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Shifting Shapes: how can local care markets support personalised outcomes?

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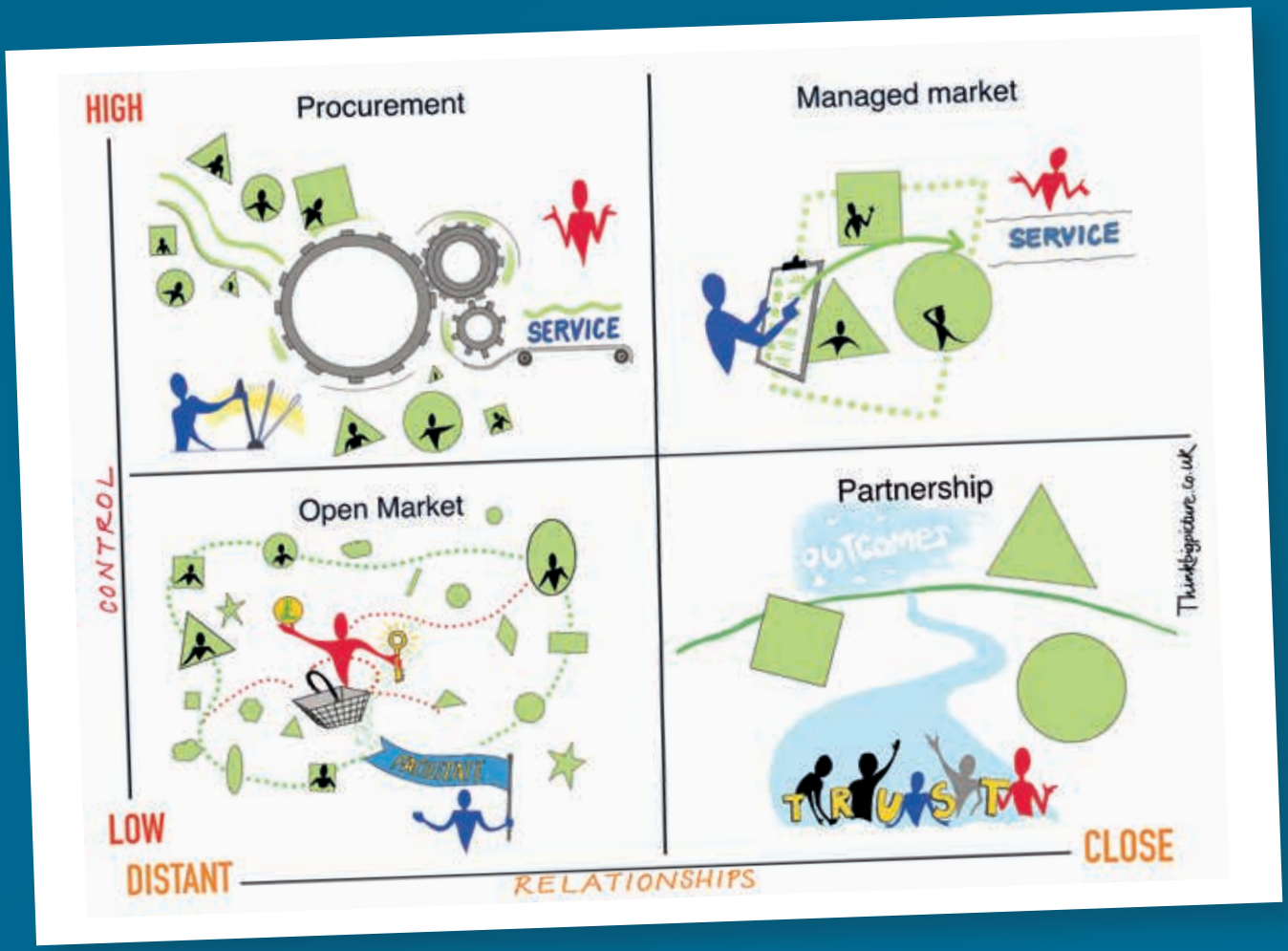

Disclaimer

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One-page summary

Local authorities have a duty under the Care Act 2014 to **shape social care markets** and a requirement to support **'personalisation'**. Through a realist literature review, secondary data analysis, a local authority survey, national stakeholder interviews, an economic evaluation and case study fieldwork in eight local authorities the research found:

- **Effective market shaping by local authorities is seen by national and local stakeholders as a prerequisite for achieving personalisation**. Working well with providers and communities can be a way for local authorities to develop stable markets and is also essential for stimulating the innovation and diversity that underpin personalised outcomes.
- The terms **'market shaping'** and **'personalisation'** lack a fixed meaning. Respondents talked about the interaction of two variables: **rules** (eg, tenders, contracts, monitoring) and **relationships** (between local authorities, providers and other local stakeholders).
- From the national interviews, **four types of local authority market shaping were identified** depending on the extent of local authority control (**rules**) and the nature of **relationships** with local stakeholders:
  1. *open market* (low control, distant relationships)
  2. *partnership* (low control, close relationships)
  3. *procurement* (high control, distant relationships)
  4. *managed market* (high control, close relationships)
- In the **open market** model, local authorities encourage maximum diversity of providers, and support individuals and families to find the best fit for care and support. In the **partnership** model, local authorities work closely with a smaller number of providers to co-design support that is innovative and supports personalised outcomes. Respondents associated these two types of rule/relationship configurations with **the aims of the Care Act**. The **procurement** and **managed market** models, in contrast, are more rule-driven and likely to limit scope for diversity and innovation. They were seen by respondents as attempts by local authorities to minimise risk and stabilise the system, in response to rising demand and fiscal pressures rather than a response to the Care Act.
- The eight local case sites were **using a combination of the four models in different sub-markets**. Older people's services were most likely to be 'high control' (ie, procurement or managed markets), whereas support for working age adults was most likely to be 'low control' (open market or partnership).
- **Sites were drifting between the four models over time**, often without purposively choosing one over another or recognising their interdependence. **High turnover of local authority staff, workforce shortages within providers and long-term funding uncertainty** militated against a coherent approach.
- The local site research enabled us to identify **the conditions in which open market and partnership approaches are likely to flourish**. Effective **combination** of the open market and partnership approaches require **different offers to different parts of the market**, to give providers incentives to innovate either to: (a) meet the needs of individual service users (including self-funders) in the open market; or (b) to develop partnerships for the long-term in ways that share risk and enable co-design with providers and communities. **Both are needed** in local care markets.
- **Partnership models** are best **pursued in an iterative way** to build trust, enable providers, service users, families and communities to adapt, and to facilitate joint working with health and housing. **Open markets** already exist in many areas but are fragile and need active **local authority facilitation** to work effectively.

Recommendations

Local authority commissioners need nationally funded support to build technical and relational capabilities, in order to:

- **Stimulate open market and partnership approaches**, with different offers to different parts of the market.
- **Develop partnership models** through forms of commissioning that foster trust, learning and long-term investment, and allow providers and communities to be part of a co-design process.
- **Facilitate open market approaches** through stimulating diverse providers and personal assistants, and helping to work with people using services (including self-funders), maximising flexibility and innovation and ensuring local quality assurance processes are proportionate to the level of risk involved.

National government needs to:

- **Develop a sustainable funding** settlement for social care, moving beyond short-term allocations that inhibit effective planning and partnerships.
- **Address shortages in the care workforce**, which local authorities and providers cannot resolve locally.
- **Ensure the regulatory system** is proportionate and responsive to both open market and partnership approaches, balancing risk with the flexibility necessary to achieve personalisation.

Executive summary

The Care Act 2014 assigned local authorities in England the responsibility to ensure that there is a wide variety of good quality care services available for people who need them. This National Institute for Health Research Policy Research Programme project initially sought to understand how local authorities have responded to duties placed on them to shape social care markets. We were also asked to look at how local authorities were responding to the Care Act's requirement that local authorities support individual choice and control through 'personalisation'. This final report brings together the findings from both strands of the research. Earlier reports from the project focused on findings from a realist review of the literature, and from 28 national stakeholder interviews and a survey of local authorities. We also published two stand-alone reports on sub-markets within the care system: one on people who pay for their own care (self-funders) and one on people using mental health services. Here we combine key insights from all of those earlier phases of the work with findings from fieldwork in eight local authority case sites, sampled to provide maximum diversity. In these sites, the research team interviewed local authority staff and stakeholders, providers and personal assistants, people accessing services (both publicly and privately funded) and family carers (410 people in total), and collected resource use and outcomes data.

The **aspirations of the Care Act** to improve market shaping and support personalised outcomes were endorsed by interviewees. However, many participants noted a disjuncture between the aspirations of the Act and the practices in localities. The multiplicity of local care markets makes market shaping a complex and fractured activity. There are multiple sub-markets in operation within a local authority. Market shaping in each is dependent on the actions of local authorities but also the interactions of providers and the people accessing services and carers, other commissioners and neighbouring authorities.

From analysis of the findings of the national interview data, **we developed a market shaping typology** – shown below – framing it as the interplay of two key variables: first, the setting of **rules**, encompassing the extent to which the local authority seeks to control the social care market; second, the development of **relationships** which reflects the closeness of associations between the local authority and the market.

Stakeholder interviewees favoured approaches in which local authorities, providers and people using services worked together to shape services (which we have called **the open market and partnership models**). They saw these as **the most likely to achieve the aims of the Care Act**, creating effective care markets that stimulate provider innovation and diversity in order to offer choice and control to people using services:

In the **open market** model, local authorities encourage maximum diversity of providers and support individuals and families to find the best fit for their care and support.

In the **partnership model**, local authorities work closely with a smaller number of providers, drawing on data and community input to co-design support that is innovative and supports personalised outcomes.

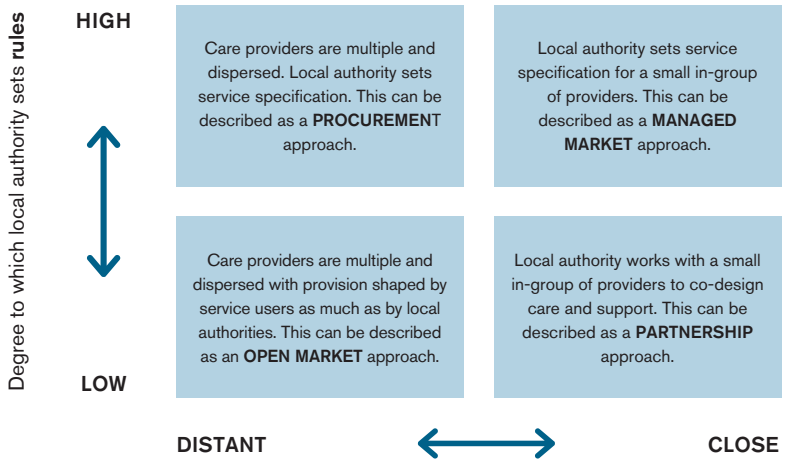
The **procurement** and **managed market models**, in contrast, are more tightly controlled by the local authority and (although they may be appropriate in some settings) are likely to limit scope for diversity and innovation, inhibiting personalisation.

Assigning market shaping practices to the typology

Research in the eight case study sites enabled us to test the validity of the market shaping typology, to develop in more detail the practices that were associated with each of the four models and to identify any unintended consequences.

We found examples of all four types of market shaping. Some sites were using all four approaches, with different ones for different

Figure 1: Market shaping typology



sub-markets; others were using two or three approaches. The **procurement approach** was found in five sites and was most prevalent within older people's services. In these cases (covering residential and home care), a dispersed market of providers was operating, with the local authority setting rigid contract specifications, such as the so-called 'time and task' approach to home care. Providers were not always 'price-takers' in this scenario – where there was a shortage of providers (for example, in learning disability services for people with complex needs), local authorities had to give out packages at the provider's rate. The key feature of this model is that there is limited collaboration between commissioners and providers and minimal choice for the people using services.

The **managed market approach** was found in five sites. Here, local authorities maintain a high level of control over the social care market and develop close relationships with a small number of providers (eg, through a block or framework contract). We found this approach in older people's residential and home care services. It may be data-driven, based on mapping of need in the local area. It is a top-down approach, in that the local authority specifies the service required. As the local authority is working with a smaller number of providers, service-users' choice of provider is limited. Several areas were using this in an attempt to secure supply, often on a neighbourhood basis, but found that it had not stabilised the market as intended.

In all of our sites, we found some evidence of the **open market approach** being used. In the open market approach, the role of the local authority is to facilitate the interaction between providers and service-users, but not to set strong limits on market entry or user choice. All sites offered some type of open market access through direct payments, particularly oriented towards working age people with disabilities. We found some examples of older self-funders employing micro-enterprises to provide their care. Direct payments take-up varied from ten to 40% in our sites. Even in the sites with higher rates of direct payment, we found limited support given to individuals or providers to stimulate supply or match it with demand, without which many people struggled to find and sustain care arrangements in the open market.

Four sites were using **the partnership approach in parts of their market**. This entails a close relationship between local authorities and providers to co-design and develop service provision, with input from other stakeholders, including communities. This model was found in sites that were taking a strategic and more outcomes-oriented approach to commissioning, particularly for working-age adults. This approach requires high trust relationships over the long-term, and the ability to support people holistically through engaging with partners such as health and housing, and wider community assets. It requires awareness of the limits of outcome measurement and attribution in a complex system, such that risk is shared and there is scope for experimentation and learning. There was widespread support for this model, even in sites that weren't yet using it. However, across all the sites, we found low levels of trust between commissioners and providers, and indeed amongst providers, which inhibited the scope for this level of partnership working.

All of the sites in our study were **in transition**, combining and travelling between the four models as they sought to discharge their market shaping duties more effectively. The dynamic nature of market shaping, moving between models and combining different models for different sub-markets, hampered efforts to identify **the costs of market shaping** and to link it to outcomes. We weren't able to draw conclusions about cost-effectiveness (discussed in Part 5).

Some sites had taken a path from procurement to managed market, then open market and now partnership, which roughly tracks **the timeline of national policy priorities** through care management (procurement), then commissioning (managed market), then personalisation (open market) and now prevention/integration (partnership). This trajectory has been encouraged by a range of sector bodies (eg, the Social Care Institute for Excellence and Think Local, Act Personal).

However, **the open market and partnership approaches require local authorities to cede considerable amounts of control** to providers and to people using services. We found the perceived risks of this generated countervailing forces pulling commissioners towards the 'high control' half of the typology. Rising demand, constraints on public spending, insufficient staffing, weak consumer power and poor flows of information had the cumulative effect of steering some local authorities towards forms of market shaping which they felt would stabilise care markets. There can be a perceived trade-off between individual choice and market stability, and local authority commissioners don't necessarily have the skills and broader organisational support needed for the 'low control' approaches to market shaping.

To fulfil the aspirations of the Care Act, **the open market and partnership approaches need to be used in combination**. This requires different offers to different parts of the market, to give providers incentives to innovate either to: (a) meet the needs of people using services in an open market; or (b) develop partnerships for the long-term in ways that share risk and enable co-design with communities. Partnership models are best **pursued in an iterative way** to build trust, enable providers, service-users, families and communities to adapt, and to facilitate joint working with other services such as health and housing. **Open markets** already exist in many areas but are fragile and need **active local authority facilitation** to work effectively. There are tensions to address when combining the two models, as discussed in Part 6: ***Getting the best of both worlds***.

Recommendations

Local authority commissioners need to:

1. **Make purposive and strategic decisions in their approach to market shaping**. The typology developed by this project can be used to recognise the nuance and interconnectedness of social care sub-markets. Whilst local authorities may be using all four approaches in the short-term to ensure continuity of supply, commissioners should be looking to stimulate the open market and partnership approaches.
2. **Develop partnership models**. Local authorities need to use forms of commissioning that foster trust, transparency and long-term investment and allow communities to be part of a co-design process. This is likely to require more open-book accounting, pooling of data and a willingness to share the risks of innovation. Achieving personalised outcomes requires sensitivity to the wide range of outcomes that people want from care and support and will require considerable flexibility and scope for variation in the support provided, as well as sensitivity to the difficulties of measuring and attributing outcomes in complex systems.
3. **Facilitate the open market model**. Local authorities also need to stimulate the emergence of a diverse range of providers and personal assistants, and help to match them with people who want to access support in this way (including self-funders), ensuring quality assurance processes are proportionate to the level of risk involved. Smaller providers and personal assistants may require help with business support and relevant care regulations.
4. **Be explicit about making different offers to different parts of the market**. Existing providers may be hostile to the stimulation of an open market of PAs and unregulated micro-providers if this feels like a lack of a 'level playing field'. The partnership approach offers long-term investment on a co-design and learning basis, which is likely to be of interest to established providers – and can be combined with the open market, so long as the tensions between the two approaches are discussed and managed.
5. **Recognise self-funders and direct payment holders as co-commissioners of care**: changes to the size and shape of care markets will have significant implications for people who commission their own care. Local authorities need to anticipate and understand these impacts, and work to ensure that individuals and families are able to navigate the market. At the same time, the actions and choices of individuals (especially self-funders) have implications for the wider local care market; failing to take account of the cumulative impact of individualised commissioning will constrain local authorities' understanding of their care markets and their ability to shape them.

All of these elements require **support and training**. There are many existing tools available to support local authority market shaping – for example the Commissioning for Better Outcomes framework and **Integrated** Commissioning for Better Outcomes (developed in partnership by the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS)), and resources from the Institute of Public Care. There are also a number of improvement initiatives within the sector, such as the LGA's Peer Challenge scheme and the Care Quality Commission (CQC)'s Local System Reviews.

However, **limited local authority capacity and high staff turnover** in commissioning has made it difficult to make effective use of these resources and has impeded long-term relationship building with external stakeholders.

Commissioning for market shaping requires:

i. **Recruiting for the right values and skills** within commissioning teams, recognising that effective commissioners require a combination of technical and relational capabilities.
ii. **Training on the relational and entrepreneurial aspects** of the role as well as on the legal and technical aspects. Resources such as the 21st Century Public Servant framework are available which offer this broader focus.
iii. **Creating opportunities to build trust** between local authority staff (encompassing procurement/legal teams as well as commissioners) and external stakeholders to facilitate co-design.
iv. Supporting **staff retention** in commissioning roles, recognising that trust is a long-term asset, and is difficult to sustain with a rapidly changing workforce.
v. Developing the **market shaping capacities of elected members**. Their broader strategic role in local authorities means that they must be part of any new approach.

Some of this support could be located at a **regional level**. Peckham et al's evaluation of the Care Act Implementation Programme highlighted how much local authorities valued the role of a regional coordinator within that programme. Some regions are already offering commissioner training, which could be further developed. Where the focus is on **building local relationships** (within and beyond the local authority) this will need to be done at a smaller scale.

These activities need to be funded through **dedicated new resources**. The Commissioning Support Programme for Children's Services could provide a useful template for such an approach, as it evaluated well and was found to have 'made a positive contribution to developing the skills and knowledge of the sector' (DfE, 2010, p.9).

National policy recommendations

Action at the local level has to be complemented by **national policy change**. Department of Health and Social Care (DHSC) funding for Care Act preparedness and national resources/toolkits have been helpful to the sector, but the Act cannot be the basis for effective market shaping and personalisation without action on other aspects of the national care system which are not the direct focus of this report:

1. Securing the **adequacy of funding** in the social care system, moving beyond short-term allocations that inhibit effective planning and partnerships. Market shaping requires stability and investment over the long-term.
2. Increasing capacity **in the care workforce**. This is a key concern among local authorities and providers, and requires **a national strategy**, alongside local action.
3. Ensuring the **regulatory system** is proportionate and responsive to both open market and partnership approaches, with a clear rationale for which parts of the system need to be regulated and which do not.

Overall, this research suggests that there is great potential and local appetite to develop partnership and open market approaches – but that this is very difficult without secure funding and a stable policy settlement. Shaping care markets cannot be the job of a heroic lone commissioner – it requires a sustained commitment by all stakeholders to deliver the Care Act's radical ambition of improving wellbeing.

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