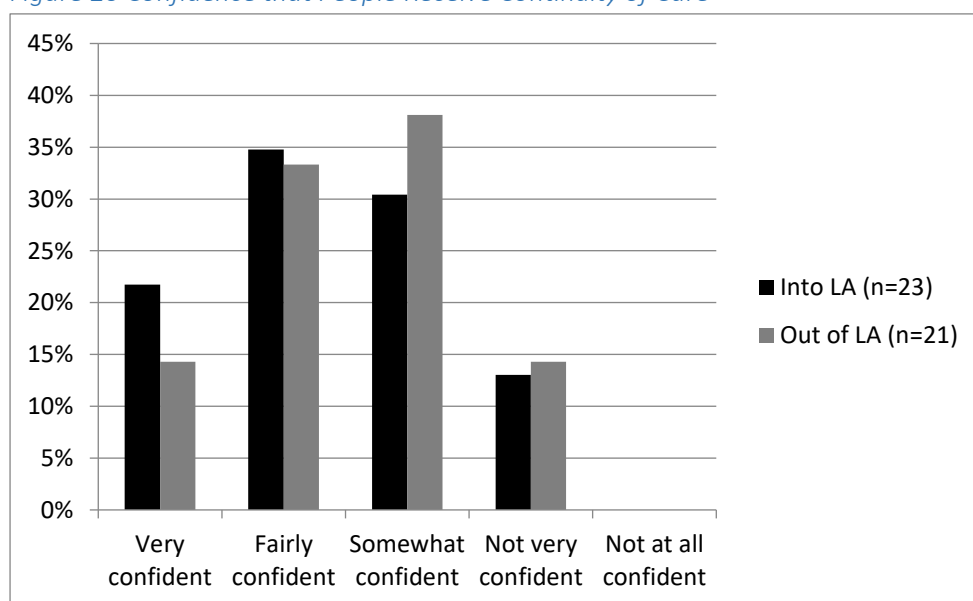


Q. How confident are you that the local care and support market is accessible to and provides for those with protected characteristics under the Equality Act 2010?

Continuity of Care

Over half (56%) of survey respondents were 'very' or 'fairly confident' that people with an assessed care need receive continuity of care when they move into the local authority. A slightly lower number (48%) were confident of continuity of care when people move out of the local authority.

Figure 20 Confidence that People Receive Continuity of Care



Q. How confident are you that people with an assessed care need receive continuity of care when they move INTO this local authority?

Q. How confident are you that people with an assessed care need receive continuity of care when they move OUT OF this local authority?

Local authorities provided a mixed response when invited to provide further information on their response to this question, with one local authority suggesting that this something that is not measured. Responses included:

*We have experience of several cases where portability of care has come into play. All cases have worked extremely well. There has only been one case where the service provided by a London Borough was not available ... but we worked with the citizen to find alternative/closest match services. **Survey Respondent 26***

*Reflects good operational practice across authorities. **Survey Respondent 20***

*This is an area we are not currently recording and measuring however, it is something that we are aware of at a regional level and have started work to look at this. **Survey Respondent 22***

National interviewees rarely had any knowledge of whether continuity of care was working well.

*It was a bigger issue in London than outside London. [Outside London] I never came across a case in the seven years [as a senior local authority manager] **Interview 13***

Conclusion

This chapter has focused on the contextual factors shaping personalisation, the mechanisms that local authorities are putting in place, and the outcomes reported in the survey about choice and control. Some of the mechanisms that local authorities are using, such as personal budgets and direct payments, play a role in improving choice and control. Others, such as high levels of monitoring, may run counter to the spirit of the Care Act. It has also looked at outcome data relating to the extent of progress in embedding personalised approaches.

As with market-shaping, we can identify variance within local authority practices around their responses to the personalisation agenda. Whilst our survey response rate doesn't allow us to generalise to the local authority experience we can theorise a different range of responses in relation to personalisation: one relating to the setting of rules (which may be tightly set or relatively loose) and the other relating to relationships with providers (which may encourage diversity of offer or may encourage the continuity of existing services). These different responses are developed into a typology of market shaping in the next chapter.

Section 4: Developing a Typology of Market Shaping

The data presented in the report has highlighted that effective market-shaping and personalisation is a feature of the interaction between local authorities, providers and local people. In particular, the national interviews and local authority survey responses highlight the importance of two sets of practices: first, the setting of rules and second, the development of relationships.

In relation to rules, local authorities can take a highly rule based approach to care markets or a more open and emergent approach: for example they can issue a rigidly specified contract to providers and impose tight limits on how people spend their personal budgets or they can use forms of co-production and alliance contracting that allow more freedom to providers and communities to shape the support that's available.

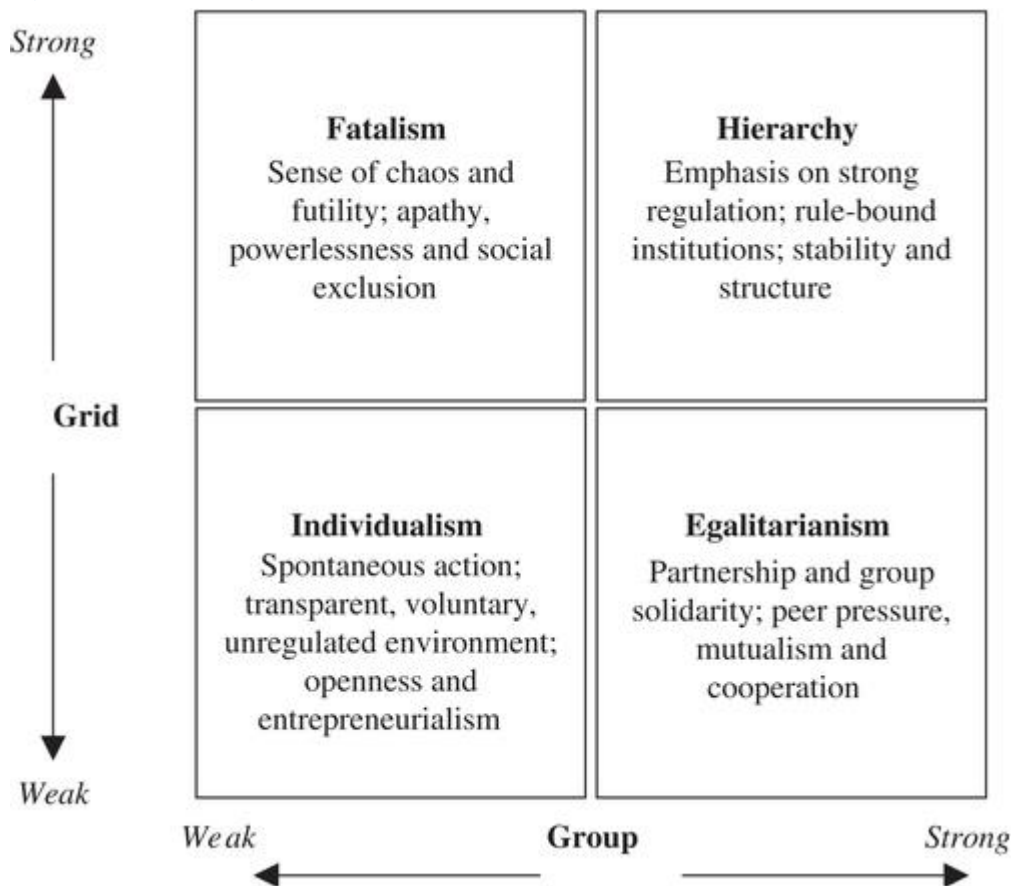
On the relationship dimension, local authorities can aim to create close relationships with providers and people who use services (for example regular provider forums and collaborative forms of commissioning) or they can take a less interventionist approach, leaving providers and consumers to develop bilateral relationships.

This section of the report uses grid-group cultural theory as a way to conceptualise rules and relationships on a two by two matrix. These are variables rather than binaries, such that many local authorities will not match these ideal types. However they do allow the development of a typology of market shaping practices which can be used when exploring how local authorities are fulfilling their Care Act duties.

Grid-Group Cultural Theory

Grid-group theory was developed by anthropologist Mary Douglas (e.g. Douglas, 2004; Thompson *et al.*, 1990) and has been widely used within institutional analysis and public management (Douglas and Wildavsky, 1983; Entwistle *et al.*, 2016; Simmons, 2016; Wildavsky, 1987). The theory considers how far people's lives are governed by external rules (the grid dimension) and how far people feel part of a loose or tightly bounded social group (the group dimension). From this emerges a 2 x 2 matrix, typifying four organisational styles. **Hierarchy** is high group/high grid, in which a strongly cohered group is governed by tight pre-set rules (e.g. a traditional bureaucracy). **Egalitarianism** is high group/low grid and describes a strongly cohered group in which rules emerge through partnership and dialogue (e.g. co-productive decision-making arrangements). **Individualism** (low group/low grid) dominates when there is no strong sense of group and where rules are minimal (e.g. in market-based systems). **Fatalism** (low group/high grid) describes a setting in which there is a weak group identity and where rules are imposed. In this setting people tend to blame others and feel powerless. The matrix is shown below:

Figure 21: Grid-Group Matrix



Source: <https://www.dustinstoltz.com/blog/2014/06/04/diagram-of-theory-douglas-and-wildavskys-gridgroup-typology-of-worldviews>

The enduring relevance of grid-group is that it draws out key dilemmas within public management and institutional design. As Hood puts it, ‘Put the “grid” and the “group” dimensions together, and they take us to the heart of much contemporary and historical discussion about how to do public management’ (2000, p.8). There is no presumption that one is better than another. The hierarchy approach, often the dominant form within government institutions, has the advantage that people are not left to work out how to behave in an ad hoc way. Egalitarianism makes the case for group solidarity and mutualism over top-down prescription. Individualism is a response to the perceived limitations of bureaucracy, freeing people up to innovate and be spontaneous. Fatalism is recognised to be a dystopian (though prevalent) alternative in which people see themselves as ‘subject to binding prescriptions...but excluded from membership of the solidarities that are responsible for making decisions’ (Thompson *et al.*, 1999, p.5) cited in (Entwistle *et al.*, 2016, p. 901).

Rather than seeing any one of these as preferred, Hood suggests that, ‘effectiveness will depend on the extent to which ideas and beliefs of the participants match the institutional structure of any control system’ (2000, p.70). This will change over time, and Hood charts the shifts in trends within public management to give preference to one of these forms over another. He does also note

though that ‘no single approach to control and regulation can ever be expected to emerge as unambiguously superior to any of its rivals. On the contrary, in the very act of becoming dominant, any one of the polar approaches discussed here might be expected to regenerate and strengthen some of those rivals, however confidently they might have been consigned to the “dustbin of history”’ (Hood, 2000, p.70).

Two recent papers in a special issue of *Public Administration* on cultural theory, have used grid-group analysis in a way that is related to local government. Entwistle *et al.* (2016) use it to consider centre-local government relations – rejecting a simple binary between strong vs weak central government control, to give a more nuanced account of these relationships. The authors survey local authority staff to identify where they position themselves in relation to the grid-group dimensions, and how this varies by service area. Simmons (2016) looks at cultures within different types of local government services (by interviewing users of the services), and in particular how far the cultures that exist in practice map onto the cultures that people want. For example he finds that in social housing, tenants feel the culture is very fatalistic whereas they want it to be more egalitarian/inclusive; in day care services people feel it is somewhat inclusive but would like it to be much more so.

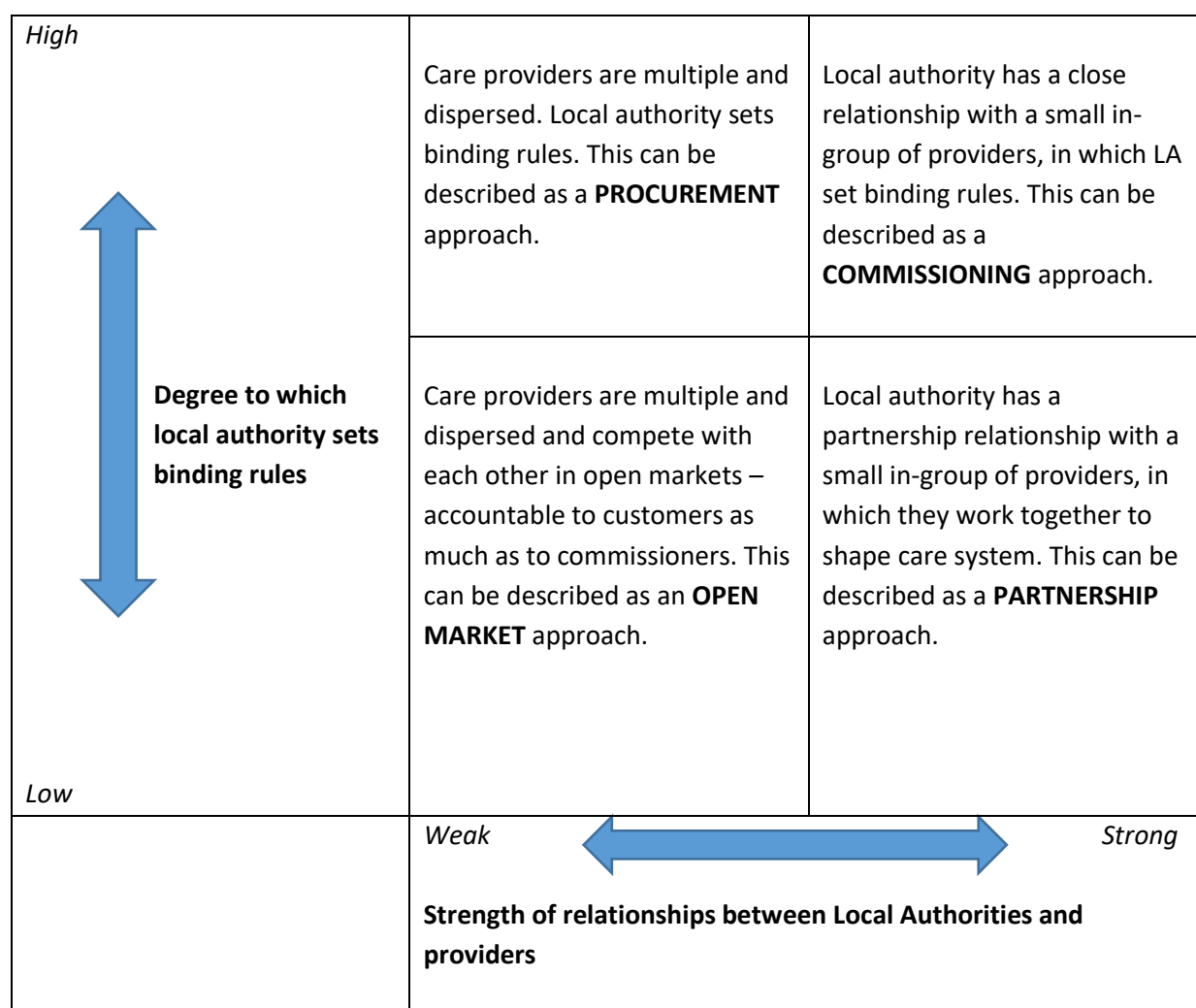
Relevance to Market-Shaping and Personalisation

Both dimensions of the grid-group analysis have relevance for market-shaping and personalisation. Looking at the grid dimension, the discussion so far has indicated that local authorities can set down rules in a prescriptive way leaving providers and users of services simply to follow them; alternatively they can be more flexible, encouraging providers, individuals and communities to innovate or to focus on outcomes with no prescribed process. Entwistle *et al.* describe a low-grid approach as ‘government having to rely on the soft instruments of diplomacy, partnership and trust’ with high grid being about ‘the use of hard regulatory instruments and the maintenance of hierarchy’ (2016, p.899). Both these types of behaviour, to a greater or lesser degree, are elements of local authority approaches to market shaping and personalisation.

The group element, when applied to care market shaping, focuses on how far there is an in-group of providers who work closely with the local authority, or how far it is a fairly open market with weak coordinating factors. Some local authorities, for example, contract with a small number of large providers, whereas others encourage large numbers of providers to operate and compete on their patch. A variant of this might be that some local authorities bring their providers together into forums, creating a sense of group identity, whereas others leave the providers to work in ways that are fairly isolated from one another.

Developing the matrix in relation to market-shaping produces the following typology shown in Figure 22.

Figure 22: Market Shaping Typology

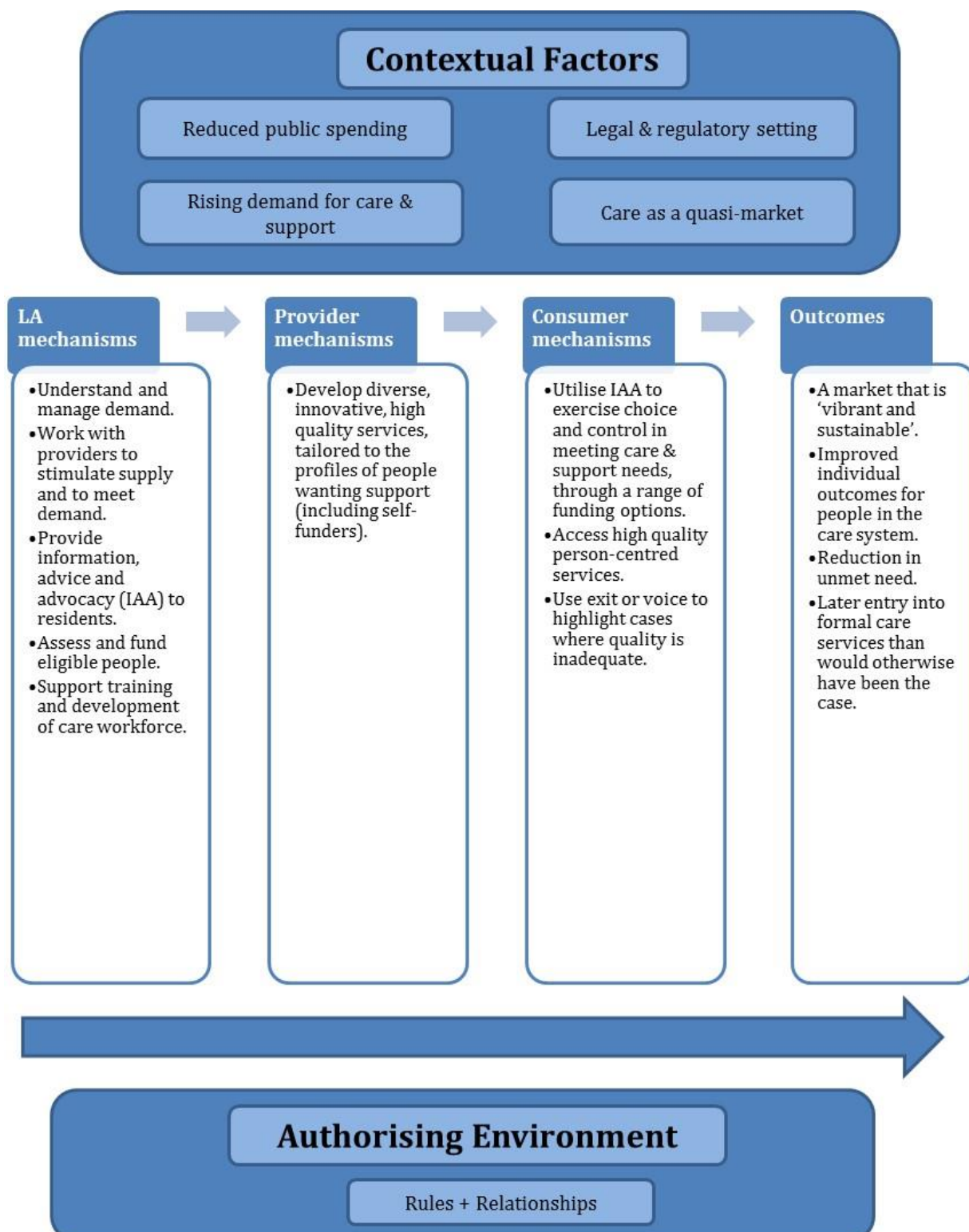


The typology shows four types of market shaping activities. If the aim of the Care Act is to create effective care markets that stimulate provider innovation and diversity in order to offer choice and control to all people using services then we can see the two low grid models as being most likely to do that. In the **open market** model, local authorities encourage maximum diversity of provider and encourage individuals and families to shop around to find the best fit for their care and support. In the **partnership** model, local authorities work closely with a smaller number of providers to ensure that the range of support is innovative and supports choice and control, for example through collaborative forms of commissioning. The **procurement** and **commissioning models**, in contrast, are more rule-driven and likely to limit scope for diversity and innovation, inhibiting personalised support.

Through their shaping of rules and relationships, local authorities create the environment to which providers and consumers respond. The discussion in previous chapters highlights the extent to which local authority actors are themselves influenced by a range of contextual factors, so they create these rules and relationships within a constrained setting. However by focusing in on the activities undertaken by local authorities it becomes possible to identify and map different approaches to the

difficult context of the current care system. Local authorities are a key actor in creating what Mark Moore (1995), in his work on public value, called the *authorising environment*. For Moore, the authorising environment reflects how key stakeholders such as elected politicians, senior public managers and the media conceive and legitimate particular courses of action. In relation to care markets, it can be applied to the way in which local authority actors interact with providers and local people to legitimise certain forms of care and support and discourage others. The authorising environment – i.e. the configuration of rules and relationships – is added into the logic model in Figure 23.

Figure 23: Adapted Logic Model – Authorising Environment



Section 5: Stratifying Local Authorities by Care Outcomes

Having identified four types of local authority approaches to market shaping the next phase of the project will use a local case study approach to assess the extent to which different local authorities, or sub-markets within those authorities, demonstrate these features and support the validity of the typology. In sampling eight local authorities, the aim is to incorporate a range of cases which differ from each other in relation to their care outcomes and other demographic factors (such as type of local authority and political party control) to provide maximum variance.

Various statistical returns for local authorities are available through NHS Digital. A number of key outcomes (dependent variables) were taken from data on the Adult Social Care Outcomes Framework (ASCOF). This relates to outcomes for adult users of local authority-funded social care for each local authority. Full details are available in the *Adult Social Care Outcomes Framework: Handbook of Definitions* (Department of Health, 2017b). Appendix 4 sets out the measures available within the ASCOF system. Associations between the structure of the social care market and the Social Care Related Quality of Life (SCRQoL) measure were also considered. Further detail on the data sources and the statistical techniques used can be found in the appendices.

This section sets out the process used to identify the sample of local authorities. Data from the Adult Social Care Survey (in particular, the SCRQoL measure) was compared against other variables to create a 'decision tree' regression which grouped local authorities into eleven groups. The SCRQoL measure is a composite measure derived from responses to the Adult Social Care Survey which cover the following domains: control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation (Department of Health, 2017b, p. 10-11).

Each question which makes up the SCRQoL has four answers for respondents to choose from, each of these responses are allocated a score and are equated with having:

- no unmet needs in a specific life area or domain (the ideal state);
- needs adequately met;
- some needs met; and
- no needs met (Department of Health, 2017b, p. 9).

The SCRQoL maximum score is 24 and higher scores are associated with better quality of life outcomes. There are two key limitations in using the ASCOF data and the SCRQoL scores. First, it does not capture the outcomes of care for people who are self-funding. Second, the SCRQoL measure does not isolate the effect of local authority services on the different domains (Department of Health, 2017b, p. 6-9). A new measure is being developed which aims to identify the 'added-value' reflecting the impact of care support provided by local authorities (Forder *et al.*, 2015, p. 3).

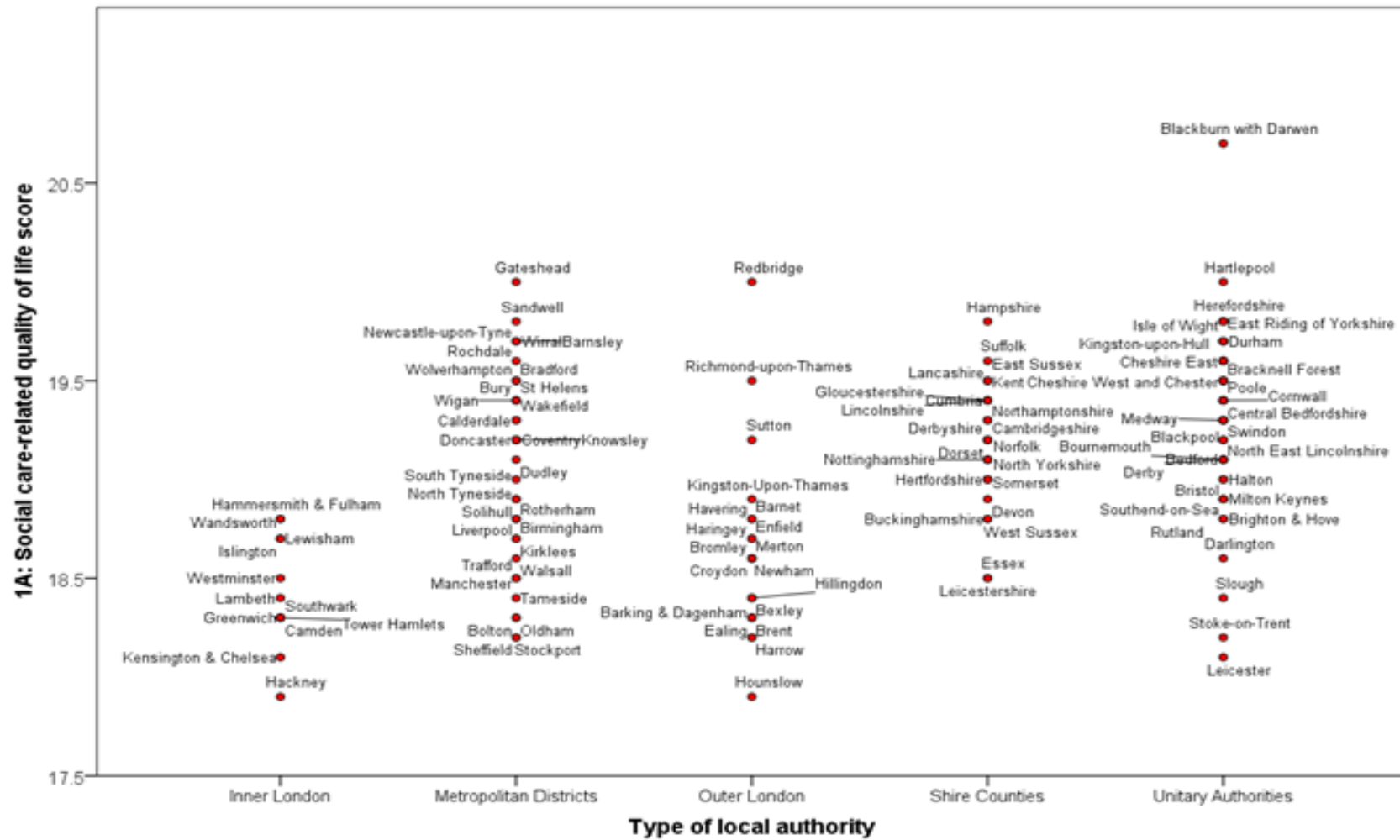
Appendix 3 lists some of the main sources used to collate information on local authorities with responsibility for adult social care. The Adult Social Care Survey is also used, below, to provide some statistical analysis at an individual level. Regulation data from the Care Quality Commission (CQC) was also included at the local authority level.

Outcomes by Type of Local Authority

There were considerable differences in the average reported social care related quality of life when averaged for each local authority. In Figure 24, each point represents a different local authority, which is labelled, and local authorities are clustered by type (e.g. unitary, shire county). The left-hand axis shows the SCRQoL measure, with higher numbers indicating better outcomes. On the right hand axis we sort local authorities into different types of local authority, combining region and urban/rural splits.

These results showed, first, that there was a strong difference in London, where reported values are lower than elsewhere in the country. This seemed to be particularly the case for those located in Inner London; a number of the authorities in Outer London had higher reported values for the SCRQoL. The second key conclusion we would draw is that there is a great deal of diversity in the outcomes reported – there were higher and lower values in each type of local authority, with not much of a statistical relationship between SCRQoL and the type of local authority, with the possible exception of Inner London which has local authorities clustered at the bottom end of the SCRQoL values. It is also worth noting that there may be different types of people living in each of these areas, and different client groups for social care.

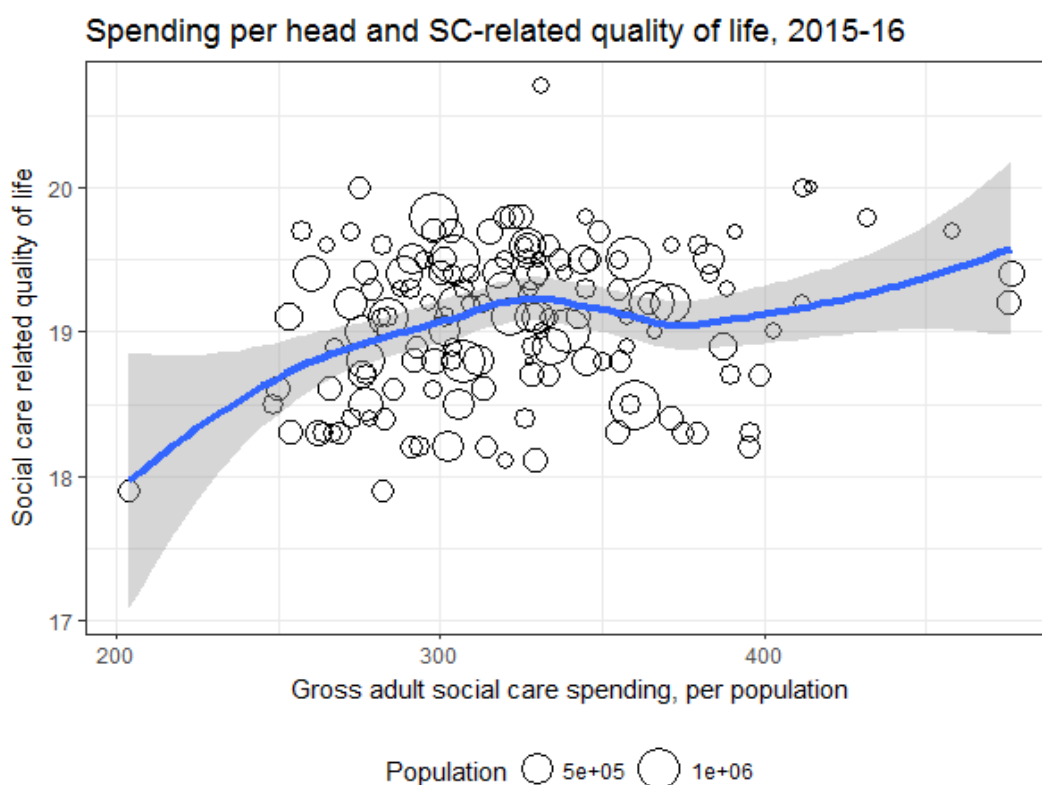
Figure 24: Social Care Related Quality of Life by Type of Local Authority



Care Outcomes by Spending per Head

In Figure 25 we show the same outcome (SCRQoL on the left-hand axis), but instead show the association with local levels of social care spending per head. One difference is that, whilst each circle still represents on local authority, they are drawn in proportion of the total population of the local authority – larger ‘bubbles’ indicating larger local authorities. From this figure, it appears that that whilst total spending had some limited association with reported outcomes, that link was actually quite weak in practice. Higher and lower levels of spending were not strongly linked to the social care outcomes, at least in a direct comparison. For the same level of local spending on adult social care, the outcomes reported can be very variable: high and low results for quality of life may be found in both high and low spending local authorities on social care. Instead, other factors must also be at work in affecting perceptions of quality of life, and these were investigated in the sections that follow.

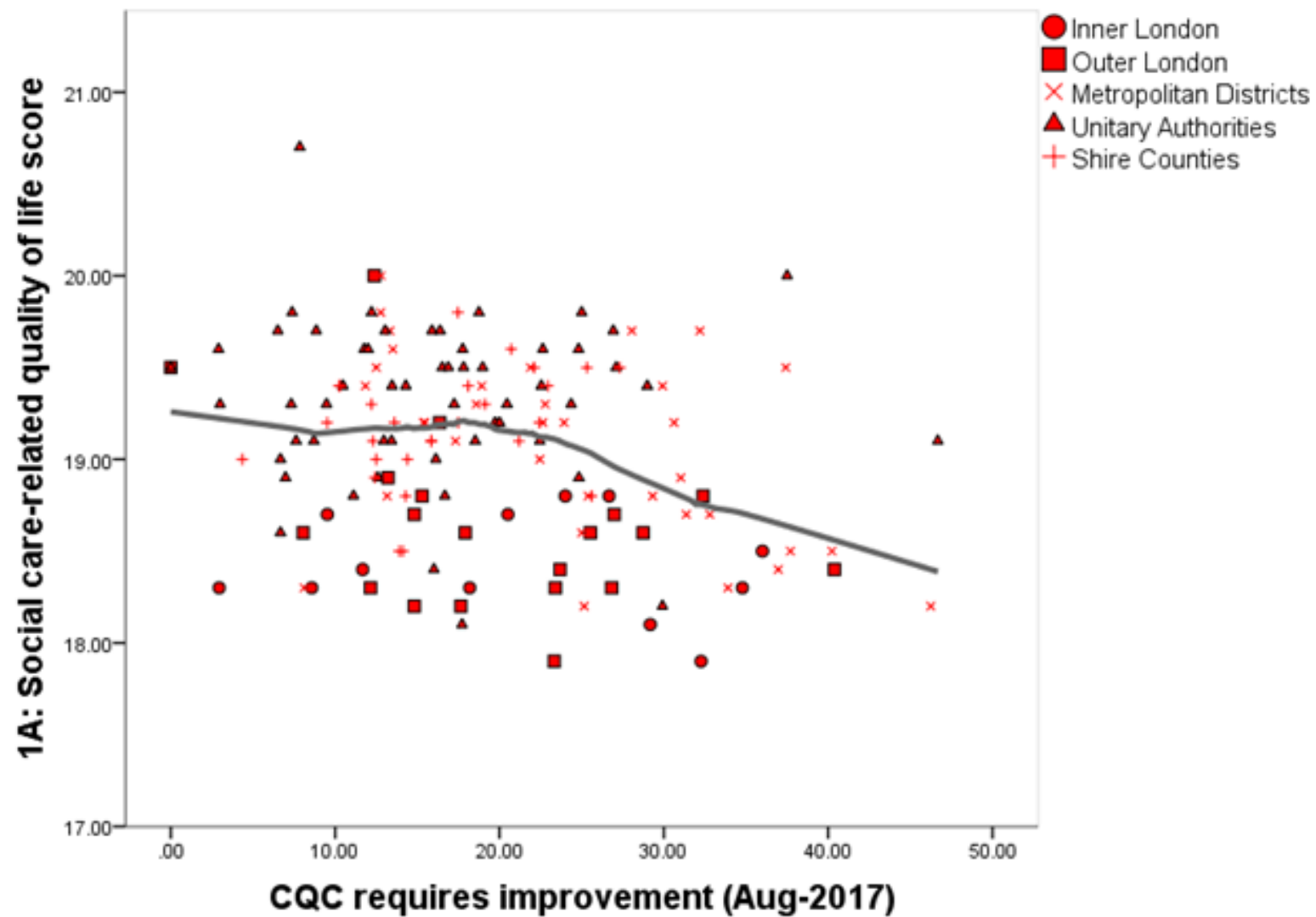
Figure 25: Local authority spend per head (£) by outcomes



Care Outcomes and CQC Ratings

There was something of an association between quality of life, and the ratings given by the CQC for each local authority (see Figure 26). In particular, the higher the proportion of organisations 'requiring improvement' (or worse) the lower the reported quality of life for service users. This seemed to be particularly true once the proportion of those requiring improvement went over 20 per cent or so, with a weaker link (a flatter line) for proportions below that. Since there is some evidence of worse outcomes for newer providers, this again tends to confirm some linkage between market structures (e.g. entry rates of new providers) and social care outcomes.

Figure 26: CQC Rating (Percentage Requiring Improvement or Worse) and Reported Quality of Life

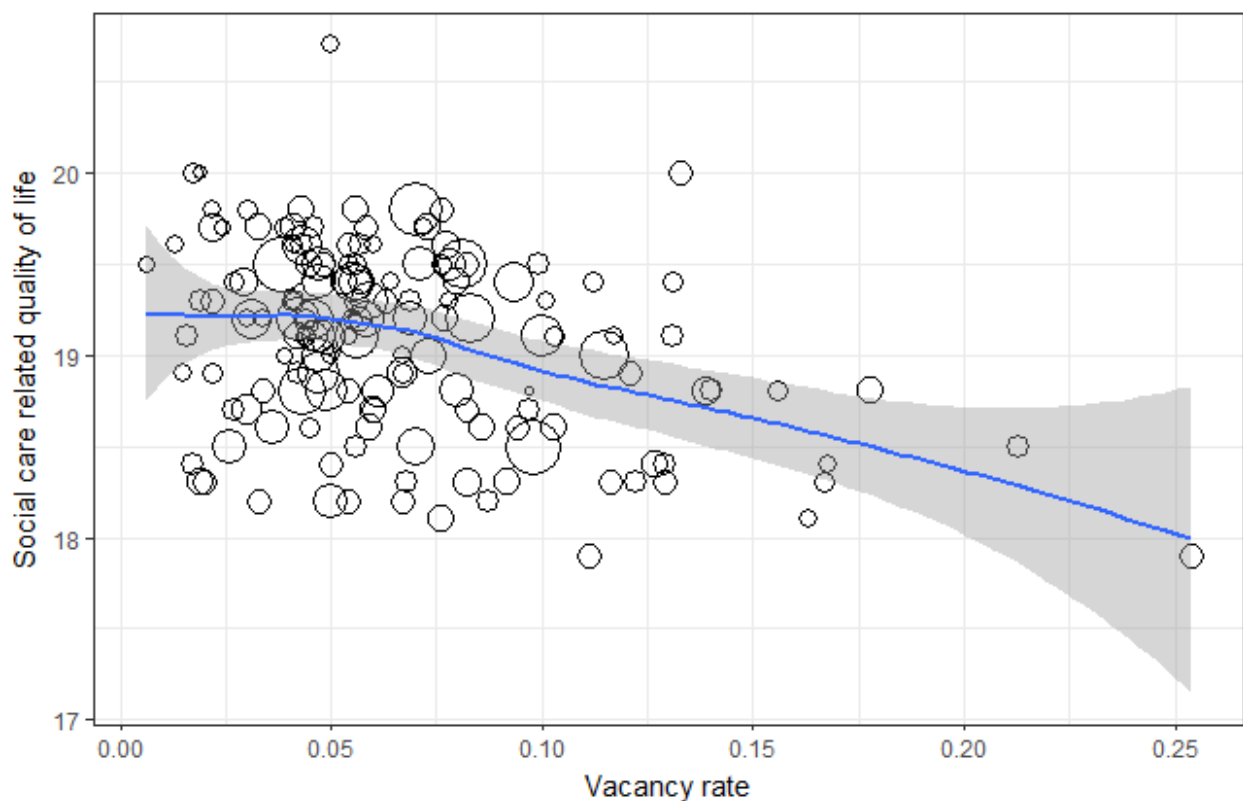


Care Outcomes and Vacancy Rates

Data from the National Minimum Data Set for Social Care (NMDS-SC) on the staff vacancy rate within social care providers was plotted against social care related quality of care in Figure 27. Again the size of the bubbles represents the size of the local authority with larger bubbles indicating a larger local authority. By way of context, a recent report from the National Audit Office (2018) indicated that levels of staff vacancies, and of staff turnover, are both very high within this sector, which they associate with disruptions in the continuity and quality of care provided. One of the key contributors to turnover and vacancies they believe to be low pay, and all these factors were used to develop our categories of local authority (Figure 29).

Figure 27 shows that there was not much of a link between social care related quality of life and vacancy rates across providers in a local authority, **where** those vacancy rates were below average (a vacancy rate of around 7 percent or so). However, in areas with vacancy rates above this, in other words above the average, there seemed to be something of an association between higher vacancies and a lower reported quality of life for users of social care services. This supports the idea that higher vacancy rates impact upon the quality of care provided, as NAO (2018) have argued. However we did find any direct link between SCRQoL and the social care workforce turnover rates when they were plotted against each other, at least not at the level of the local authority.

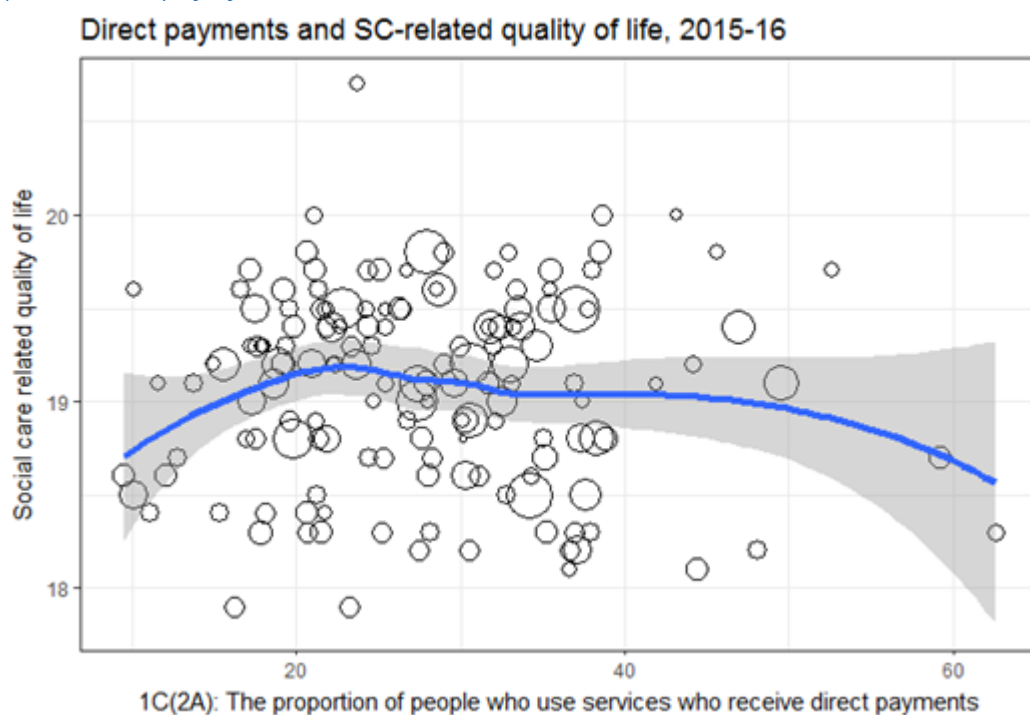
Figure 27: Staff Vacancy Rate and Service User Reported Quality of Life



Care Outcomes and Direct Payment Rates

Last in this series, we consider how the SCRQoL measure varied with the proportion of service users using direct payments to fund their care (Figure 28). The cautious interpretation we might make is that increasing, from a low base, the proportion of people accessing direct payments tends to be beneficial in terms of achieving a higher average value of SCRQoL. However, once a moderate proportion of people access direct payments (around 20 per cent of people accessing local authority services), there was little further association between higher values of SCRQoL and higher rates of direct payments. As with the previous charts, there is also a great deal of diversity in outcomes which is not associated with this method of payment. The right-hand side of the chart includes relatively few local authorities, so the apparent downward slope of the line of best fit is not reliable and so interpretations suggesting that higher rates of direct payments produce lower values of SCRQoL should be avoided.

Figure 28: Proportion of People Accessing Care Services who receive Direct Payments (percentage) and Reported Quality of Life



The above charts have included data at the level of each local authority which means that the data presented is at an aggregated level. In the next table we move to looking at results at the level of the individual person. In Table 2 we show the results of a statistical regression, which seeks to link a particular outcome (the dependent variable) with a number of different potential causes (independent variables), each of which may be acting independently to affect that outcome. We focus on the results that related to funding and type of social care. Table 2 show the results of the regression analysis after controlling for differences in age-groups, gender, region and the type of local authority. This means that the influence of these variables on SCRQoL have been removed from the resulting analysis.

This regression analysis indicated that better outcomes were reported on an individual basis where people were using direct payments, either in part or in full, compared with SCRQoL measures when only local authority commissioned support, or a Local Authority managed personal budget are received. The lower half of the table shows that those most likely to report higher levels of SCRQoL were those in nursing homes, and in residential care, compared to those in community settings. Whilst we cannot directly examine respondents' level of expectations of their social care, which may affect satisfaction, this result is after controlling for differences in age group and so cannot be attributed to the potential differences of perceptions between those aged 65+ and those who are younger than this.

Table 2: Regression Model of Reported Social Care Related Quality of Life (SCRQoL) Values

Variable	Coefficient	Statistical significance (p value)
Funding		
Direct Payment Only	1.398	<0.01
Part Direct Payment	1.204	<0.01
Local Authority Managed Personal Budget	1.0	Reference
Local Authority Commissioned Support Only	1.005	Not significant
Setting		
Community	1.000	Reference
Residential Care	2.294	<0.01
Nursing Care	1.355	<0.01

Note: Other independent variables with results not shown – age-group, gender, region, type of Local Authority. N ~ 70,000 individuals included in this regression model.

Source: Statistical analysis of Adult Social Care Survey 2015-16.

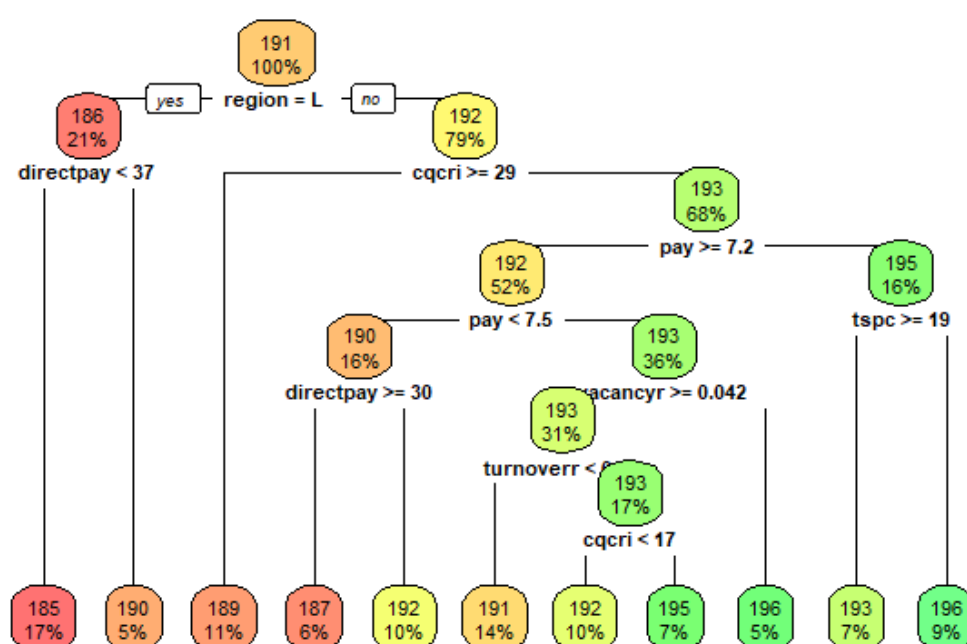
Using Outcome Data to Create a Sample of Local Authorities

There are various ways of creating a sampling frame for different local authorities, based on their approach to social care provision and to market-shaping, or the characteristics of the types of areas in which they are found. A number of studies have developed typologies of their own, relating to different aspects of location, demography or service provision. As set out above, we used the Social Care Related Quality of Life (SCRQoL) scores as the outcome measure and explored which characteristics of local authorities were most strongly linked to the SCRQoL. This was then used to construct 11 different sets of local authorities. In some fields this is known as a segmentation analysis.

To identify the sets a 'decision tree' regression was developed, successively splitting the population of local authorities into 11 smaller groups, with the local authorities within these groups being alike. A pictorial representation is shown as Figure 29 below. The outcome measure is SCRQoL, which we have multiplied by a factor of 10 to aid readability – i.e the average value is 19.1, which at the top of this hierarchy is shown as 191. The decision tree approach identifies the factor that splits the set of local authorities into groups of local authorities which are similar to one another. At the first stage, whether a local authority was based in London had the largest effect of any single variable – local authorities in London have a SCRQoL of 18.6, compared with 19.2 for the rest of the country. The percentages within the chart relate to the proportion of local authorities within each 'segment' of the split.

Then, below each of these groups, successive further factors are identified as providing the most information at each splitting point. Within London, the only other factor that seemed to provide a reasonable split was the level of direct payments being used. In the rest of the country, the next most important piece of information was the proportion of institutions (in each local authority) requiring improvement (or worse) according to the CQC. Local authorities outside London, and with a high proportion requiring improvement, form a distinct sub-group of their own (11% of all local authorities in this analysis, and with an average SCRQoL of 18.9). That leaves non-London local authorities which do not have a high proportion with poorer inspection results. The right hand side of the figure follows the effects of other factors, including: workers' level of pay, turnover and vacancy rates, and proportion of institutions within the third sector on the grouping of local authorities.

Figure 29: Creating a Typology of Local Authorities Using A Segmentation Approach



Source: Analysis of local authority outcomes and input data.²

Eight case sites were selected to give variance across this list, but also to represent local authorities in relation to geographical spread; numbers of self-funders; political control; and type of local authority; along with advice from the Project Reference Group and other stakeholders to ensure a sample of case study sites which are not over-researched in other ongoing projects.

² Note for chart: cqcri = CQC requires improvement; tspc = third sector proportion of organisations; vacancyr = vacancy rate; turnover = turnover rate.

Conclusion

This report has explored local authority responses to market shaping and personalisation through a range of lenses: national stakeholder interviews, local authority survey responses and secondary data. Market shaping has been recognised to be a complex activity, given the range of markets operating within a single locality, and the overlap with markets in neighbouring local authorities. Drawing on the available data, the report has developed a typology of market shaping behaviours and a sampling strategy for local authorities based on differential care outcomes.

What is clear from the interview and survey data is that there is a link between market-shaping and personalisation of social care services. Effective development of relationships with providers and communities can be a way for local authorities to develop stable markets but also to stimulate the innovation and diversity that underpin person-centred care. Of the four models of market-shaping developed in the typology, the open-market and partnership models of market shaping offer the best ways to combine market shaping and personalisation across the whole market, rather than being oriented only towards local authority funded people or traditional models of care.

Whilst market shaping and personalisation are compatible, the relationship between them can be rendered fragile in the difficult contextual conditions of the current care system. Rising demand, constraints on public spending, insufficient staffing, weak consumer power and poor flows of information can steer local authorities towards forms of market shaping which stabilise care markets in their current form rather than moving to more person-centred approaches. As one interviewee indicated, there can be a trade-off between individual choice and market stability, and local authorities don't necessarily have the capacity and skills in market management and future planning to address this trade off. This can lead to an over-reliance on block contracts to stabilise support.

Integration with health offers one route to more person-centred services, but it is an approach that increases complexity, and may risk being shaped into a health-oriented model rather than balancing health and care around a whole person approach. Interviewees and survey respondents saw some useful innovation here in integrated care but were concerned that system-level integration could limit rather than enhance diversity and responsiveness at the level of the individual.

Implications for Policy and Practice

If local authorities are to successfully implement the Care Act, and meet their duties in relation to market shaping and personalisation, they will need further support on the following aspects.

- **Gathering and analysing data on market demand and future projections**, and using that to develop a strategy for effective care and support with communities and providers. The limits of local authority skills in relation to data gathering and analysis have been stated elsewhere (CMA, 2017). However, attention needs to be paid also to how local authorities, communities and providers work co-productively to use data as the basis for rethinking local care and support systems.

- **Shaping multiple markets within one locality.** Local authority commissioning practices can be fragmented between different types of user group, with self-funders often left out altogether. Older people's services are often more traditional and rigid than the support on offer for other people. More support is needed to think about how far market shaping can share learning between different markets.
- **Designing local rules in ways that enhance diversity and choice rather than reduce it,** either on the open market model or the partnership model. Procurement and commissioning models that focus on prescriptive approaches to contracting and monitoring, or that narrow the focus to local authority funded people, need to shift towards models that can better support diversity and innovation.
- **Building effective relationships with providers** to share risk and stimulate innovation. Relationships between local authorities and providers are often low on trust and transparency, and the tight funding context can further intensify distrust between the two. More support needs to be given to embed good practice around modes to improve trust and transparency such as provider forums and alliance contracting.

National Policy Needs to Address:

- **The adequacy of funding in the social care system.** The government needs to identify a way to bring sufficient funding into adult social care for the current and future generations, without which the principles of the Care Act will falter.
- **Workforce supply** is a national issue in relation to investment in training and career progression for care workers, as well as attention to how national policies such as the National Living Wage can be implemented locally without putting further strain on local care systems.
- **Approaches to integration which support person-centred approaches.** Whilst a lot of work is going on within localities around integration, continued funding and support from central government is helpful to build an evidence base around what works in relation to person-centred integration. Integration here could go beyond health to consider how to support independence and aging in place.

Next Steps

The next stage of the research is to move into eight local authority sites. Through interviews with people working in those localities and people using and providing care services, we will explore the approach taken to market shaping and personalisation. The configuration of rules and relationships will be studied to identify if there is a predominant model of market shaping within that locality, or whether this differs by sub-locality or service type. Interplay between the authorising environment (the rules and relationships) and care outcomes will be explored.

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Appendix 1: List of Organisations Interviewed

ADASS
Age UK
BUPA
Care England
Carers' UK
Castle Oak
Centre for Welfare Reform
Community Catalysts
Community Navigators / TLAP
Competitions and Markets Authority
Care Quality Commission
Department for Communities and Local Government
In Control
Institute of Public Care
Kings Fund
Local Area Co-ordination Network
Local Government Association
National Care Forum
NHS England
Skills for Care
Shared Lives
United Kingdom Homecare Association (UKHCA)
University of Durham

Appendix 2: National Stakeholder Interviews – Topic Guide

These interviews are being undertaken with reference group members and other national level experts that we identify or other interviewees suggest.

The purpose of these national stakeholder interviews is to:

- *Understand what market shaping is and whether it is happening/working (providing choice and quality to diverse populations). If not, what are the barriers?*
- *Understand the extent to which care services are personalised (so that people have individualised funding, appropriate information, choice and control (even if moving areas)). If not, what are the barriers?*
- *Understand the extent to which the Care Act has made a difference to practices around market shaping and personalisation. If not, what are barriers (if different from above)?*
- *Understand how far integration with health services is affecting market-shaping and personalisation*
- *Identify localities that would make interesting case studies due to their practices around market shaping and/or personalisation*
- *Gain recommendations of new/current literature/research on market shaping/personalisation which might not have been picked up in literature searches*
- *Gather insights which contribute to a typology of market-shaping and personalisation practices*

*Information sheet and summary of topic guide to be provided prior to the interview.

Introduction

[Interviewer to run through consent form and answer any questions about the study]

1. Interviewee to confirm name, job title/role, organisation

Market-shaping

2. What is your own and your organisation's role/involvement with 'social care market-shaping' specifically. (Any specific work/research/policy development undertaken linked to this topic?)
3. How would you define or understand the term market shaping? **How is it supposed to work** and for who? (Probe about diversity and innovation in service provision i.e. to what extent is market shaping about providing non-traditional services and also providing care and support to different types of service users.)
4. How do you think 'market shaping' for social care is happening **in practice**? Have local authority practices changed as a result of the legal duty expressed in the Care Act? If not what do you think may be preventing this?

(Probe for different factors: knowledge, historic legacy of providing services in a non-market way (key preferred providers), capacity (workforce, providers, other resource), rural/urban difference, different population needs. Also probe about barriers to developing market shaping, particularly in light of funding issues for local councils; whether delays in phased implementation of Care Act have had an impact on the pace of local developments)

5. What good practice in relation to market shaping are you aware of within local authorities? How would you define good practice in this area?

6. How do you expect care markets to change in the future? (Probe: demographic change; technology; workforce; power of self-funders?)

Personalisation

6. How would you define or understand the term personalisation? **How is it supposed to work** and for who? (Probe about choice and control, personal budgets, direct payments; link to better care outcomes. Has the understanding or meaning changed, and if so in what ways).

7. How do you think personalisation is being implemented **in practice**? Have local authority practices changed as a result of the care planning approach set out in the Care Act? If not what do you think may be preventing this? (Probe: costs of personalisation/PBs and austerity; different populations (less developed for older people?).

8. What good practice in relation to personalisation, choice and control are you aware of within local authorities? (Probe, what stops good practice being more widespread)

9. Do you see a link between personalisation and market-shaping, or are they separate?

Cross cutting themes

11. Do you think **integration with health** will impact market-shaping and personalisation? If so, how? (Probe around whether health partners have shared understanding of market shaping and personalisation goals).

12. One aspect of the Care Act was to improve **continuity of care as people moved** to a new locality. Do you think that has improved? (Probe around scale of the issue – are many people affected by the continuity issue; is there awareness of its importance for a minority)

13. Can you offer any **other interesting examples and/or contacts for this study**? (Not necessarily 'Best practice', just people who might have experience, insights and something to say about social care).

14. Can you signpost us towards any key evidence or national guidance that you think we should be aware of (particularly most recent stuff which searches may have missed)?

Signing off – ask if they can let us know if they come across any new research or report that links to our project.

Appendix 3: Key Sources of Data

Adult Social Care Outcomes Framework (ASCOF)

The adult social care outcomes framework (ASCOF) measures how well care and support services achieve several important social care outcomes.

Adult Social Care Survey (ASCS)

The Personal Social Services Adult Social Care Survey (England) takes place on an annual basis, with the eighth survey taking place during 2017-18. All local authorities in England, that have responsibility for providing adult social care services, have to conduct a postal survey of their service users. The data collected from this survey are used to help create several measures used for the Adult Social Care Outcomes Framework (ASCOF) – specifically these measures:

- 1A Social care related quality of life.
- 1B The proportion of people who use services who have control over their daily life.
- 1I1 The proportion of service users who report that they have as much social contact as they would like.
- 1j Adjusted Social care-related quality of life – impact of Adult Social Care services.
- 3A Overall satisfaction of people who use service with their care and support.
- 3D1 The proportion of service users who find it easy to find information about services.
- 4A The proportion of people who use services who feel safe.
- 4B The proportion of people who use services who say that those services have made them feel safe and secure.

Care Quality Commission (CQC) data

At local authority level we bring in data from the Care Quality Commission regarding the proportion of institutions requiring improvement or inadequate (labelled as cqcri).

English Longitudinal Study of Ageing (ELSA)

A survey of people aged 50+, and their partners, drawn from households previously responding for the Health Survey for England (1998-2011). People are interviewed every two years. The sample has been refreshed at waves 3, 4, 6 and 7.

The National Minimum Data Set for Social Care (NMDS-SC)

The NMDS-SC is an online database holding information about the adult social care workforce. It contains data on around 25,000 establishments and 700,000 workers across England.

Appendix 4: Adult Social Care Outcomes Framework (ASCOF) data

Domain 1 – Enhancing quality of life for people with care and support needs

(1A) Social care-related quality of life

(1J) Adjusted Social care-related quality of life – impact of Adult Social Care services

(1B) Proportion of people who use services who have control over their daily life

(1C) Proportion of people using social care who receive self-directed support, and those receiving direct payments

(1D) Carer-reported quality of life

(1E) Proportion of adults with a primary support reason of learning disability support in paid employment

(1F) Proportion of adults in contact with secondary mental health services in paid employment

(1G) Proportion of adults with a primary support reason of learning disability support who live in their own home or with their family

(1H) Proportion of adults in contact with secondary mental health services living independently, with or without support

(1I) Proportion of people who use services and carers, who reported that they had as much social contact as they would like.

Domain 2 – Delaying and reducing the need for care and support

(2A) Long-term support needs met by admission to residential and nursing care homes, per 100,000 population

(2B) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

(2D) Outcome of short-term services: sequel to service

Placeholder for 2017/18 (2E) Effectiveness of reablement services

(2C) Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population

Placeholder for 2017/18 (2F) Dementia – a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

Domain 3 – Ensuring that people have a positive experience of care and support

(3A) Overall satisfaction of people who use services with their care and support

(3B) Overall satisfaction of carers with social services

Placeholder for 2017/18 (3E) Effectiveness of integrated care

(3C) The proportion of carers who report that they have been included or consulted in discussion about the person they care for

(3D) The proportion of people who use services and carers who find it easy to find information about support

Domain 4 – Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

(4A) Proportion of people who use services who feel safe

(4B) Proportion of people who use services who say that those services have made them feel safe and secure