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Market Shaping and Personalisation in Social Care:

A Realist Synthesis of the Literature

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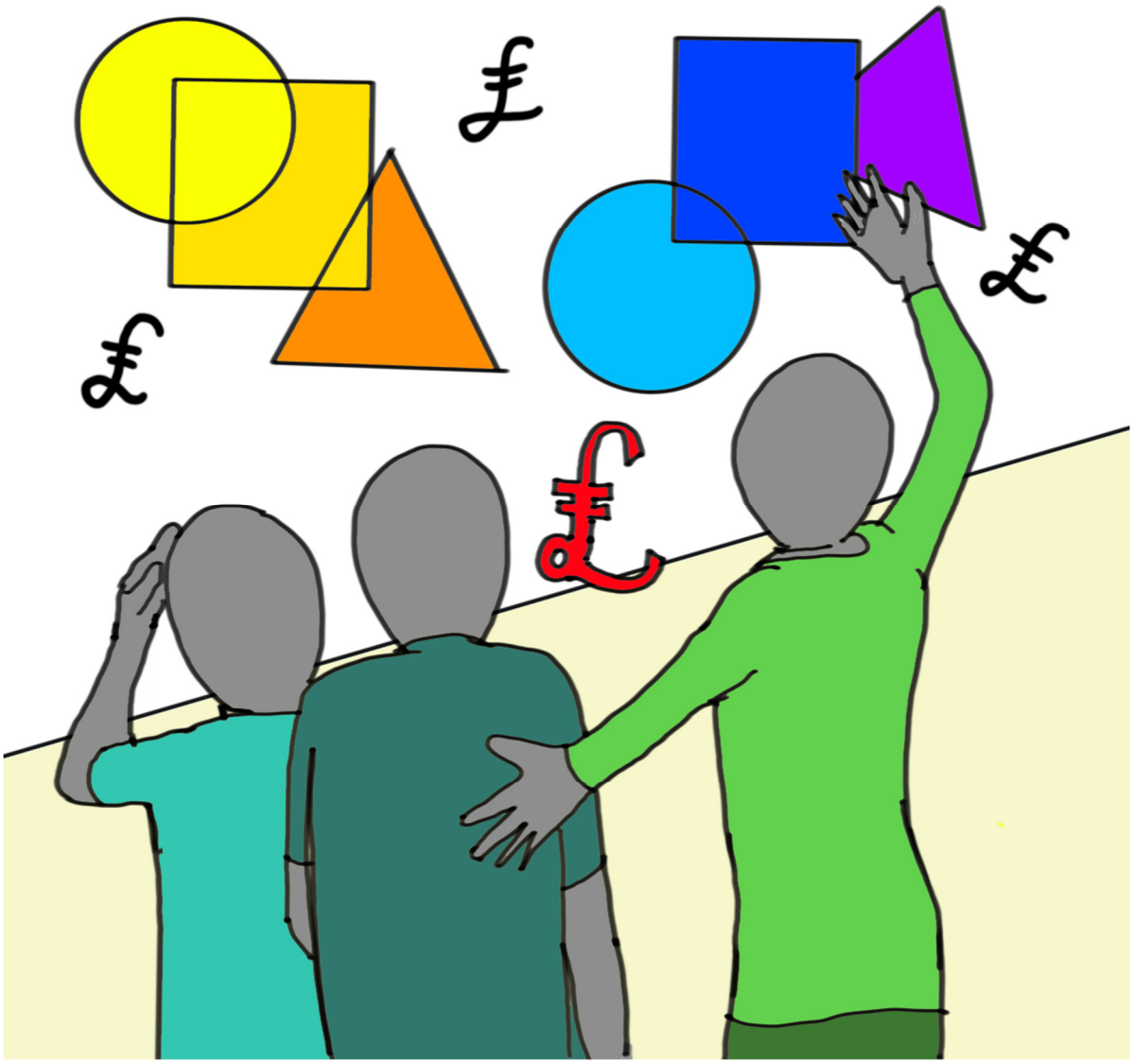

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This is an interim report, presenting the findings of a realist synthesis of the literature, and has not been peer reviewed. The final report from the research projects will be peer-reviewed prior to publication.

Contents

Executive Summary

Under the Care Act 2014 local authorities in England have a 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 have access to information about what services are available. Those services should be person-centred and high quality.

This report reviews the literature relating to two aspects of the Care Act: market shaping and personalisation. It is part of a broader research project assessing how far local authorities are discharging their legal duties relating to market shaping and are enhancing personalisation, choice and control. The review of the literature brings together existing research and knowledge on these topics to develop an understanding of the programme theories which underpin them. The review questions are informed by adopting a realist approach to highlight contexts, mechanisms and outcomes (Pawson *et al.*, 2005). These questions are:

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 important contexts which determine whether or not the different mechanisms produce the intended outcomes?

Applying these questions to the literature led to the identification of the programme theories that underpin market shaping and personalisation and the development of a logic model which separates out the relevant context, mechanism and outcome factors. Synthesis of the literature identified 64 relevant studies, most of which were policy documents or reports ('grey literature') rather than peer reviewed academic studies ('research').

Contexts

Within this literature the key **contextual factors** in relation to care were:

- the distinctive legal and regulatory context of the care sector;
- rising demand for care due to demographic change;
- reduced local authority expenditure on care in the period from 2010-2016;
- workforce shortages in appropriately trained care staff;
- the quasi-market structure of care services.

Mechanisms

Key **mechanisms** in the literature relate to three categories:

- the market logic;
- the interplay of supply and demand between local authorities and providers;
- the role of the care user as an active consumer.

Seven programme theories were derived from the literature to explain and understand how these different categories linked together. Considered together, these set out the ways in which market shaping is expected to drive commissioner strategies, provider responses and the behaviour of people who need care and support.

Theory 1: Market logic

A diverse set of providers, operating in a quasi-market environment, is the best way to ensure adequate supply of high quality, person-centred care and sustainable services, now and in the future.

There is a theory, implicit in much of the care policy literature, that a market-based system is the appropriate model for care services, given the scope it offers for competition-driven efficiency, diversity and innovation. This is the basis for the reorientation of social care services from the largely in-house provision of services in the 1980s to a largely outsourced model, with 79 per cent of full-time equivalent social care jobs now in the independent sector (Skills for Care 2017, p. 22).

Theory 2: Market limitations

Local authorities have a legal duty to 'shape' local markets, without which supply may not be adequate, stable or of sufficiently high quality.

It is recognised that markets in care services require careful steering from central and local government if they are to secure adequate, stable and high quality care services. The contextual factors in social care – particularly demand rising at a rate that outstrips available funding – suggest that the market alone is unlikely to provide the optimum combination of quality, price and coverage. The extent to which such market limitations are prevalent is not consistent across regions, or even within localities, highlighting the difficulty of talking about 'the care market' as an undifferentiated whole. Care markets in areas dominated by self-funders have different features than those which concentrate on local authority-funded care users, typically paying lower fees. In localities where a high percentage of people using social care are self-funders, local authorities may play a limited role within the care market. It is also important to note that, although social services departments within local authorities are the main focus of the Care Act, market shaping requires a broad strategic approach involving multiple stakeholders.

Theory 3: Demand

Local authorities gather information about (existing and future) demand with co-produced input from communities. They share that information with existing and potential providers (across care, health and housing) and provide other forms of support to stimulate appropriate provision (including support for prevention).

In a legal context in which local authorities must shape local markets, this theory focuses on the work that local authorities do to understand, plan for and meet demand for services in their area (as well as potentially reducing demand through preventative work). These activities constitute a key mechanism within the market shaping duty. They require local authorities to support and stimulate activity from other partners to ensure that high quality and personalised care services are delivered in sufficient volume. This role is broader than the established commissioning role that local authorities have undertaken since it needs also to incorporate planning for the local population needing care and support, encompassing self-funders as well as people who receive public funding.

Theory 4: Supply

Providers develop diverse, innovative, high quality services, tailored to the profiles of people wanting support (including self-funders). Some of these will span health and care, as these services become more integrated. Some will be informal arrangements with non-regulated providers.

Effective market shaping assumes that care providers will respond to the demands and preferences of a range of purchasers and commissioners, whether those are local authorities, people using direct payments or Individual Service Funds (ISFs), or self-funders. This theory requires that providers are able to easily enter the market in order to respond to demand and to drive innovation. There has been concern within the social care sector about declining supply as providers hand back contracts for publicly funded clients. The low-fee, low-pay nature of the sector may also discourage diversity of provision, since there are limited incentives or financial capacity to innovate. Once operating, care providers have to sustain demand for their services, working closely with local authority commissioners for framework contracts and/or marketing their services to individual purchasers. Providers need to be able to charge sufficient fees for their services to cover operating costs and also to service any capital costs and to have revenue to reinvest in the service. There has been extensive debate about whether the fees that local authorities pay for care are sufficient to meet these resourcing needs and a lack of consensus between local authorities and providers about what level of profit is acceptable. Open-book accounting approaches have been suggested as one way to improve trust and accountability.

Theory 5: Information

Local authorities ensure citizens (including self-funders) understand what support is available, through the provision of information, advice and advocacy (IAA).

Information, advice and advocacy services shape the market by setting out both the options available and the quality of care provided, thus sustaining (or increasing) demand for some services and reducing demand for others (IPC, 2016a). The provision of timely, reliable and accurate information on providers and quality is critical to enable users to make effective choices that meet their needs. As part of its review of care home markets, the Competition and Markets Authority (CMA) commissioned qualitative research to explore peoples' experience of navigating the care home sector. A key theme to emerge from this research was the difficulty in accessing information faced by individuals and families planning a move into a care home (Ipsos MORI, 2017).

Theory 6: Personalisation

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

The aspiration to deliver choice and control to people using services through person-centred forms of support has been a formal ambition of English care services for over a decade. The link between personalisation and market shaping is made clear in the Care Act guidance: 'High quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers' (HM government, 2014, para 4.1).

Individualised funding options are a key mechanism for achieving personalisation. However, research into personal budgets and outcomes indicates mixed findings to-date. Whilst outcomes can be better for many people using direct payments (particularly if used to purchase personal assistant (PA) support), the process can involve delays, restrictions, disproportionate bureaucracy and confusion. There is growing evidence of the positive impact of ISFs to deliver more flexible support, with monies being held by a third party. However, there has been limited progress in offering the ISF option more widely, and it is not well understood. The 2014 Care Act also extended the eligibility for personal budges to family carers. Studies have found that aspirations around personalisation may not extend to family carers as assessment and resource allocation processes tend not tend to recognise carers' roles as co-clients.

Theory 7: Quality

Person-centred and high quality services help people improve their wellbeing. Continuity of care is assured, even if moving to a new locality or if funding arrangements change.

If the logic set out in the programme theories holds, then care markets should lead to quality services which will enhance individual wellbeing. The King's Fund and Nuffield Trust note that a 'central change in the [Care] Act is a shift from defining social care as a set of interventions to the duty to promote wellbeing across a population' (2016, p. 64). Effective market shaping and support for personalisation should deliver quality services which support wellbeing, and should give confidence that services will continue even if there is a move to a new locality or a change in needs.

Rival Framings

Two rival framings are also evident in the literature, which challenge the logic underpinning the theories set out above.

Rival Framing A: Local authorities can't shape the market

Local authorities cannot gather sufficient information about supply or demand and cannot provide the market with sufficient incentives to stimulate adequate, stable and high quality support.

In order to shape the market, local authorities need to have sufficient information about supply and demand factors, and have the tools to be able to influence provider and consumer behaviour. This rival framing questions whether local authorities can gather the necessary information and can influence providers to deliver affordable and good quality care and support, given the conflicting incentives and levers held by different stakeholders. Whilst the importance of market shaping activities reflecting whole care systems has been acknowledged, there are enduring organisational, professional and financial barriers between different parts of the system. It may be that local authorities have a good understanding of the needs of the people who use directly commissioned services. However, as other funding options become more established local authorities are finding it harder to keep track of care choices, or to provide investors with sufficient information about future demand.

With the shelving of the cap on care costs that was to have been introduced as Phase 2 of the Care Act, it is not clear whether or how local authorities are working to identify and support self-funders in their care choices. The limited role of local authority commissioning of services in self-funder dominated localities means that much care provision goes on beyond the scope and sight of the local state. Many of the key influencing factors for care quality, such as a well-trained and stable workforce depend on local economic conditions outside the control of the local authority. The broader financial context of local government in which council staff bases are shrinking makes it harder to embed good market shaping skills and to develop sustained links with providers and other stakeholders.

Rival Framing B: Choice is the wrong goal

People don't want (or can't cope with) choice and diverse funding options. They want adequate, stable and high quality support to be provided or managed for them by the state.

This second rival framing rejects the care market logic entirely, and argues that people want a good local service provided by the state. Choice, in this interpretation, creates stress and uncertainty at a time when people may be facing a particular crisis or the onset of frailty that makes them ill-equipped to exercise choice effectively. Choice, the theory argues, also requires a range of 'positively valued alternatives' as well as a good understanding of the care system (Larkin and Mitchell, 2016, p. 190), neither of which are usually in place in a care context. Older people may encounter care services at a time when choice is particularly hard to exercise. They are more likely than younger people to have a cognitive impairment or to require care services (especially residential care) at a time of crisis. In this rival framing of the issues facing the English care system, innovation and improved quality cannot come from the purchasing choices of active consumers because people using care services lack market power. They don't have the financial resources, information or flexibility to contribute to care market shaping, and therefore it cannot be assumed that giving people choice will lead to more person-centred support.

Outcomes

If the programme theories operate as envisaged by the Care Act and its guidance (contra the rival framings), then it is possible to identify a number of expected **outcomes** within the literature which contribute to system effectiveness as well as to enhanced individual wellbeing.

Key outcomes highlighted in the literature include:

- A market that is vibrant and sustainable.
- Improved individual outcomes for people in the care system.
- Reduction in unmet need.
- Later entry into formal health and care services than is currently the case.

Conclusion and next steps

This realist synthesis draws on the literature to identify and interrogate the programme theories that underpin the assumptions and objectives of market shaping in adult social care, and to explore these as a context-mechanism-outcome formation. It draws 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 service commissioning and provision. The review highlights 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 in public spending; insufficient staffing; weak consumer power; and poor flows of information.

The synthesis of the literature and development of the programme theories has been undertaken to inform and structure ongoing research into market shaping and personalisation. The empirical stages of the project which follow will use these programme theories to examine the mechanisms through which local authorities are undertaking their market shaping activities and the extent to which they are able to achieve the outcomes that the theories propose. Appendix 2 on page 66 sets out the stages that follow in the empirical phases of the research.

1. Introduction

Under the requirements of the Care Act 2014 local authorities in England have a 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 have access to information about what services are available. Those services should be person-centred and of high quality.

This report reviews the literature relating to two specific aspects of the Care Act. The first is the duty placed on local authorities to shape local care markets. The second is 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. Consensus is lacking among stakeholders as to what is meant by market shaping, how to do it well, and what outcomes to expect. Similarly, there is a lack of specificity relating to the principles and implementation of personalisation, although the term is in wide use. In response to the absence of clear definitions of what both market shaping and personalisation encompass, this review of the literature brings together existing research on these topics to develop an understanding of the programme theories which underpin them. Consequently, this review is limited to the development and articulation of programme theories.

The review is part of a broader research project assessing how far local authorities are discharging their legal duties relating to market shaping and are enhancing personalisation, choice and control. It is within this wider remit where the programme theories articulated within this review will be empirically tested. The review questions are informed by adopting a realist approach to highlight contexts, mechanisms and outcomes (Pawson *et al.*, 2005). These questions are:

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

The first section discusses the methods employed for the realist synthesis. The report then goes on to present the findings from the literature, along with a logic model derived from the programme theories which underpin market shaping and personalisation.

2. Methods

Given the conceptual ambiguity of both market shaping and personalisation, the literature review focuses on surfacing the different understandings inherent in the terms and the practices associated with them. A systematic review, requiring a standardised and comparable intervention, was not appropriate for this task. Instead a realist synthesis was undertaken, following the model developed by Pawson *et al.* (2005). A realist approach is described as one that:

> seeks to unpack the mechanism of *how* complex programmes work (or *why* they fail) in particular contexts and settings (Pawson *et al.*, 2005, p. S1:21).

This methodology provides an opportunity to identify the logics that underpin a programme, and sets out the relationship between context, mechanism and outcome (Wong *et al.*, 2013, p.2). A realist review is theory-driven; Pearson *et al.* (2013) state that the primary goal of such an undertaking is:

> to produce a contextualised understanding of the functional mechanisms by which interventions produce different patterns of outcomes (Pearson *et al.*, 2013, p. 18).

The present review was designed to identify the mechanisms that constitute market shaping and personalisation within social care, the underlying contextual factors and what outcomes were likely to be achieved. Often it is the mechanisms which are poorly understood and explained in policy evaluation, leaving unopened the black box through which an intervention results in an outcome (Wong, *et al.*, 2012). Here we understand mechanisms as the processes that may lead to outcomes – the 'how' of complex service interventions (Wong *et al.*, 2013). Contexts are seen as the conditions within which mechanisms operate, including the legal and regulatory setting in which the service is located (Pawson *et al*, 2005). Taken in combination with the mechanisms, contexts can explain 'why' the intervention is expected to achieve particular outcomes (or conversely why it might be expected to fail) (Pawson *et al.*, 2005).

2.1 Phase 1: Background search and articulation of key theories

The aim of phase 1 of the literature review was to establish a working definition of market shaping and personalisation and to identify preliminary programme theories. Within the realist method, the identification and refinement of propositions about how any given programme should achieve its intended outcomes are identified as programme theories, described by Pawson *et al.* (2005, p. S1:26) as:

> the theories, the hunches, the expectations, the rationales and the rationalizations for why the intervention might work.

Following the RAMESES publication standards for realist reviews, initial engagement with the topic area involved informal 'browsing' of the literature as well as external consultation (Wong *et al.*, 2013, p. 7). It was recognised that the breadth of approaches which could be contained within market shaping and personalisation meant that there was likely to be more than one programme theory. An exploratory background search was designed to 'get a feel' for the literature (Pawson *et al.*, 2005, p. 25-8) and to define the scope of the review. This approach to scoping out the concepts follows the method undertaken by Pearson *et al*. (2013). During this stage we drew on very selected literature, our own professional knowledge and discussions with national stakeholders and the Project Reference Group. This is a group representing key interests and expertise in relation to care markets; a list of members is included in Appendix 1. The selected literature sources used during the first phase were the Care Act 2014 (HM Government, 2014); the statutory guidance accompanying the Act (DH, 2017); and reports produced by the Institute of Public Care to support local authority market shaping activities (IPC, 2014a; IPC, 2014c; IPC, 2015a; IPC, 2015b; IPC, 2016a; IPC, 2016b; IPC, 2016c).

Statutory guidance for the Care Act (DH, 2017, section 4.6) defines market shaping as follows:

> Market shaping means the local authority collaborating closely with other relevant partners, including people with care and support needs, carers and families, to encourage and facilitate the whole market in its area for care, support and related services.

Expectations relating to personalisation are also set out in statutory guidance that accompanies the Act (DH, 2017, section 4.46):

> Local authorities should facilitate the personalisation of care and support services, encouraging services (including small, local, specialised and personal assistant services that are highly tailored), to enable people to make meaningful choices and to take control of their support arrangements, regardless of service setting or how their personal budget is managed.

Initial browsing of selected literature allowed the development of an expanded definition of the purpose and scope of market shaping and personalisation, which in turn acted to define the parameters of this review (see table 1 on p.16). In undertaking the review we were mindful that

market shaping and personalisation are not what Wong *et al*. (2012, p. 90) describe as 'intervention-on/intervention-off' types of activity. Rather they encompass a set of practices undertaken by local authorities to secure quality care services, some of which may predate the Care Act itself, and around which it is hard to draw clear boundaries.

Table 1 Working definition of market shaping and personalisation used for screening sources of evidence (derived from Care Act (HM Government, 2014), Care Act statutory guidance (DH, 2017) and IPC (2016c))

	Market shaping	**Personalisation**
Purpose	'[T]o engage with stakeholders to develop understanding of supply and demand and articulate likely trends that reflect people's evolving needs and aspirations, and based on evidence, to signal to the market the types of services needed now and in the future to meet them, encourage innovation, investment and continuous improvement'(DH, 2017, para 4.7).	'Local authorities should facilitate the personalisation of care and support services, encouraging services (including small, local, specialised and personal assistant services that are highly tailored), to enable people to make meaningful choices and to take control of their support arrangements, regardless of service setting or how their personal budget is managed' (DH, 2017a, para 4.46).
Activities	Market intelligence (IPC, 2016c). Market influencing (IPC, 2016c). Co-production with partners (HM Government, 2014). Engaging with providers and local communities (HM Government, 2014). Making available information about the providers of services (HM Government, 2014).	Personal budgets, direct payments and individual service funds (DH, 2017, paras 11.7-11.9). Brokering services (DH, 2017, paras 10.15).
Output examples	Market positioning statements. Joint strategic needs assessments.	Directories of service providers. Care and support plans.
Measures of success	A person wishing to use services should have 'sufficient information to make an informed decision about how to meet the needs in question' (HM Government, 2014, Section 5(1c)). '[A] workforce whose members are able to ensure the delivery of high quality services (because, for example, they have relevant skills and appropriate working conditions' (HM Government, 2014, Section 5(2f)).	'The [care and support] plan must detail the needs to be met and how the needs will be met, and will link back to the outcomes that the adult wishes to achieve in day-to-day life as identified in the assessment process and to the wellbeing principle in the Act' (DH, 2017, para 10.31). 'People should be encouraged to take ownership of their care planning, and be free to choose how their needs are met, whether through local authority or third-party provision, by direct payments, or a combination of the 3 approaches' (DH, 2017, para 12.3).
Outcome (What does good look like?)	'[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' (DH, 2017, para 4.2).	'Care and support should put people in control of their care, with the support that they need to enhance their wellbeing and improve their connections to family, friends and community' (DH, 2017, para 10.1). 'Both the process and the outcomes should be built holistically around people's wishes and feelings, their needs, values and aspirations, irrespective of the extent to which they choose or are able to actively direct the process' (DH, 2017, para 10.5).

Telephone interviews with Project Reference Group members provided further insight into the expert framing of market shaping and personalisation. These interviews also identified the implicit logic model connecting context, mechanisms and outcomes. Together with the initial scoping documents, these fed into the development of a long list of 11 programme theories which were then collated and refined during phase 2, into the 9 theories shown in Box 1 below.

Box 1: Programme theories for Market Shaping and Personalisation

Theory 1 - Market Logic: A diverse set of providers, operating in a quasi-market environment, is the best way to ensure adequate supply of high quality, person-centred care and sustainable services, now and in the future.

Theory 2 – Market Limitations: Local authorities have a legal duty to 'shape' local markets, without which supply may not be adequate, stable or of sufficiently high quality.

Theory 3 – Demand: Local authorities gather information about (existing and future) demand with co-productive input from communities. They share that information with existing and potential providers (across care, health and housing) and provide other forms of support to stimulate appropriate provision (including support for prevention).

Theory 4 – **Supply:** Providers develop diverse, innovative, high quality services, tailored to the profiles of people wanting support (including self-funders). Some of these will span health and care, as these services become more integrated. Some will be informal arrangements with non-regulated providers.

Theory 5 – **Information:** Local authorities ensure citizens (including self-funders) understand what support is available, through the provision of information, advice and advocacy (IAA).

Theory 6 – Personalisation: People who want care and support can exercise choice and control. This is true across people funded in different ways, and accessing different types of support (some of which may not be regulated care services).

Theory 7 – Quality: Person-centred and high quality services help people improve their wellbeing. Continuity of care is assured even if moving to a new locality or if funding arrangements change.

Rival Framing A – **Local authorities can't shape the market** because they cannot gather sufficient information about supply or demand and cannot provide the market with sufficient incentives to stimulate adequate, stable and high quality support.

Rival Framing B – Choice is the wrong goal: People don't want (or can't cope with) choice and diverse funding options. They want adequate, stable and high quality support to be provided or managed for them by the state.

2.2 Phase 2: Developing and 'Testing' Theory

Having identified a working definition and programme theories, phase two required a detailed search of the literature. Initial searches indicated that only a limited number of peer-reviewed empirical studies exist in this area and so the search was widened and included literature reviews, discussion papers, policy documents and other grey literature.

Search terms displayed in Table 2 were developed based on scoping searches of databases, informed by recent reviews of commissioning undertaken by Bovaird *et al.*, 2012; Williams *et al.*, 2012, and particularly the literature review for Commissioning for Better Outcomes (Mangan and Newbigging, 2014) undertaken for the Department of Health, Local Government Association and ADASS.

Table 2: Search terms used

Search 1	Commissioning AND (outcome OR quality of life OR strategic OR coproduction OR adult* OR children* OR local government services OR indicators OR integrated OR joint) AND care
Search 2	Needs assessment AND (strategic OR joint OR holistic OR outcomes) AND care
Search 3	Personalisation OR Personal budgets OR individual service funds
Search 4	Reablement AND (risk OR safe* OR control OR choice OR independ* AND care
Search 5	Procurement AND (strategic OR joint OR holistic OR outcome OR integrated OR adult* OR children* OR local government services) AND care
Search 6	Planning AND (joint OR care OR outcome OR strategic OR service OR user OR patient OR client) AND care
Search 7	(Market shaping OR market management OR market development OR market diversity) AND care
Search 8	Performance AND (commissioning OR strategic) AND care
Search 9	Carers AND commissioning
Search 10	Micro commissioning AND care
Search 11	Care Act

Multiple database searches identified evidence that enabled our theories of market shaping to be confirmed, challenged and modified. Sources included Google and Google Scholar and the following bibliographic databases: HMIC; Medline; Assia; Proquest; EBSCO; Social Care Online; Social Sciences Citation Index; Social Services Abstracts; EMBASE; and the ISI Citation Index.

Web-searching of organisational databases on the above search terms was also conducted including LGA, TLAP, ADASS, Commissioning Academy, SCIE, King's Fund, Nuffield Trust, Institute of Public Care, NIHR, NEF, NESTA and the Department of Health. In addition hand searches of social policy and public administration journals were conducted, alongside citation chasing from the key sources identified early on. All sources were managed using Endnote. Whilst over 10,000 sources were initially identified, this was quickly refined to 197 once duplicates were removed and inclusion/exclusion criteria relating to dates and language of publication were applied (see Box 2 below).

The 197 abstracts were independently screened by two of three reviewers (CN, KH, KA). Material that met the inclusion criteria was included in the review and read in full. Data were then extracted and recorded onto standardised data extraction sheets (see Appendix 3). Following other realist methodologies (Pawson *et al.*, 2005, p. 29; Wong *et al.*, 2013, p. 9) quality appraisal of the abstracts was based on two criteria:

1. relevance – whether it can contribute to theory building and/or testing; and
2. rigour – whether the method used to generate that particular piece of data is credible and trustworthy.

Box 2: Inclusion/Exclusion criteria

Inclusion criteria

- Focus on market shaping
- In English
- Focus on England
- Related to adults social care
- Published since 2004
- Meets the criteria for relevance or rigour

Exclusion criteria

- Does not concern market shaping, care or England
- Published before 2004
- Focuses on children's social care
- Does not meet the criteria for relevance or rigour

2.3 Phase 3: Synthesising the Evidence

In total 64 literature items were included, which are listed in Appendix 4. It is notable that 19 of these are peer-reviewed academic texts and 45 are forms of grey literature. This reflects the relative recency of the language of market shaping and the underdevelopment of academic theorisation about market shaping and personalisation or the development of a logic model. Outcomes are often implicit rather than specified.

Pawson *et al.* (2005) argue that in a realist review the task of synthesis is one of 'refining theor[y]' (p. 24) and 'fine-tuning of the understanding of how the intervention works' (p. 31). Our synthesis was guided by the review questions:

- What are the intended outcomes of care market shaping by local authorities?
- What are the mechanisms by which market shaping by local authorities is believed to achieve those outcomes?
- What are the important contexts which determine whether or not the different mechanisms produce the intended outcomes?

Drawing on the process set out by Wong *et al.* (2013, p. 31), literature was interrogated for its development of programme theory to understand the relationship between the context, mechanism and outcomes. Data synthesis was undertaken by three members of the research team (CN, KH, KA) and results were shared and discussed between the three 'to ensure validity and consistency in the inferences made' (Wong *et al.*, 2013, p. 9). The review was then shared with members of the broader project team (CM, MH, JG) to assess the face validity and comprehensiveness of the points covered. Quality assurance of the review was also undertaken through sharing it with an expert in realist synthesis based at a different academic institution.

The resulting review sets out a logic model for market shaping and personalisation, identifying the context, mechanism and outcomes, and separating out the mechanism into a set of programme theories. The contexts, mechanisms and outcomes embedded in the theories are summarised as a diagram in the logic model on p. 54 of the report. The report also reflects two rival framings (theories A and B) which argue that the logic cannot work as stated. The next section sets out the contextual factors that shape how market shaping and personalisation are likely to work, before going on to set out the programme theories through which a mechanism will link to an outcome. The discussion is based on a synthesis of the literature derived from the search process described above, with a small number of additional sources used when reporting factual data (e.g. Office for National Statistics report on population characteristics) or relevant theories (e.g. Le Grand and Bartlett's 1993 work on quasi-markets).

3. Context

There are a number of contextual factors which recur in the literature relating to care markets and personalisation. These are:

- the distinctive legal and regulatory context of the care sector;
- rising demand for care due to demographic change;
- reduced local authority expenditure on care in the period from 2010-2016;
- workforce shortages in appropriately trained care staff.

These four aspects are considered in turn.

3.1 Legal and regulatory context

Adult social care provision is located within a distinctive legal and regulatory setting. Care services within England are the responsibility of higher tier local authorities, with 152 councils holding social care duties. The Care Act 2014 was the most wide-ranging care legislation since the 1948 National Assistance Act, codifying over 50 years of care policy and guidance. It established individual wellbeing as the underlying principle shaping care services. It introduced national Fair Access to Care criteria to determine eligibility for means-tested state-funded care services, replacing a variety of local eligibility criteria across England. The Act set personal budgets into law for the first time – giving all eligible state-funded individuals a personal funding allocation, which they can take either as a direct payment, as a budget managed by the local authority (managed personal budget) or managed by a third party (Individual Service Fund). Rights for carers were also extended and codified more formally than in the past, including their own right to a personal budget. Local authorities were given the legal duty to shape local care markets. The principles of choice and control were established as key elements of effective care services (DH, 2017).

Alongside this legal context is a regulatory regime, led by the Care Quality Commission (CQC). Through its inspection of registered care services, the CQC designates care providers as outstanding, good, requires improvement or inadequate. The CQC inspects residential and domiciliary care services and some community activities (e.g. day centres for people with learning disabilities). The CQC also has a key role in market shaping, partly through its regulatory role as the inspector of care services which may include the forced closure of poor quality services, but also in the more explicit market oversight regime established by the Care Act (DH, 2017). The CQC now monitors the 'financial health' of care providers which, 'because of

their size, geographic concentration or other factors, would be difficult for one or more local authorities to replace, and therefore where national oversight is required' (DH, 2017, para 5.17).

Other regulatory bodies also have relevance for care markets, such as the Competition and Markets Authority (CMA) and NHS Improvement. In 2016, the CMA announced a market study of care homes to review how well the market works and whether people are treated fairly (CMA, 2017a). The findings from that study are discussed later in this report. NHS Improvement (formerly Monitor) oversees NHS services, and may have an indirect impact on care markets, e.g. hospitals must meet waiting time and financial targets set by NHSI which may require rapid discharge of patients into available care services.

3.2 Rising demand for care services

Demographic change – and particularly the ageing of the population – is recognised to be a significant factor shaping levels of demand within the care system. The CQC's State of Care report for 2017 notes that the number of people aged 85 or over will double over the next two decades (CQC, 2017b). Projections from the Office for National Statistics suggests that 'by 2036, over half of local authorities are projected to have 25 per cent or more of their local population aged 65 and over' and it is also noted that there will be geographic variation in terms of the proportion of the population aged over 65 years old (ONS, 2017, section 2).

These population trends create demand for social care services, as people are living longer with long-term and complex health conditions (NAO, 2016b, p. 5). The King's Fund and Nuffield Trust (2016, p. 6) estimates that by age 65 most people will have at least one long term condition (LTC) and by 75 most people will have at least two LTCs. There are likely to be requirements for substantially more social care provision in the future. For example, the CQC State of Care report 2015/16 (2016, p. 41) estimates a 49 per cent increase in demand for state-funded care home places for older people from 2015 to 2035. The CMA's final report from its market study of care homes notes that, 'As well as increases in the number of care home beds needed, there is also likely to be a shift to people in care homes having more acute needs, which means there is a growing need for care homes that provide nursing care and can accommodate residents with dementia' (2017c, p. 94).

3.3 Reduced local authority expenditure on care

A third contextual factor, widely discussed in the literature, is the reduction in local authority spending on care services. According to analysis by the Institute for Fiscal Studies (IFS, 2017,

p.28) social care spending by councils in England dropped by 11 per cent per adult resident in real terms between 2009/10 and 2015/16. The King's Fund and Nuffield Trust (2016, p. 3) reported that, following six consecutive years of Local Authority cuts, 26 per cent fewer people receive help. In response to the Communities and Local Government Select Committee Report on Social Care which highlighted the depth of cuts to the sector, the Government affirmed that the 'social care sector is a key Government priority' (HM Government, 2017, p. 16). The Government response emphasised that the introduction of the social care precept has given Councils greater flexibility to increase funding to adult social care and that funding had also been increased within the Better Care Fund, in addition to an additional £2 billion provided to Councils in the Spring Budget 2017 (HM Government, 2017, p. 3). Spending on social care did increase in 2017 for the first time since 2009-10, although rising costs such as the national living wage meant there was little increase in the amount of care provided (NHS Digital, 2017).

The literature reflects widespread concerns about the extent to which local authorities are able to satisfy the additional responsibilities and roles embedded in the Care Act at a time of increasingly tight funding. The CMA report concluded, 'Under the current system, public expenditure on LA-funded care services would need to increase substantially to ensure fees are at a level that can sustain adequate capacity, and to care for the increasing numbers of elderly people' (2017c, p100). Slasberg and Beresford (2014) point out the legal paradox facing local authorities: councils are mandated to produce a balanced budget each year, which (given rising demand) is potentially incompatible with the Care Act requirements that all eligible needs must be met. In its 2016 State of Care report, the CQC described the care sector as being at a 'tipping point' in some localities:

> The fragility of the adult social care market… [is] now beginning to impact both on the people who rely on these services and on the performance of secondary care… The combination of a growing and ageing population, people with more long-term conditions, and a challenging economic climate means greater demand on services and more problems for people in accessing care (CQC, 2016, p. 4).

These interlocking challenges facing the care sector will have differential impacts within different local authorities, reflecting varying population profiles (ONS, 2017) and the spending priorities set by councils. Individual councils' expenditure on adult social care is highly variable, with one in ten council areas in 2015-16 spending less than £325 per adult resident, while the same proportion of councils spent more than £445 per adult (IFS, 2017, p. 17). In part this may be indicative of the variety of demand within different areas – for example those with a higher proportion of older people, or with less affluent populations who cannot afford to fund their

own care – although local spending variance can be explained only partially by demographic factors (IFS, 2017).

In considering the financial viability of the care market, it is also important to acknowledge that public expenditure is only one input into the overall care spend in England. It is estimated that around 41 per cent of care home places (CMA, 2017c, p.7), and around 35% of domiciliary care services (LaingBuisson, 2017) are self-funded by private individuals. Public and private funding streams have shown different patterns over the last five years. Whereas the trajectory of local authority funding has been downward, self-funder expenditure has remained stable. Higher fees for self-funding clients have been used by some care home providers to offset and subsidise the lower local authority rates (CMA, 2017c, p. 40). Whilst most homes continue to provide support to both publicly funded and self-funded clients, there is evidence that investment in new care home provision is targeted at self-funders rather than local authority-funded places (CMA, 2017, p. 38).

3.4 Workforce shortages in appropriately trained care staff

Workforce bodies also have a role to play in setting the context of care services. Skills for Care is the workforce sector skills body, which supports the development of the adult social care workforce. Health Education England and Skills for Health also make a contribution to the viability of services, given that nursing homes require qualified nursing staff, a position which can often be hard to recruit (HEE, 2015; Skills for Care, 2016a).

The contextual challenges facing social care are as much about workforce supply as they are about funding and demand (King's Fund and Nuffield Trust, 2017, p. 76). This includes: problems in staff recruitment and retention, underpinned by a culture of low pay, and under-investment in training, and by the reliance in many areas on migrant workers (King's Fund and Nuffield Trust, 2017, p. 76). Skills for Care found 90,000 staff vacancies across adult social care at any one time (2017, p. 32). Projections based on demographic trends observed between 2012 and 2016 suggest that an additional 350,000 care sector jobs are needed by 2030 (Skills for Care, 2017, p. 96). Skills for Care also reported a turnover rate of 28 per cent in the care sector, higher than in non-care sectors (Skills for Care, 2017, p. 32). A King's Fund and Nuffield Trust (2016, p. 78) report found that there is a lack of a coherent strategy to improve workforce capacity.

4. Mechanisms

To understand how market shaping and personalisation are expected to improve outcomes, it is necessary to draw out the programme theories which link the contextual factors set out above to a set of mechanisms and to the planned outcomes. These programme theories are discussed below under three headings:

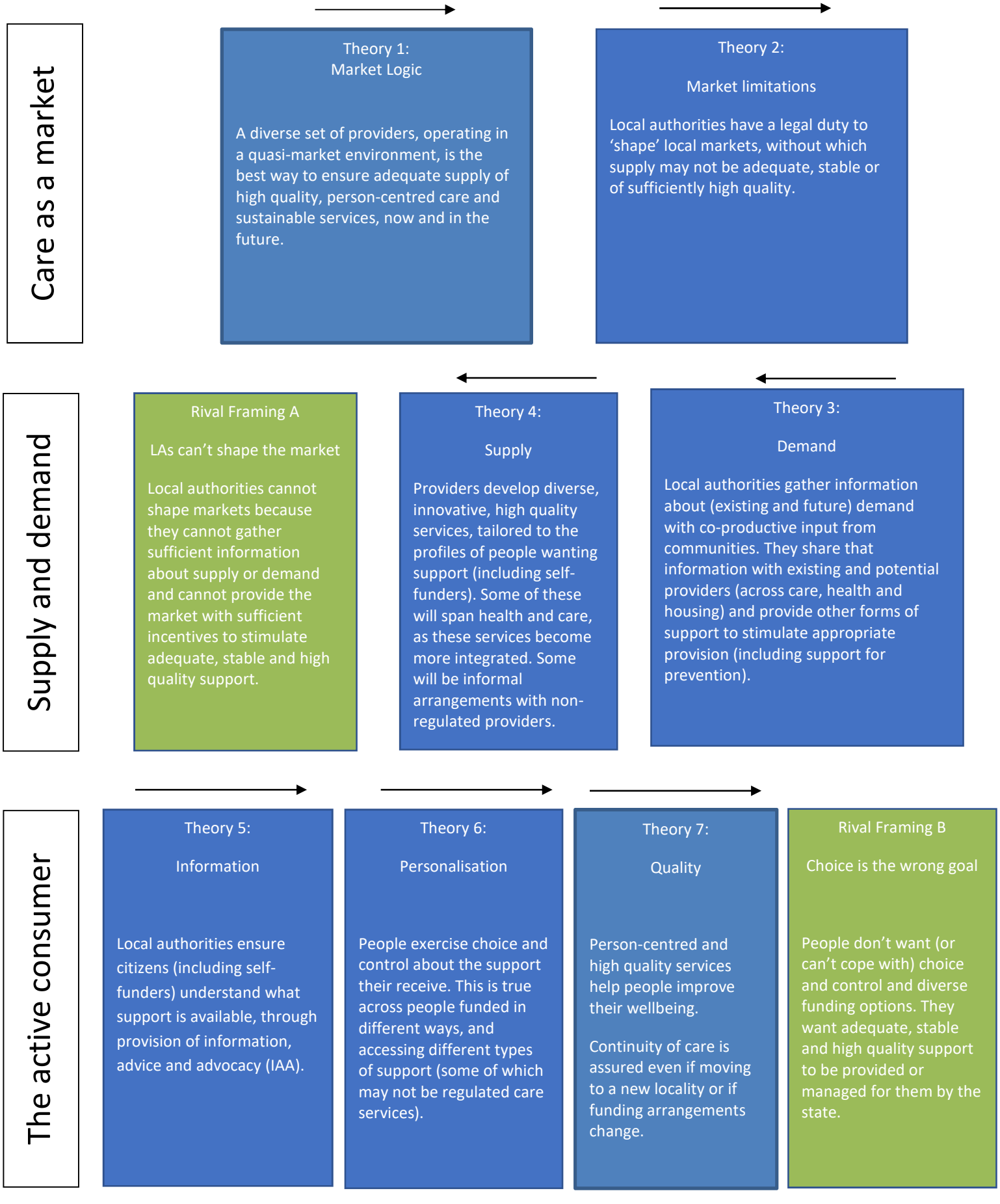
- **Care as a market:** what is the underpinning theory about the operation of quasi-markets in a care setting that supports market shaping and personalisation as intervention mechanisms?

- **Supply and demand:** what are local authorities expected to do to shape care markets and support personalisation and what is the expected response from providers?

- **The active consumer:** what assumptions about the behaviour of individuals and families using care services are embedded within the market shaping logic?

Figure 1 below presents the programme theories as they relate to these three aspects of the care system.

Figure 1: A programme theory map for Market Shaping and Personalisation



4.1 Care as a market

Market shaping and personalisation are located within overarching assumptions about how a quasi-market of care services is supposed to operate.

4.1.1 Market logic

There is a theory, implicit in much of the care policy literature, that a diverse set of providers, operating in a quasi-market environment, leads to an adequate supply of high quality, person-centred care and sustainable services, now and in the future. This is the basis for the reorientation of social care services from the largely in-house provision of services in the 1980s to a largely outsourced model, with 79 per cent of full-time equivalent social care jobs now in the independent sector (Skills for Care 2017, p. 22). Consistent with the broader approach to outsourcing taken by a succession of governments over three decades, it establishes a quasi-market of providers, competing for business from local authorities and self-funders (Le Grand and Bartlett, 1993; Lewis and West, 2014). This is a *quasi*-market in the sense that the state continues to fund a majority of social care services (and to exercise a monopsony purchasing power), and providers are regulated by the CQC (Dearnaley, 2013). The state is a key player as purchaser and/or regulator, and has a residual role as provider in some care settings.

In discussing care markets Dearnaley offers the following general definition of market success:

> [T]o achieve market success it is assumed vital that a company seeks to create the conditions ascribed to competitive advantage, to achieve market prominence. The ultimate aim is to be the supplier or product/service of choice for more customers than its competitors, at a price that generates more profit than the competition, securing sufficient investment in future growth (Dearnaley, 2013, p. 81)

Within a quasi-market, these same measures of success are also broadly applicable. For-profit providers usually seek to grow market-share and profit. Not-for-profit providers have a related goal to generate income to reinvest, although they may be particularly focused on serving a particular community rather than growth per se. A key issue for both sectors is that in a quasi-market it is assumed that their incentives align with the state interest such that there is a win-win: providers maximise their return by providing quality services that the public want to use, at a price that the state or individual citizens are willing to pay. Competition between providers is presumed to create incentives for innovative, personalised and high quality provision. A multiplicity of providers, with low barriers to entry, is seen as both a source of innovation and as ensuring sufficient capacity to ensure consumer choice within the market (TLAP, 2015). This can be stated as theory 1:

Theory 1 - Market Logic

A diverse set of providers, operating in a quasi-market environment, is the best way to ensure an adequate supply of high quality, person-centred care and sustainable services, now and in the future.

As with the evidence base relating to public service markets more generally, the theory cannot be tested, given a lack of consensus on what should be measured and the absence of a counterfactual. A pro-market approach to public service reform by successive UK governments is treated here as an additional contextual factor (in the context, mechanism, outcome configuration) rather than a mechanism which is amenable to testing. This is shown in the logic model on p. 54. The sub-theories which sit underneath this pro-market approach are more conducive to exploration and empirical testing and are discussed in subsequent sections.

4.1.2 Market limitations

It is recognised that markets in care services require careful steering from central and local government if they are to secure adequate, stable and high quality care services. The contextual factors in social care – particularly rising demand at a time of reduced state funding – suggest that the market alone is unlikely to provide the optimum combination of quality, price and coverage. Even within the self-funder segment of the market where supply and demand may be more closely aligned, the nature of care as a 'distress purchase' is recognised to lead to weak consumer power (IPC, 2014a, p. 5; Henwood, 2011; CMA, 2017c; Henwood *et al.*, forthcoming).

A report from IPC (2014a, p. 6) sets out the following characteristics of a stable care market:

> Demand and supply would be roughly in equilibrium…. Price would be at a level to deliver the quality purchasers demand and to secure future investment…Consumers would have good access to information and providers would be readily able to respond to consumer demand…Regulatory or legislative change would be planned well in advance…Entry and exit would occur…without consumers being disadvantaged. Providers are able to access reliable information about the market to plan for the future and make investments.

The IPC analysis goes on to highlight the multiple ways that care markets do not meet these criteria:

> The product is highly differentiated, e.g. due to different services or style of provisions… The market in some parts of its operation splits into two with a higher priced element funded by individuals which in turn subsidises a lower priced state funded

> element…The state is still the biggest purchaser, through Local Authorities, who exert a large influence over the market…Information available to consumers is imperfect and people are often making purchases at short notice and in a hurry... Government regulation is extensive…[P]rivate, not for profit, voluntary and state run providers all 'compete' to provide similar services to similar customers (IPC, 2014a, p. 5-6).

The extent to which such market limitations are prevalent is not consistent across regions or even within localities, highlighting the difficulty of talking about the care market as an undifferentiated whole, when it is actually characterised by multiple markets. Areas with a density of demand (e.g. urban and suburban areas) and with high numbers of self-funders (i.e. relatively affluent areas) are likely to have more of the features identified by IPC as characterising a functioning market than areas that don't have these features. In other words they are likely to have a diversity of providers and organisation types with some spare capacity to facilitate user choice and to give coverage in case of provider failure (DH, 2015). Care markets in areas dominated by self-funders tend to be more stable than those which concentrate on lower fee local authority-funded care users (King's Fund and Nuffield Trust, 2016, p.33-4). In localities where a high percentage of people using social care are self-funders, local authorities may play a limited role within the care market: people who fund their own care have a direct relationship with providers in which the local authority may have little or no involvement (CLG Committee, 2017, p. 30). Such diversity in the quasi-market of care will be reflected within a similar diversity of responses in the pursuit of market shaping and personalisation (mechanisms) and related outcomes.

Given how many factors can inhibit the effective working of the care market, Section 5 of the Care Act 2014 places a duty on local authorities to 'promote the efficient and effective operation of a market in services for meeting care and support needs' (HM Government, 2014, Section 5 (1)). The local authority must ensure that there is a range of different services and providers to choose from; that the market is sustainable; that there will be continuous improvement in quality, and that the workforce is able to deliver high quality services. This gives us theory 2:

Theory 2 – Market Limitations

Local authorities have a legal duty to 'shape' local markets, without which supply may not be adequate, stable or of sufficiently high quality.

Within the duty, the Care Act requires local authorities to move from influencing the care market solely through their commissioning role to a more proactive one where, with providers and people who use services, they should seek to shape, facilitate and support the whole care and support market (including for self-funders) (IPC, 2016c). 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. (DH, 2017, para 4.2).

Although social services departments within local authorities are the main focus of the Care Act, the act and guidance make clear that market shaping is a broad strategic task involving multiple stakeholders. As the IPC *What is Market Shaping?* report notes:

> Social services alone cannot effectively shape the market and it remains the responsibility of the local authority to determine who within the authority should lead on this strategic role. Given the need for cross stakeholder working with health and others, it is preferable that someone at a senior level takes this lead role for ensuring promotion of an efficient and sustainable market. Consideration should also be given as to the role that the Health and Wellbeing Board should play in exercising this duty (2016c, p. 10).

As well as market shaping being a broad task spanning local authority departments and requiring senior local leadership, it is also clear that many other stakeholders play a role in shaping care markets. Locally, provider organisations will shape the market through their choices about what services to provide and which groups of people to target. The local health system will be another key influence on care markets, particularly as the integration agenda gathers momentum. A report on *Place-based Market Shaping* by IPC advocates place-based market shaping in which NHS services, local authority partners and providers collaborate to understand how the actions of one organisation impact on the ability of others to meet need. Consequently, it is noted that care models need to 'extend beyond organisational and service boundaries' (IPC, 2016b, p. 3). Closer working between health and social care is also critical in addressing the recurrent challenge of delayed transfers and care, and the estimated £820m a year spent keeping older patients in hospital who no longer need to be there (NAO, 2016a, p. 7). Delayed transfers reflect workforce and service capacity issues, and ongoing poor coordination and information sharing.

Housing providers are also relevant local stakeholders. The Housing White Paper, launched in early 2017 (Department for Communities and Local Government, 2017), proposes new statutory duties for councils to meet the housing needs of older and disabled people. This includes ensuring that there is sufficient housing stock of the right size and specification that people can remain at home rather than entering residential care sooner than might otherwise be the case. There has been a growth in the provision of housing with care options such as retirement villages and Extra Care housing (Shipley, 2003). LaingBuisson (2016) estimate that 590,000 extra care housing units are needed in the next ten years in order to meet potential demand.

Beyond the local level, national government sets the broad eligibility criteria, the regulatory rules and the financial settlement within which local authorities operate. The Department of Health (DH) has framed this role as one of market 'steward' – as opposed to the market shaping role of the local authority. This role encompasses 'having overall responsibility for the care workforce, overseeing work by bodies such as Skills for Care, Health Education England and the NHS' (House of Commons Committee of Public Accounts, 2016, p. 14). However, the Public Accounts Committee noted, 'it struck us that the "steward" role is poorly defined, and it is not clear who is accountable for failures in local care markets, nor whether the Department has effective levers to change local care markets' (House of Commons Committee of Public Accounts, p. 14).

The multiplicity of stakeholders involved both locally and centrally underlines the legal and regulatory contextual complexity of market shaping. The next section looks at relationships between local authorities and providers within localities to understand the interplay of the mechanism of supply and demand within the market shaping role.

4.2 Supply and demand

Market shaping theory makes assumptions about the role that the local authority will play on the demand side of care services and the ways in which providers will respond on the supply side.

4.2.1 Demand

In a legal context in which local authorities must shape local markets, this theory focuses on the work that local authorities do to understand, plan for and meet demand for services in their area (as well as potentially reducing demand through preventative work). These responses to the wider legal and regulatory context in which the social care market operates constitute a key mechanism within the market shaping duty. They require local authorities to support and

stimulate activity from other partners to ensure that high quality and personalised care services are delivered in sufficient volume. As a result of this shift in context, this role should be broader than the established commissioning role that local authorities have undertaken since it needs also to incorporate planning for the local population needing care and support, encompassing self-funders as well as people who receive public funding.

The Care and Support Statutory Guidance states that, '[t]he core activities of market shaping are... to signal to the market the types of services needed now and in the future..., encourage innovation, investment and continuous improvement...' (DH, 2017, para 4.7). The IPC's analysis of market shaping sets out a range of questions for local authorities to address including:

- Is the range of care and support provision locally appropriate to meet needs and sufficient to meet anticipated demand?
- Who is developing, or wishes to develop, new forms of provision?
- Is the local market able to deploy a workforce that is able to deliver sustainable, high quality care and support?
- Which providers have the potential to diversify or offer a more integrated and/or efficient service? And which local care companies and organisations might be at risk and why? (2016c, p. 4).

Market shaping is therefore about understanding current and emerging demand and also about influencing the supply-side factors that will shape market responsiveness to that demand. This can be expressed as theory 3:

Theory 3 Demand

Local authorities gather information about (existing and future) demand, with co-productive input from communities. They share that information with existing and potential providers (across care, health, housing) and provide other forms of support to stimulate appropriate provision (including support for prevention).

IPC summarises market shaping practices under two headings: *market intelligence* involving activities that 'seek to understand the market', and to build commercial awareness; and *market influencing* 'that seeks to influence the current and future range of care and support services available' (2016c, p. 5). To understand demand, local authorities have to have good *intelligence* about local populations now and in the future. This includes recognising the diversity of demand, including, for example, the numbers of people with a physical disability, a learning

disability, an age-related impairment or people with mental health needs, all of whom will engage with different aspects of the care market. Local authorities also need to understand the different types of care and support that may be required – including residential, domiciliary and day activities, but also universal and open access services and other forms of community support which may not always be the responsibility of regulated care providers.

Local authority commissioners are encouraged to work with providers and local people through strong engagement and co-production (TLAP *et al.*, 2015, p. 10). This partnership work involves gathering information about demand, but also working closely with providers and other stakeholders to share information about demand. A key tool to fulfil this is the Market Position Statement which summarises supply and demand in a local authority area and forms the basis for strategic commissioning and can also be used by providers to inform forward planning (IPC, 2016c). As discussed above, a diverse social care market also sits within a wider local economy of other services under local authority responsibility including housing and transport (TLAP *et al.,* 2015). The local Joint Strategic Needs Assessment (JSNA) is therefore a key document through which to map and plan for need across a range of services and local Health and Wellbeing Strategies should also form a common focus for organisations across a locality (DH, 2017).

Demand also needs to be understood in relation to the spectrum of models of paying for services e.g. as self-funders, local authority funded and managed, direct payment holders or Individual Service Fund (ISF) recipient. For self-funders, people with direct payments and ISFs, the state is not the purchaser of care, but needs to ensure that people have access to the services and support they want to buy, including personal assistants (IPC, 2016a). Where care is publicly funded, the state also has a role to approve individual spending choices, such that they will contribute to an agreed care outcome.

Local authorities have a range of tools for market *influencing* (IPC, 2016c), focused around building relationships; focusing on outcomes; and managing demand. Building strong relationships with providers and other relevant stakeholders (such as advocacy groups) will be a key part of an effective influencing strategy (CLG Committee, 2017, p. 29). The 'soft' tools of influencing will become increasingly important as more people commission their own care:

> The purchasing power of the local authority to negotiate on price, quality and level of service is likely to be reduced. Transaction costs may increase as a result of the growing number of people purchasing their own care (IPC 2016a, p. 12).

In their approach to building relationships with providers, it is clear that local authorities are deploying a range of strategies. The National Audit Office (NAO) notes that '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' (NAO, 2016b, p. 9). At the other extreme: '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, 2016b, p. 43).

Where the local authority retains a role as a commissioner of services, there has been a growing interest in how to move towards outcome-based commissioning in place of time and task-based contracts:

> Moving to an outcomes-based approach therefore means changing the way services are bought: from units of provision to meet a specified need (for example, hours of care provided) to what is required to ensure specified measurable outcomes for people are met. The approach should emphasise prevention, enablement, ways of reducing loneliness and social isolation and promotion of independence as ways of achieving and exceeding desired outcomes, as well as choice in how people's needs are met (DH, 2017, para 4.16).

However a review of emerging practice in outcomes-based commissioning in social care (Bolton, 2015) cited by the NAO found that:

> while the approach has potential, it requires major changes in order to be done well. Furthermore, the measurement of outcomes is challenging. There are limited studies to date exploring the impacts of outcomes-based commissioning (NAO, 2016, p. 41).

Whilst some local authorities are experimenting with giving providers the relative freedoms promised by outcomes-based commissioning, others are retaining tighter control of contract specifications and this demonstrates differences in local authorities' response to the wider financial context. The difficult financial context has led some local authorities to refocus their commissioning 'on a 'task and time' basis' resulting in short visits and also a 'lack of continuity of care' (Lewis and West, 2014, p. 5). The CLG Committee inquiry on adult social care argued that rather than focusing on outcomes, 'the system had become focused on 'functionality', or washing and dressing, with no regard to combatting isolation and loneliness' (CLG Committee, 2017, p. 14). Such commissioning models run counter to the Care Act and the articulation of personalised care and support in the Care and Support Statutory Guidance (2017, para 4.16).

These discussions draw attention to local authorities' broad market shaping roles – e.g. market intelligence-gathering and market-influencing – and the range of activities which these encompass. It is important also to acknowledge that market shaping can happen by omission as well as by commission, being an unintended consequence rather than a deliberate intervention. 'Inadvertent market shaping' by individual local authorities e.g. cuts to a bus route used by a care workforce or changes in the available public housing stock will impact on the shape and sustainability of the care market (IPC, 2016c, p. 6).

4.2.2 Supply

Effective market shaping assumes that care providers will respond to the demands and preferences of a range of purchasers and commissioners, whether those are local authorities, people using direct payments or Individual Service Funds (ISFs), or people paying for their own care and support. How they do this will depend on the demand-side activities of the local authority, discussed above, but also on the ways in which providers develop supply-side options. There are over 20,000 registered social care providers in England, offering residential and nursing homes, domiciliary care and community care (Skills for Care, 2017). These are predominantly for-profit providers, although with a substantial minority of not-for-profit provision and a small residuum of state providers.

Providers vary in the quality of the service on offer. The CQC's State of Care report 2016/17 (2017b) reported that 19 per cent of adult social care services require improvement, whilst between 1 and 3 per cent are inadequate. Size of provider also varies widely. The care market continues to be dominated by small to medium services operating in a limited geographical area, but larger national providers are gathering increased market share. The 10 largest providers now hold a market share of 19 per cent, and there has been a growth in the development of care chains, some of which may trade under different brands to appeal to different sectors of the market (LaingBuisson, 2017). At the intersection of care and quality, the CQC has raised concerns about the quality of some large-scale care (CQC, 2017a). However whilst smaller providers tend to perform better, they are particularly susceptible to closures accounting for 59 per cent of closures despite making up only 43 per cent of the market (CQC, 2016, p. 63).

Alongside these registered providers are a wide range of local community groups, social enterprises and small firms providing support to people with a care need but falling outside the formal regulated sector. These might include befriending services and other social activities,

leisure and craft opportunities. The individualisation of care budgets within the personalisation agenda was designed to encourage people to exercise choice and control through looking beyond 'service land' into other opportunities to enhance their wellbeing (TLAP, n.d.). Together these supply-side activities can be expressed as theory 4:

Theory 4 Supply:

Providers develop diverse, innovative, high quality services, tailored to the profiles of people wanting support (including self-funders). Some of these will span health and care, as these services become more integrated. Some will be informal arrangements with non-regulated providers.

This theory requires that providers are able to easily enter the market in order to respond to demand and to drive innovation. New care providers may find it relatively easy to enter the care market, as long as they can meet the requirements set by local authorities and external regulators (CMA, 2017c). Finding an appropriate site can be a slow process for providers of residential care (IPC, 2015a, p. 5). Once operating, care providers have to sustain demand for their services, working closely with local authority commissioners for framework contracts and/or marketing their services to individual purchasers (either self-funders or direct payment holders) (IPC, 2016a). Providers therefore need to have a good understanding of aggregate demand in their locality which will affect the sustainability of the market. There are also broad policy trends that shape demand for particular services. For example, national policy aimed at supporting people to remain independent for as long as possible, has led to people being admitted to permanent residential care at a higher level of frailty than in the past and having a shorter period of residency before death (CMA, 2017). These trends can reduce occupancy rates and increase costs (Davies and Drake, 2007). Changes to housing policy, such as reforms to the Supported Housing scheme, can alter the viability of housing provision and incentivise or discourage new housing investment. National policies in relation to the workforce – such as minimum wage rates and training requirements – also change the extent to which the market is a conducive environment for providers (Skills for Care, 2017).

Providers need to be able to charge sufficient fees for their services to cover operating costs and also to service any capital costs (buildings in the case of care homes) and to have revenue to reinvest back in the service and/or provide a profit to shareholders. There has been extensive debate about whether the fees that local authorities pay for care are enough to enable providers to meet these resourcing needs. The 2017 CMA inquiry into care homes was driven in part by

widespread concerns that high fees for self-funders were cross-subsidising inadequate fees from local authorities for publicly funded residents. Indeed their final report did find that this was the case: 'on average a self-funding resident is paying over £12,000 a year more than an LA to have a place in the same care home' (CMA, 2017c, p. 40). The CMA noted that such practices were occurring despite the fact that, '[a]lmost all providers we asked submitted that the costs to serve local authority and self-funded residents does not significantly differ within a home' (2017b, p. 21).

Concerns have also been expressed that low local authority rates are being passed on to care staff, such that there is underpayment of the minimum wage (e.g. through not paying travel time), inadequate National Insurance and pension contributions and training provision (IPC, 2015b). Such practices can further intensify the workforce shortages discussed above. An IPC report (2014a) cited employment factors as the biggest threat to market stability, and this can often lie outside of the direct control of providers and the local authority, such as the introduction of the National Living Wage.

The CMA report on care homes undertook detailed assessment of profitability and concluded that:

> primarily LA-funded care homes, in aggregate, have covered their operating, but not total costs. This suggests that while these care homes may continue to operate in the short term, they may not be able to undertake future investments in order to: update their existing capacity when required; prevent closure; or increase their capacity towards LA funded residents (2017c, p.78).

The report identified a £0.9-1.1 billion gap between local authority fees and the total costs for LA-funded residents (2017c, p.69). In the domiciliary care sector, United Kingdom Homecare Association (UKHCA) estimated the minimum sustainable price for home care at £17.19 an hour (UKHCA, 2017), which is substantially higher than the local authority average price.

What is clear however is that profit levels within the sector are a highly contentious issue. Reflecting on the 'fair price for care' figure promoted by UKHCA, a report from the Centre for Research on Socio-Cultural Change (Burns *et al.* 2016) argued that this builds in a 12 per cent return on investment – beyond what would be expected in other sectors, and is driven by the need to service high debt levels and private equity investors rather than to support further innovation and investment. Modelling by the CMA used a rate of return of 6.5% (2017c, p. 58). The Communities and Local Government Committee report into adult social care draws attention to the lack of consensus between local authorities and providers about what level of

profit is acceptable (2017, p. 26). The report's recommendation that councils should take account of the need for providers to make a profit in order to invest in the workforce and capital assets and to attract new entrants to the market, fails to settle the moot question of how much profit is *enough* (2017, p. 76). Open-book accounting approaches (IPC, 2014b) have been suggested as one way to improve trust and accountability between local authorities and providers.

There has been concern within the social care sector about declining supply as providers succumb to financial and workforce pressures and hand back contracts for publicly funded clients. ADASS' 2016 budget survey (2016a) reported that in 77 local authorities at least one care home provider had ceased trading in the previous six months, with 48 local authorities reporting that a home care provider had ceased trading. Risk is especially prominent where quality is low or where there are higher levels of competition (Allan and Forder, 2015, p. 143-4). The CMA interim report noted that 'highly-geared providers [especially those owned by private equity funds] also have significant exposure to local authority funded residents.' (2017b, p. 7).

In a context of highly constrained public spending on care, Davies and Drake (2007) suggest that care providers have two options to increase financial viability: one is to increase economies of scale through consolidation in the marketplace, or alternatively to seek efficiency improvements through technology-based improvements. However both of these solutions require an investment of time and money which many care providers may not have. In a briefing paper on intervening in the care market, the IPC points out that most social care services are delivered by small providers who have little capacity for business planning or strategic thinking, as meeting regulatory requirements and managing day to day business takes all of their time (IPC, 2014c). Similarly, innovation may be stifled by independent providers having few incentives to take risks, as they have limited capacity to raise capital needed to innovate (IPC, 2014c). The low-fee, low-pay nature of the sector may also discourage diversity within the sector, since there is limited incentive or financial capacity to innovate. Small new providers who wish to target 'non-traditional communities may also be discouraged from entering the market (Needham and Carr, 2015). Much of the recent sector growth has been within large care providers, where CQC have noted concerns about impaired quality at scale (CQC, 2017a).

4.2.3 Rival Framing: Local authorities can't shape the market:

In order to shape the market, local authorities need to have sufficient information both about supply and demand factors, and have the tools to be able to influence provider and consumer

behaviour. There is a rival theory in some of the care literature which hypothesises that councils do not have and indeed cannot effectively get adequate information and understanding about care service users, both in terms of their numbers and characteristics, but also their needs and preferences. Without such understanding the ability of councils to shape the market appropriately will be very limited. This theory also questions whether local authorities can influence providers to deliver affordable and good quality care and support, given the conflicting incentives held by different stakeholders. It challenges the notion of win-wins that underpins the marketization of public services. These challenges can be expressed as Rival Framing A:

Rival Framing A: Local authorities can't shape the market:

Local authorities cannot shape markets because they cannot gather sufficient information about supply or demand and cannot provide the market with sufficient incentives to stimulate adequate, stable and high quality support.

Central to this rival framing is a challenge to the assumption that key stakeholders can work effectively together as required in pursuit of market shaping. Whilst the importance of market shaping activities reflecting whole care systems has been acknowledged, there are enduring organisational, professional and financial barriers between different parts of the system (NAO, 2017, p. 46-7). Providers and local authorities can have conflicting views about what constitutes an acceptable level of profit, as discussed above (e.g. CLG, 2017, p. 26). Central and local government have clashed about whether enough money is coming into the public care system (HM Government, 2017). Local authorities and health system leads have disagreed about whether delayed transfers of care are the fault of the NHS or of the social care systems (e.g CLG, 2017, p. 20).

In undertaking market information gathering, it may be that local authorities have a good understanding of the needs of the people who use directly commissioned services. However as other funding options become more established – direct payments and Individual Service Funds – local authorities are finding it harder to keep track of care choices or to be proactive around shaping markets (IPC, 2016a). Some care services will be commissioned directly by Clinical Commissioning Groups and NHS Trusts (NHS England, 2017). Information on self-funders is also particularly difficult to access given that many people purchasing care make no contact

with the local council at all. The NAO (2011) found that 60 per cent of local authorities did not know how many self-funders there were in their area (DH, 2015).

The Care Act was expected to stimulate greater local authority awareness of, and engagement with, self-funders, since the proposed cap on care costs required local authorities to monitor what self-funders were spending. However with the shelving of the care cap proposal, it is not clear whether or how local authorities are working to identify and support self-funders in their care choices (IPC, 2016a). It is also important to acknowledge that the boundary between publicly funded care recipients and self-funders is not as rigid as is often assumed. Some people begin their care journey as self-funders and then run out of money – this was the case with a quarter of self-funders entering residential care according to an LGiU (2011) report (cited by IPC 2015c). Many people who are publicly funded 'top up' their fees from their own or family resources. This complexity makes it more difficult to understand the shifting pattern of local population needs.

There is also likely to be uncertainty about levels of unmet need within localities. The cuts to state funded care services have led to an increase in the numbers of people who fail to meet eligibility criteria, despite having some difficulties with the tasks of daily living (CLG Committee, 2017, p. 12). The King's Fund and Nuffield Trust (2016, p. 72) observes that no one has a full picture of how the people no longer eligible for state-funded care are coping. The CQC State of Care report (2017b, p. 8) estimates that 1.2 million people are not receiving the care they need – an increase of 18 per cent on the previous year. The CLG Select Committee cites evidence from ADASS that only 34 per cent of councils have monitoring arrangements in place to identify unmet need in their area (2017, p. 15; ADASS, 2016b).

The difficulties of gathering information about the demand for care services may be accompanied by a lack of incentives or levers to shape provider behaviours. The limited role of local authority commissioning of services in self-funder dominated localities means that much care provision goes on beyond the scope of the local state (IPC, 2016c). Many of the key influencing factors for care quality, such as a well-trained and stable workforce depend on local economic conditions beyond the scope of the local authority (Skills for Care, 2017).

The problems councils face in relation to market shaping stem in part from the broader financial context of local government in which council staff bases are shrinking and they have reduced capacity to operate beyond basic statutory roles (Burns et al., 2016). The Communities and Local Government Committee Select Committee report notes that 'the churn in council staff has made it difficult to maintain provider-commissioner relationships' (2017, p. 32). Hudson argues

that the lack of in-house capacity for market shaping results from decades of outsourcing which 'tends to rid governments of the knowledge, capacities and capabilities that are necessary for managing change' (2014, p. 288). The CMA also noted a potential lack of skills and capability with local authorities to undertake the planning and forecasting work needed for future sustainability (2017c, p.94).

Commissioning practices in general and Market Position Statements in particular have been recognised to be of highly variable quality (CLG Committee, 2017, p. 30; CMA, 2017c, pp88-90). The CMA report concluded: 'many of these documents lack the kind of evidence and insight that would be useful in helping the private sector determine appropriate investment' (2017c,. p.90). The lack of cooperation between neighbouring local authorities was also a concern, making it difficult to 'optimise capacity across their areas' (CMA, 2017c, p.90). The report also drew attention to differences between local authorities in their capability to deal with the complexity of forecasting future needs and identifying the best way to meet those needs, calling for more coordinated support and advice (CMA, 2017c, p99).

Reflecting on deficiencies in local authority market shaping practices, the CMA concluded that there was no need to amend the existing statutory duties, but rather than councils needed to be supported to discharge them more effectively. It recommended that an independent body be given oversight of the planning and commissioning of care services, to support more effective market shaping practices (2017c, p.109). Further, it suggested that the CQC would be best placed to undertake this role.

In calling for more support and oversight of commissioning practices, the CMA is in line with proposals from the CLG Select Committee (2017, p. 70), provider groups (e.g. UKHCA, 2017) and trade unions (CLG Committee, 2017, p. 36). The role proposed by the CMA may be seen as a revival of the work formerly undertaken by CSCI, the Commission for Social Care Inspection, which had a responsibility for inspecting social care departments, a power which was removed soon after the creation of CQC in 2009 (Dunning, 2010). During 2017 the CQC did review the functioning of some local systems at the health and care boundary in response to concerns about delayed transfers from hospital – arguably an example of moving back into the role of overseeing commissioning as well as provision (HM Government, 2017, p. 8-9). The complexity of the mediation between demand and supply indicates how local authorities can be constrained in the attempt to shape the market, as noted in the rival framing.

4.3 The Active Consumer

The market shaping mechanism makes assumptions about people using services (and their family carers), and the role that they are expected to play if market shaping is to deliver its expected outcomes. The Care Act guidance states that one of the core activities of market shaping includes 'working to ensure that those who purchase their own services are empowered to be effective consumers' (DH, 2017, para 4.7).

4.3.1 Information

The requirements of the Care Act around the provision of Information, Advice and Advocacy (IAA) are potentially one of the most wide-ranging reforms of the legislation. Section 4 of the Act requires a local authority to 'establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers' (HM Government, 2014, para 4.1). This service is to be available to all people in the local authority's area, regardless of whether they have needs for care and support, or whether their needs meet eligibility criteria. Local people are to be given information about the system and how it operates in the area; about the choice and types of care and support, choice of providers, how to access care and support; and independent financial advice. As the explanatory notes to the Care Act explain, this includes the local authority ensuring that people understand how and where to get financial information and advice on the range of financial options available (DH, 2017).

Information, advice and guidance services shape the market by both setting out the options available and (ideally) the quality of care provided, thus sustaining (or increasing) demand for some services and reducing demand for others (IPC, 2016a). The provision of timely, reliable and accurate information on providers and quality is critical to enable users to make effective choices that meet their needs. The IPC (2014c, p. 6) highlight that there is a need to ensure 'good quality, jargon free information is available about which providers provide what services, to whom, and at what cost'. Provision of such information is the basis for theory 5:

Theory 5 Information:

Local authorities ensure citizens (including self-funders) understand what support is available, through the provision of information, advice and advocacy (IAA).

As part of its review of care markets, the CMA commissioned Ipsos MORI to undertake qualitative research to explore peoples' experience of navigating the care home sector (Ipsos

MORI, 2017). A key theme to emerge from this research was the difficulty accessing information faced by individuals and families planning a move into a care home, consistent with the findings of earlier literature (Henwood, 2011). In particular, it was noted that a decision often needed to be made quickly which inhibited full engagement with available information. A theme frequently mentioned was the perception of a lack of choice of provision and a sense of disempowerment within the decision-making process. People tended to place most weight on their experience of visiting a care home rather than on other sources of information, such as quality reports (Ipsos MORI, 2017, p. 8). An earlier study found that older people are most likely to seek information on care services from 'friends or neighbours that were already employing carers and support agencies' (Rodrigues and Glendinning, 2015). Younger people are more likely to access information online (Turnpenny and Beadle-Brown, 2015). Some local authorities operate e-marketplaces and these have been found to deliver improved outcomes for service users, better management of demand, better interactions with council services and potential cost efficiencies (DH, 2017). However the extent to which people are able to make good use of available information, particularly if making a choice at a time of crisis, is limited, a point returned to in the rival framing section below.

4.3.2 Personalisation

The aspiration to deliver choice and control to people using services through person-centred forms of support has been a formal ambition of English care services since the 2007 Putting People First Concordat (HM Government, 2007). Choice and control over aspects of daily life are typically referred to in the social care discourse by the shorthand of 'personalisation'. Personalisation is a 'way of working that respects and tailors services to the uniqueness of the individual' and emphasises the importance of person centred working and co-ordination of services (Gridley *et al.*, 2014, p. 592). This also includes continuity in care such as having the same worker or team delivering support over time (Gridley *et al.*, 2014, p. 593). Statutory guidance on the Care Act similarly describes the approach as looking 'at a person's life holistically, considering their needs in the context of their skills, ambitions and priorities (…) The focus should be on supporting people to live as independently as possible for as long as possible' (DH, 2017, para 1.15).

The link between personalisation and market shaping is made clear in the Care Act guidance: 'High quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers' (HM Government, 2014, para 4.1). Personalisation is closely linked to the previous section of this review, assuming that access to IAA will enable people not only to know and understand what provision is available and how to access it, but to

do so in ways that help them to make choices and have control over the quality and nature of such support. This gives us theory 6:

Theory 6 Personalisation:

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).

To embed the personalisation of care services into the legal framework for adult social care, the Care Act uses the mechanism of individualised funding, requiring local authorities to give all eligible users – including carers – a personal budget (HM Government, 2014). Personal budgets were developed over a decade ago, as an umbrella category for a range of individualised funding mechanisms within a care setting. An estimated 500,000 people in 2014/15 received a personal budget, with an average of 22% of those receiving a direct payment (NAO, 2016b). However the PAC report on Personalised Commissioning expressed scepticism about the reliability of these figures, drawing on DH witnesses to their inquiry:

> the Department does not believe that everyone counted by local authorities as having a personal budget does actually have genuine choice and control over the services they receive. In particular, it considers that some local authority areas who reported that 100 per cent users had personal budgets in 2014–15 may be over-stating the position; being less rigorous than other areas in the definition they use of what constitutes a personal budget (2016, p. 5).

NAO research found variations in the level of support received with Personal Budgets leading to 'regional differences in the purchasing power of individuals' (DH, 2015, p. 14; NAO, 2011).

Take up of direct payments has historically been higher among young people with disabilities than among older people or people with mental health support needs, and there has been much discussion of how more people can come to experience the benefits of individualised funding (NAO, 2016b). A study by Rodrigues and Glendinning (2015) found that older people using direct payments reported improvements in satisfaction, flexibility and control over a care schedule, greater care worker punctuality and more responsiveness to changing circumstances and preferences. The authors also note that these respondents had often taken direct payments 'because of previous unsatisfactory experiences with local authority commissioned home-care

including getting the services they wanted', a lack of continuity in service provision or delays in receiving care (2015, p. 659).

Research around personal budgets and outcomes indicates mixed findings to date (Glendinning *et al.*, 2015; Davidson *et al.*, 2012; Think Local Act Personal, 2014b, p. 2). It is direct payments in particular, rather than personal budgets in general, where there is strongest evidence of improved outcomes (Slasberg and Beresford, 2016). Data from the POET evaluation run by In Control gives the most comprehensive data about the link between personal budgets and care outcomes, and again underlines the conclusion that it is people with direct payments who report the best outcomes (In Control *et al*., 2017). Reflecting on what it known in relation to personal budgets and outcomes, the PAC report on Personalised Commissioning also noted that there remains uncertainly within government about *how* personal budgets improve outcomes (2016, p. 11).

TLAP's Personalisation Action Plan (2014b) argues that whilst outcomes can be better for many people using direct payments, the process can involve delays, restrictions, disproportionate bureaucracy and confusion. The IPC note that the effectiveness of all forms of personal budget depend on there being something to buy beyond the standards set of state services: '[o]ffering people the same services with different methods of payment is not personalisation' (2016a, p. 2). This point is echoed in the NAO (2017) report on *Personalised Commissioning* and also by TLAP:

> the reality of increased choice and control is often different from the rhetoric, where local care markets often offer more of the same, and there are limited examples of people and communities being involved in strategic commissioning decisions…[M]ore work is needed to ensure all those working in the sector understand that the goals of personalisation are independence, wellbeing and community resilience, and the huge cultural shift still needed if these goals are to be realised (TLAP, 2014b, p. 6).

An *In Control* (2007) report on the use of pre-payment cards highlighted the ways in which such cards can constrain the very innovation that personal budgets were designed to unleash.

Other analysis found that outcomes for direct payment holders tend to be better if they are used to purchase personal assistant (PA) support rather than purchase a standard service from a care provider (Rodrigues and Glendinning, 2015). Strong arguments have been advanced, particular by people who use services, that direct payment holders be able to use their budgets flexibly and with any provider including those not registered with CQC such as PAs (IPC, 2016a).

However support in using PAs may be needed as there is some evidence that this can be an onerous responsibility. Some PAs feel that disabled people are not good employers as they are not trained to understand the complexities of employment law (Graham, 2015).

There is growing evidence of the positive impact of individual service funds (ISF) to deliver more flexible support. These are arrangements where the service provider works with the person using services to provide flexible support. This can provide a middle way for people who want greater flexibility and control but does not want the responsibility of managing a direct payment (TLAP, 2014a). However, TLAP report that there is 'limited progress in people being offered the ISF option and it is poorly understood by service users, families, service providers and councils' (2014a, p. 4). Many providers are not currently contracted with councils in ways that allow them to use ISFs and indeed only 1 per cent of council spending is organised using ISFs (ADASS, 2014 cited in TLAP 2014a, p. 44). More flexible contracting arrangements are therefore likely to be required to realise the ambitions of personalisation.

It is important to note that individualised funding mechanisms are not the only factor to consider in supporting personalised care. The CQC uses person-centred care as one of its measures of quality, and that can include the consistency and attentiveness of staff rather than control over funding. In its *State of Care 2017* report the CQC commented that:

> A clear focus on person-centred care was another key theme that shone through in high quality services. In these services, staff were supported to really get to know people as people, understanding their interests, likes and dislikes (2017, p. 53).

The importance of a stable and well-trained workforce, as well as the sufficiency of the support provided may make personalisation difficult to deliver at a time of workforce shortages. The PAC report on personal budgets in social care stated:

> We are not assured that local authorities can fully personalise care while seeking to save money and are concerned that users' outcomes will be adversely affected. Local authorities face a substantial challenge supporting sustainable local care markets which offer the diverse range of provision needed for users to personalise their care, while care providers are struggling to recruit and retain appropriately qualified staff as financial pressures increase (2016, p. 3).

The 2014 Care Act also extended the eligibility for personal budges to family carers. However studies have found that aspirations around personalisation may not extend to family carers as assessment and resource allocation does not tend to recognise carers roles as co-clients

(Glendinning *et al.*, 2015). Choice for carers can be particularly complex as their decisions have implications for service users and providers. A meaningful choice for carers may include the choice to cease to be a primary carer, which would have profound consequences on the demand and need for formal support. Carers have also reported that they do not have enough information to make informed choices (Larkin and Mitchell, 2016).

4.3.3 Rival Framing: People don't want choice

Whilst the discussion above highlights concerns that aspects of personalisation, choice and control are not necessarily working as planned at this stage of implementation, there is a further critique of personalised approaches which rejects the care market logic entirely, and argues that people want a good local service provided by the state. Choice, in this interpretation, creates stress and uncertainty at a time when people may be facing a particular crisis or the onset of frailty that makes them ill-equipped to exercise choice effectively (Lewis and West, 2014). This gives us Rival Framing B.

Rival Framing B: People don't want choice:

People don't want (or can't cope with) choice and diverse funding options. They want adequate, stable and high quality support to be provided or managed for them by the state

Larkin and Mitchell (2016) argue that choice can be both positive or negative. Whilst it can be related to independence, wellbeing, principles of citizenship and better quality services, it can also lead to anxiety and stress (2016, p. 190). Choice, they argue, also requires a range of 'positively valued alternatives' (Larkin and Mitchell, 2016, p. 190) as well as a good understanding of the care system. Some user groups are more likely to have a poor understanding of the care system in the first place – for example due to a 'lack of information, language barriers, and migration from countries without welfare states', and so are less able to achieve control over their care (Willis *et al.*, 2016: 1379). Research by Burchardt *et al*. (2015) highlighted that choice policies can fail to address deep seated inequalities in the opportunities people have for autonomy. Policies to support active decision making and interventions to tackle underlying inequalities of health, wealth and locality are therefore a prerequisite for effective choice in a care setting (Burchardt *et al.*, 2015).

Older people may encounter care services at a time when choice is particularly hard to exercise. They are more likely than younger people to have a cognitive impairment or to require care

services (especially residential care) at a time of crisis. There is also evidence that older service users 'prioritise the way a service is delivered' (Lewis and West, 2014, p. 8), or where it is based, over choice of provider. Furthermore, older people are less likely to want to recruit an unknown person as a PA and may prefer to use a direct payment to purchase care from a registered service provider (Rodrigues and Glendinning, 2015).

The CMA report, discussed elsewhere in this report, has highlighted the need for people to get 'good quality, relevant and timely support when they are making life-changing decisions about care' (CMA, 2017a, p. 147). However the consumer data on the difficulties people have in using information for a rushed and stressful purchase may limit the scope to which this is an issue that can be solved by a more information rich environment. Choice can be hindered by an excess of information: '[t]he amount of information available online can be overwhelming and hinder decision making' (Turnpenny and Beadle-Brown, 2015, p. 356). Directories of services may not make clear which ones have vacancies, further complicating the choice process: the CMA final report notes that, with care home occupancy rates at 90 percent to sustain profitability, there is not the slack capacity in the system to facilitate choice (CMA, 2017c, p. 34).

Users can find it difficult to judge care home quality until they are resident, and family members will tend to judge quality on the basis of the appearance of front of house facilities (Ipsos MORI, 2017). Lack of adequate information on alternative providers, or practical difficulties in making a move, are likely to mean that people remain in a care home once they have chosen it even if they are dissatisfied (Dearnaley, 2013, Lewis and West, 2014). The CMA's consumer research by Ipsos MORI found that, when making an initial choice of home, it was often felt that there was the potential to change home if a more appropriate option became available, however, frequently, this 'became less realistic once the resident was settled', and residents and their representatives felt that alternative homes were likely to be of a similar, or worse, quality and that there was little appetite to go through the upheaval that moving home would entail (Ipsos MORI, 2017, 9).

If one of the goals of market shaping is adequacy of supply and stability of providers, then the extension of choice to a multiplicity of individual care recipients may inhibit effective market shaping. The CMA report points out that block contracts rather than spot contracts 'can be a more effective means for LAs to secure required investment in care home capacity because they…reduce provider exposure to uncertainty around future demand…' (2017b, p.45).

In this rival framing of the issues facing the English care system, innovation and improved quality cannot come from the purchasing choices of active consumers because people using care services lack market power. They don't have the financial resources, information or flexibility to contribute to care market shaping and therefore giving people choice will not lead to more control (Slasberg and Beresford, 2014). The fragmentation that comes from more individualised commissioning may indeed be antithetical to the goals of market shaping, rather than assuming that market shaping and personalisation are an aligned set of goals.

5. Outcomes

If the logic set out in the programme theories holds, then care markets should lead to quality support which will enhance wellbeing. The King's Fund and Nuffield Trust note that a 'central change in the [Care] Act is a shift from defining social care as a set of interventions to the duty to promote wellbeing across a population' (2016, p. 64). This then provides us with Theory 7 which relates to quality services and wellbeing. It also includes the confidence (set out in the Care Act) that continuity of services will continue even if there is a move to a new locality or a change in needs.

Theory 7: Quality

Person-centred and high quality services help people improve their wellbeing. Continuity of care is assured even if moving to a new locality or if funding arrangements change.

The Care Act statutory guidance (DH, 2017, para 6.111) sets out the wellbeing duty as encompassing the following:

> Well-being, in relation to an individual, means that individual's well-being so far as relating to any of the following –
>
> a) Personal dignity (including treatment of the individual with respect);
> b) Physical and mental health and emotional well-being;
> c) Protection from abuse and neglect;
> d) Control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
> e) Participation in work, education, training or recreation;
> f) Social and economic well-being;
> g) Domestic, family and personal relationships;
> h) Suitability of living accommodation;
> i) The individual's contribution to society.

Underneath this broad wellbeing duty it is possible to identify a number of related outcomes within the literature which contribute to system effectiveness as well as to enhanced individual wellbeing. These are:

(1) A market that is 'vibrant and sustainable'

The Care Act guidance (DH, 2017, para 4.6) suggests that effective market shaping results in a care market which is 'vibrant and sustainable'. Vibrancy is suggestive of innovation and diversity within the market. Sustainability suggests that providers are financially sound and that supply and demand are well aligned.

(2) Improved individual outcomes for people using care services

Drawing on the wellbeing elements set out above, data can be gathered on the extent to which these are being met at an individual level for people who are using formal care services. Data from the national Adult Social Care Outcomes Framework or In Control's POET evaluation of personal budget users gives an account of individual outcomes (In Control *et al.*, 2017; PAC, 2017).

(3) A reduction in unmet need

Concerns about the growth in unmet need have been articulated by a number of reports included in this review. This is acknowledged to create problems in relation to equity and to pass costs onto other parts of the system such as health (CQC, 2017b; King's Fund and Nuffield Trust, 2016). A reduction in unmet need is therefore one aspect of system effectiveness and individual wellbeing.

(4) Later entry into formal health and care services than would otherwise have been the case

A key objective for local authorities is to undertake preventative and early intervention work to keep people out of care services as long as possible. As noted by Bolton (2016), there are various approaches to prevention that could be progressed by local authorities including: supporting people to make healthy lifestyle choices throughout their lives, encouraging people to self-manage their long-term conditions, providing timely support at a time of crisis, and also providing support to people to 'recover from the problems they have experienced' (p. 26-7). This outcome can include reduced demand on non-care services (eg hospital admissions). A measure of effective market shaping could be, for example, that people are less likely to present at hospital Emergency Departments due to conditions that

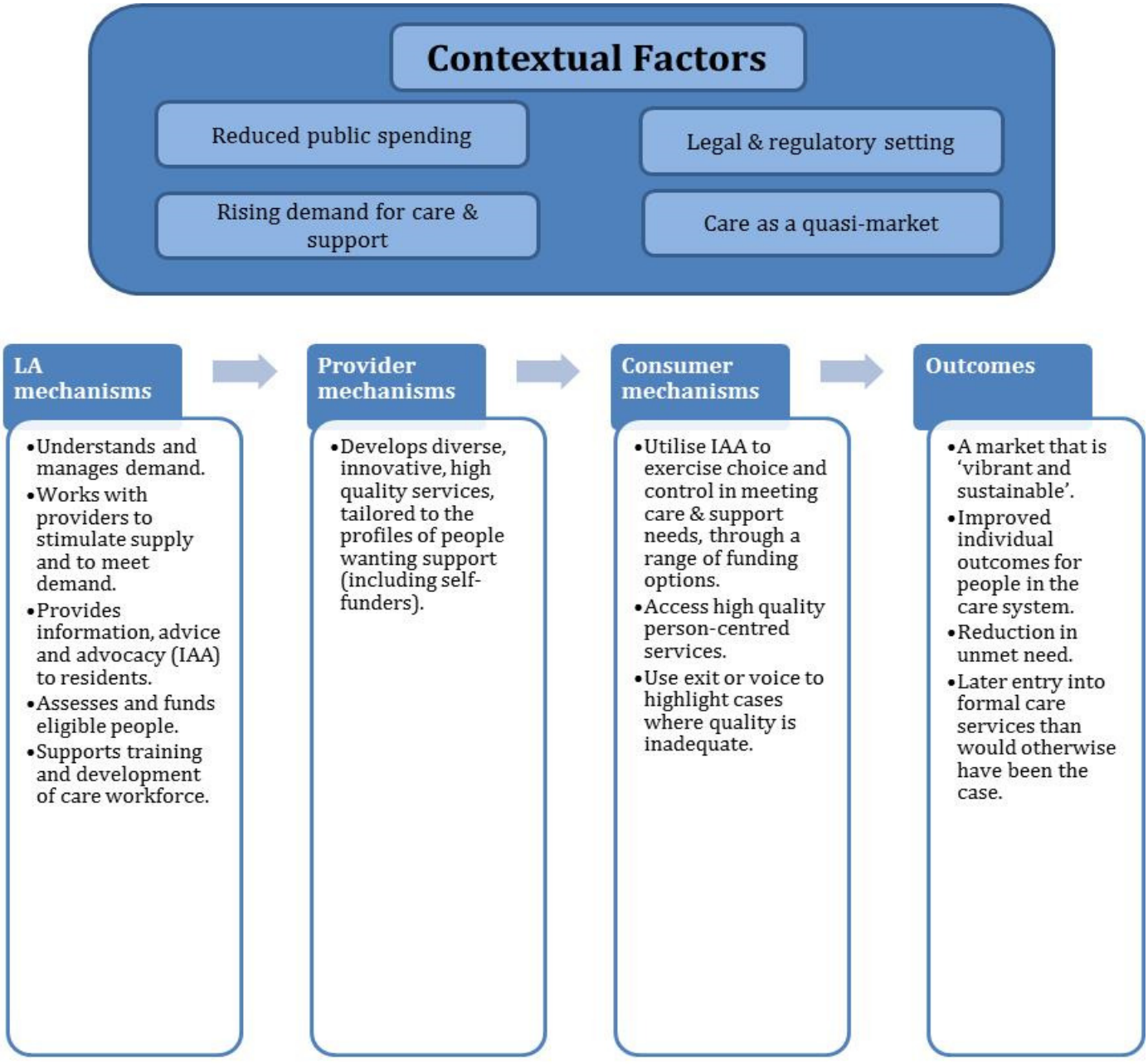
might be preventable or better managed elsewhere (CQC, 2017b; King's Fund and Nuffield Trust, 2016).

In the next section these outcomes are linked with the context and mechanisms identified earlier in the report, and are presented as a logic model.

6. Logic Model

Drawing on the preceding sections, the relationship between context, mechanism and outcomes is set out in the logic model below. Mechanisms are considered in terms of how local authorities (LAs), providers, and people using care services respond to the contextual factors. The model provides a structure for the empirical testing of programme theories which will be undertaken in later phases of the project.

Figure 2: Logic Model – Care Market Shaping and Personalisation



7. Conclusion

This realist synthesis has drawn on the literature to identify and discuss the programme theories that underpin the assumptions and objectives of market shaping and personalisation in adult social care, and to explore these within a context-mechanism-outcome framework. It has drawn attention to the different conditions which are required for the theory to be coherent, and the extent to which the literature suggests these conditions, and their underlying assumptions, are currently in operation and are shaping commissioning and the provision of care services.

The benefit of the context-mechanism-outcome framework is that it foregrounds how outcomes are dependent on the pre-existing context and the responses (mechanisms) which are generated by this context. Mechanisms are not independent but are directed and shaped by the wider conditions and environment in which they occur. The dependency within the context-mechanism-outcome framework, and the framing of mechanisms as responses to the context, compels analysis to account for complexity and to (in future research on this project) to examine the variance in outcomes.

This realist synthesis has demonstrated how such complexity is present within social care provision. As indicated throughout the report, market shaping and personalisation are inter-linked concepts. The ability of the local authority to shape the market will be dependent on the way in which providers and people accessing services respond to these attempts. Similarly, personalisation of services is dependent on there being enough variety in the market to allow people to access their preferred services and type of support. The market within social care then is a complex web of responses by local authorities, providers and people accessing services. The realist synthesis has highlighted that the existence of sub-markets, influenced by locality and the type of services provided, means it is somewhat of a misnomer to refer to 'the' social care market. Instead, there is an opportunity to consider how the context generates different responses, or mechanisms, within each sub-market and, consequently, how outcomes may vary across the sub-markets.

Three overarching questions were used to structure the realist synthesis. The first sought to identify the intended outcomes of care market shaping and personalisation by local authorities. The second identified how these outcomes were informed by the responses of local authorities to the wider context in which they operate. The third research question then focused on these

contexts. The reverse tracing of the context-mechanism-outcome framework foregrounds the intended outcomes and highlights what potentially could inhibit or facilitated the achievement of such outcomes. A brief summary of findings in response to each question has been noted below.

1. ***What are the intended outcomes of care market shaping and personalisation by local authorities?***

Synthesising the literature on market shaping and personalisation highlighted the intended outcomes of market-shaping and personalisation which were identified as:

- a market that is vibrant and sustainable;
- improved individual outcomes for people in the care system;
- reduction in unmet need; and
- later entry into formal health and care services than is currently the case.

However, the realist synthesis identified a lack of consensus as to what market-shaping and personalisation means in practice. This was seen to limit the attribution of outcomes to market-shaping activities.

2. ***What are the mechanisms by which it is believed that local authorities' market shaping and personalisation practices will achieve those outcomes?***

The intended outcomes were found to be affected by the mechanisms, or responses, of local authorities, providers, and people accessing services. Overall, three key mechanisms were identified:

- the market logic;
- the interplay of supply and demand between local authorities and providers; and
- the role of the care user as an active consumer.

The logic of the market was centred on how market-shaping activities would facilitate high-quality social care services through creating the conditions required to encourage a range of providers to enter the market. However, rival framing within the programme theories highlighted the difficulties local authorities may encounter in attempting to shape the market, demonstrating that market shaping is reliant on the interactions between local authorities, providers, and those accessing services.

These interactions are captured within the relationship between supply and demand. Here, supply is dependent on providers appreciating that there is a market for their services and this

is influenced by demand for services. This has two distinct elements, one of which relates to understanding the needs of the local population, both now and in future, along with appreciating how the tripartite relationship between local authorities, providers and people in need of support can be affected by the method used to fund services.

The effects of the method used to fund care services relates to the third mechanism; people accessing services responding as active consumers through directly, or indirectly, purchasing services that meet their specific needs. This requires the provision of a range of services, along with accessible information as to the options available to service-users. Choice and the interaction between providers and care users it generates will influence the sustainability of market-shaping activities as providers need to have a degree of certainty that there is demand for their service. However, this is dependent on the care user wanting to exercise such choice, a potential challenge captured in the programme theories in the second rival framing.

3. ***What are the important contexts which determine whether or not the different mechanisms produce the intended outcomes?***

The realist synthesis highlights the complexity of the social care market and drawn attention to the variety of sub-markets within the social care market. The following were noted to be particular contexts which affect the operation of the social care market:

- the distinctive legal and regulatory context of the care sector;
- rising demand for care due to demographic change;
- reduced local authority expenditure on care in the period from 2010-2016; and
- workforce shortages in appropriately trained care staff.

Contextual factors are likely to differ in their effects according to the wider demographic and socio-economic profile of the local authority. For example, the number of self-funders in the local authority will affect the interaction between local authorities and providers; the ability to attract and retain the social care workforce will be dependent on the local economy. The market-shaping activities of local authorities, and resulting responses from providers, will be conditioned by these contextual factors and have the potential to facilitate or inhibit processes of personalisation and the outcomes achieved by those who access social care services.

The review has 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 in public spending; insufficient staffing, weak consumer power, and poor flows of information.

The synthesis of the literature and development of the programme theories has been undertaken to inform and structure ongoing research into market shaping and personalisation. The empirical stages of the project which will follow will use these programme theories to examine the mechanisms which local authorities are using to undertake their market shaping activities and the extent to which they are able to achieve the outcomes that the theories propose, and which the Care Act embodies in its ambition. The programme theories explore the aspects of realist evaluation which are not well articulated in the existing literature: *what* is it about practices to shape and personalise care markets that works, for *whom*, in what circumstances and *how*?

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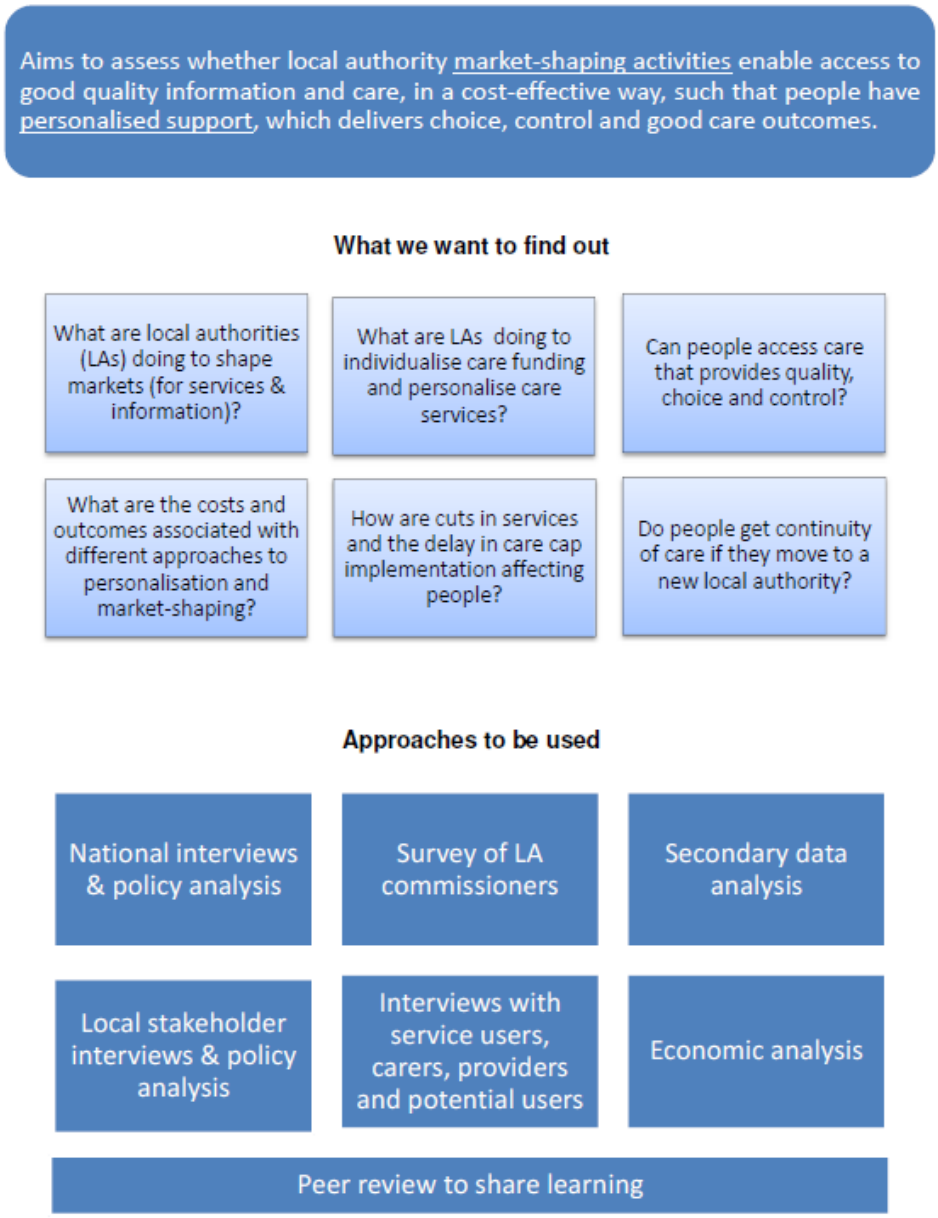
9. Appendices

Appendix 1 Shifting Shape Reference Group Membership

- Professor Paul Burstow – Chair Social Care Institute for Excellence (Chair), Professor of Mental Health Policy at the University of Birmingham
- Professor John Bolton – Visiting Professor, Institute for Public Care, Oxford Brookes
- Lynne Bowers – West Midlands ADASS
- Clenton Farquharson, MBE – Chair, Think Local Act Personal Programme Board, Community Navigator Services CIC
- Professor Jon Glasby – Professor of Health and Social Care, University of Birmingham
- Professor Martin Green, OBE– Chief Executive, Care England
- Emily Holzhausen, OBE – Director of Policy and Public Affairs, Carers UK
- Professor Bob Hudson – Honorary Professor in the Centre for Public Policy and Health, University of Durham
- Sara Livadeas – Director, Social Care Works Ltd.
- Sarah Pickup, OBE – Deputy Chief Executive, Local Government Association
- Vic Rayner – Executive Director, National Care Forum
- John Waters – Research and Evaluation Lead, In Control

Appendix 2 Project Research Design



Appendix 3 Blank Data Extraction Sheet Exemplar

Source	
Strengths and weaknesses	
Source type	
Aim(s)	
Location studied	
Description of care provision and/or population	
Research methods and sample	
Develops or tests programme theory	
1 Market Logic – competition = good supply	
2 Market Limitations - Supply poor without state involvement	
3 Demand - LAs know what the demand is and communicate it to providers	
4 Supply – providers know what demand is and meet it	
5 Information - IAA services available to all	
6 Personalisation - People have choice and control	
7 Quality/Wellbeing - User outcomes are good	
8 Rival Framing A – LAs have insufficient Info and Incentives	
9 Rival Framing B - Providers lack profitability and workforce. Integration will make this worse	
10 Rival Framing C – Users don't have enough info or funding options to make choices	
11 Rival Framing D – Users don't want (or shouldn't have) choice and control	
Other Findings/Thoughts	
Follow up readings	

Appendix 4 List of Sources included in the Literature Synthesis

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