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

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

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Disclaimer

Acknowledgments

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 purposely 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

Strengths of **relationships** between local authority and providers
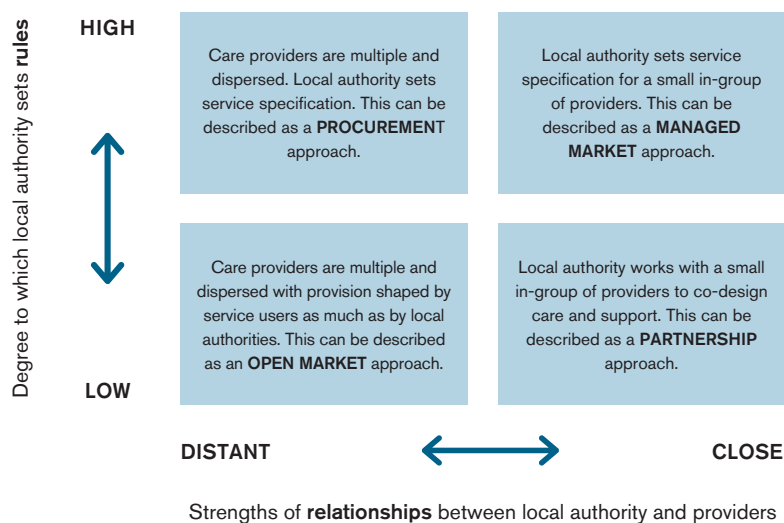
sub-markets; others were using two or three approaches. The **procurement approach** was found in five sites and was most prevalent within older people's services. In these cases (covering residential and home care), a dispersed market of providers was operating, with the local authority setting rigid 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*.

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.

Part 1: Introduction and research methods

The Care Act 2014 assigned local authorities in England a broad wellbeing duty and responsibility to ensure the availability of a wide variety of good quality care and support services for people who need them. Older people, people with disabilities, people using mental health services, and people with caring responsibilities should all have access to information about what support is available locally, whether publicly or privately funded. That support should be person-centred and high quality.

This document reports on independent research by the University of Birmingham commissioned and funded by the National Institute for Health Research Policy Research Programme. It draws on two projects: PR-R14-1215- 21004 **Shifting-Shapes: how can local care markets support quality and choice for all?** and PR-ST-1116-10001 **Shaping Personalised Outcomes – How is the Care Act promoting the personalisation of care and support?** These projects focus on two aspects of the Care Act which underpin high-quality support: first, the duty placed on local authorities to shape local care markets; second, the requirement to support individual choice and control within the broader wellbeing duty, which is referred to by the term 'personalisation' in the Care Act statutory guidance. Whilst these are two separate elements in the Care Act, they are closely interrelated, and we were asked to look at both of them together.

This is the final project report. Earlier reports from the project focused on findings from a **realist review of the literature**, and from **national stakeholder interviews and a survey of local authorities**. We also published two stand-alone reports on elements of the care system: **on people who pay for their own care (self-funders)** and **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.

Statutory guidance on the Care Act (DH, 2017, para 4.7) defines market shaping as follows:

The core activities of market shaping are to engage with stakeholders to develop understanding of supply and demand 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. It also includes working to ensure that those who purchase their own services are empowered to be effective consumers, for example, by helping people who want to take direct payments make informed decisions about employing personal assistants.

This role is discharged by local authorities. The Care Act also gave the Care Quality Commission (CQC) a national role in market shaping, monitoring 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). Here, we focus on the local authority element of market shaping rather than on the CQC role.

Expectations relating to personalisation are also set out in statutory guidance that accompanies the Act (DH, 2017, para 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.

Below, we set out the methods used in the research and then examine how local authorities are shaping care markets to achieve personalised outcomes. Research instruments and coding frame are available on request in a supplementary file.

1.1 Methods

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

Involving people with lived experience: The research was undertaken alongside people with lived experience of using social care services. Isabelle Brant, a co-applicant on the project, has a diagnosis of autism and has experience of accessing statutory services. She was involved in the research design, analysis and writing, and developed the training for the co-researchers. These were 19 people with lived experience of care services, located across the eight local case sites, who co-designed interview questions, interviewed participants, and contributed to analyses and recommendations.

First stage: National level: The first stage of the project, undertaken in 2017, considered the context of social care market shaping and personalisation at a national level (further details can be found in **Shifting Shapes Report of Work Package 1**). Twenty-eight senior leaders of key national organisations and opinion formers in the care sector were interviewed. An online questionnaire was sent to 152 local authorities in England with primary social care responsibilities, with a response rate of 18%. This stage also included secondary analysis of national datasets on care outcomes reported by people using state-funded services, which we combined with other data (the estimated prevalence of

self-funding in each local authority site, type of council, geographical spread and political control) to develop the sample of eight case sites used in the second stage.

Second stage: Local level: Eight local authorities agreed to participate in the research under the condition of anonymity. These were balanced according to the sampling criteria set out previously. In total across these case study sites, the research team interviewed and ran focus groups with 410 people (face-to-face or by telephone) during 2018. These encompassed local authority commissioners and care managers, elected members, other local stakeholders (eg, from health or the voluntary sector), providers, people using services and families, and potential users. Participants were recruited through snowball sampling, using the local authority to recommend providers, and then providers or other local stakeholders to recommend users and carers. We made use of local third sector organisations to identify potential users – people who were attending groups such as lunch clubs but not yet using statutory care services – so that their views could be included. Interviews and focus groups were transcribed and analysed in QSR-NVivo 11, using a two-stage thematic coding process (Attride-Stirling, 2001). Comparisons were made between each team member's coding and discussions took place on interpretations of the codes, after which refinements were made to the final coding frame. In the final months of the project, local authority commissioners from the case sites took part in a peer-learning exercise to discuss market shaping practices, member-test our findings and to shape emerging recommendations.

Economic evaluation: The project team also conducted an exploratory economic evaluation of market shaping. A total of 75 service-users were recruited at baseline and 49 service-users completed follow-up surveys at six months, giving a response rate of 65%. For the main base case analysis we restricted the sample to only those respondents who had provided both baseline and six-month follow-up data. This was to isolate the effect of market shaping on resource use and quality of life over time and avoid making any misleading conclusions that could be simply due to losses to follow-up. Ninety-two carers were recruited at baseline and 54 carers completed follow-up questionnaires at six months, giving a response rate of 59%. Participants accessing services and family carers were asked to complete a questionnaire which captured self-reported measures of quality of life and resource use – combining the Client Service Receipt Inventory (CSRI), the Adult Social Care Outcomes Toolkit (ASCOT) and the ICEpop CAPability measure for Adults (ICECAP). A follow-up questionnaire was then completed after six months to gauge whether there had been any change in participants' levels of reported quality of life and resource use.

Limitations: The response rate on the local authority survey was disappointingly low. We utilised ADASS's communication channels to try to improve the responses, but weren't able to raise it above 18%. We recognise that this is a limitation of the survey data as it may be those local authorities with the greatest interest in (or problems with) market shaping who responded. Findings from the survey were used to identify general themes which were then explored in the local case study fieldwork, rather than to derive generalisations about the sector. Two of our original eight local authority case sites dropped out and had to be replaced; although we retained the balance of sampling characteristics, we recognise that the eight participating sites may be atypical in being open to research about their market shaping activities. Similarly, people who agree to be interviewed, take part in focus groups and complete the questionnaires may be those who are most motivated to talk about their experiences, and may not represent the broader care population.

In terms of the overall recruitment in the sites, as shown in Table 1 we under-recruited in most categories, particularly in targeting 'potential users' who by definition were not yet using services. As Table 2 shows, we did not get a representative sample across all types of care service users (we over-recruited people with learning disabilities and under-recruited people with physical disabilities). This was a limit of our snowball sampling, where we were reliant on contacts given to us by others. However, we did not have alternative routes for accessing people across multiple care services, including those such as self-funders who are often hidden.

For the economic analysis, most of the carers (95%) and two-thirds (67%) of the service-users completed the CRSI, ASCOT and ICECAP surveys at the point of interview, with assistance from the researcher where requested. The return rate was lower than hoped during the second wave of data collection. This is likely to be due to this being a postal survey, whereas the first wave of questionnaires were face-to-face, and also to changes in health and other circumstances. To maximise the response, we gave a £10 voucher to people who posted back the second wave surveys. However, we were not able to raise the response rate beyond 65% for service-users and 59% for carers.

A further limitation of the economic analysis is that the study included a wide range of people with different types of social care need. This meant that the analysis encompasses people with a wide variance in terms of their care spend, a point that is discussed later in terms of implications when reporting average weekly spending.

Table 1: Summary of target and achieved number of interviews

Participant type	Target	Achieved	%
INTERVIEWS AND FOCUS GROUPS			
National stakeholder interviews	30	**28**	**93%**
Local authority staff member interviews	56	**66**	**118%**
Local stakeholder interviews	24	**14**	**58%**
Managers of care providers/microproviders/personal assistant interviews	72	**66**	**92%**
People accessing care and support services interviews	160	111	**69%**
Carer interviews and focus group participants	128	**97**	**76%**
Potential user interviews and focus group participants	128	**56**	**44%**
Total included	**598**	**438**	**73%**
SURVEYS			
Local authority survey	152	**27**	**18%**
Cost-effective analysis questionnaires people accessing services (Time 1)	160	**75**	**47%**
Cost-effective analysis questionnaires people accessing services (Time 2)	75	**49**	**65%**
Cost-effective analysis questionnaires carers (Time 1)	128	92	**72%**
Cost-effective analysis questionnaires carers (Time 2)	92	**54**	**59%**

Table 2: Profile of sample by type of service compared to national profile (NHS Digital, 2018a; 2018b)

	Sample (%)	National estimate %
Older people services	**48**	**66**
Learning disability or autism services	**36**	**15**
Mental health services	**11**	**7**
Physical disability services	**6**	**10**

Part 2: The national context

The system-wide contextual factors influencing market shaping and personalisation have been well covered in existing literature and discussed in detail in earlier project reports (see for example, Communities and Local Government Select Committee, 2017; Health and Social Care and Housing, Communities and Local Government Committees, 2018; King's Fund and Nuffield Trust, 2016; Needham, *et al.,* 2018a; Needham, *et al.,* 2018b). The combination of cuts in local authority funding and workforce shortages in the sector has created a very difficult context for Care Act implementation. Across all levels of our research there was support for the principles of the Act, alongside dismay at a financial context which had hampered its implementation.

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

National interviewees said that **at a local level the Care Act had had limited impact**. Some interviewees reported that the legislation had helped to raise the profile of market shaping and also signalled to local authorities their wider responsibilities. Despite this, interviewees felt that they had seen little actual change since the Act and that the legislation was a weak lever for change. There was a general consensus that aspects of the care market were often beyond the control of local authorities.

Attempts to shape markets could be influenced by external factors, as well as cross-departmental relationships within local authorities (eg, with procurement and legal teams).

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

Market position statements were recognised by national interviewees as a potential channel to communicate the local authority's vision for social care. However, interviewees believed that these statements, in their current form, did not facilitate this and did not supply the data required to support providers' service development. It was noted in particular that the data within the statements were often focused on demographic projections rather than developing a vision as to how a holistic care system can respond to possible future demands. Some interviewees noted the potential role of technology in facilitating innovation in social care. While generally viewed positively, technology was seen as a supplement to caring relationships between care staff and people accessing services rather than a replacement. There was recognition that it required investment, both financially and in terms of staff training, but there was also uncertainty about the best time to invest in technology given the pace of change.

National interviewees and local authority survey respondents reported a great deal of concern around the **adequacy of social care funding** both now and in the future, with almost all (96%) survey respondents reporting they were concerned about the sustainability of care providers in their locality in the current financial climate. Whilst there have been some additional resources allocated to social care nationally in recent years (NHS Digital, 2018a), austerity was a dominant theme in all phases of the fieldwork, and it is difficult to overstate the extent of anxiety about sufficiency of resource and capacity. The perception of funding scarcity was the lens through which all of our local authority respondents framed their understanding of market shaping:

> *…we're desperate to support the market, but actually we haven't got sufficient funds available to be able to do that in the way we would want.* **Site 8, local authority interviewee 2**

> *The Care Act was great on paper. I don't think it's had much influence at the bottom end… If you haven't got the mechanisms and means to support it to make it work, then it becomes a good coffee table support.* **Site 1, provider 7**

Conditions of scarcity were evident in relation to overall local authority care budgets and the need to ration care more tightly. They also related to workforce shortages, including the uncertainty over national immigration rules. Lack of capacity was particularly evident in relation to nursing care, where two of the sites indicated that they were considering entering the market in partnership with health commissioners in order to increase the supply of beds.

> *[We are] competing with retail and tourism, so even where providers are paying more the National Living Wage, recruitment and retention is a major issue.* **Local authority survey respondent 14**

Cuts to local authority budgets had had an impact on social care teams in local authorities, with **job cuts reported in all of our sites**. Workloads had increased and this had led to delays in assessment and review processes. The accompanying churn in commissioning staff was seen as resulting in a loss of organisational memory, which fractured relationships with stakeholders and risked repeating previous errors. Local stakeholders from outside the local authority reported that high staff turnover in the local authority made it difficult to maintain working relationships. This voluntary sector leader pointed out:

> *Change of personnel… it's chronic within the local authority, absolutely chronic, they just keep changing jobs. So, they have no history. So, literally, people on the outside, the providers are saying to them, 'Do you not know you did this five years ago?' And they're saying, 'No, no, we have nobody here who actually remembers that.'* **Site 2, local stakeholder 1**

Many interviewees reported that the need to make short-term savings was prioritised over **innovation**; providers frequently said that their conversations with local authority commissioners were focused on fee levels rather than wider service provision. Some providers reported that cuts to their fees meant that they had to concentrate on their business surviving rather than investing in service development.

> *I think innovation and social care is really hampered by lack of strategic, long-term planning with commissioners, and providers, and families, and individuals, because people are just so desperate with their in-house yearly pressures. There's no joined-up thinking or big plan.* **Site 4, provider 1**

In contrast, there was optimism from some national interviewees that the need to make efficiencies had prompted local authorities and providers to develop **more creative ways to deliver care** by forcing them to work differently with providers.

> *All the cuts that have happened to local authority funding you know have a significant impact… Necessity is the mother of invention and it's forced people to think differently…* **National interview 16**

Whether conditions of scarcity and uncertainty stimulate innovation or risk-aversion may in part be dispositional – a feature of the attitudes of the people we interviewed or the broader cultures of their organisations. However, by exploring in more detail the local authority market shaping approaches in the case sites we were able to better understand how different types of market shaping fostered or stifled innovation.

> ❝
> **Cuts to local authority budgets had had an impact on social care teams in local authorities, with job cuts reported in all of our sites.**
> ❞

Part 3: How are local authorities shaping their markets to ensure personalised outcomes?

We have structured our findings around how four types of market shaping link to personalised outcomes. The four models are derived from analysis of the national stakeholder interviews in the first phase of our data collection, which we then tested in the eight case local authorities. The market shaping typology positions effective market shaping and personalisation as a feature of the patterned interaction between local authorities and providers, and in particular the setting of **rules** and the development of **relationships**. Having found these two themes in our stage one data, we developed them using the grid/group theory of anthropologist Mary Douglas (eg, Douglas, 1970/2004; Douglas and Wildavsky, 1983; Entwistle et al., 2016; Simmons, 2016; Wildavsky, 1987). Grid/group theory has been used extensively in institutional analysis and public management to consider how far people's lives are governed by external rules (the grid dimension) and how far people feel part of a loose or tightly bounded social group (the group dimension).

In relation to market shaping and personalisation, the rule dimension positions local authorities on a spectrum between taking a rule-based approach or a more open and emergent approach: for example, they can create highly specified contracts for providers and impose tight limits on how people spend their personal budgets; or they can be more flexible on these aspects to maximise diversity and choice. On the **relationship** dimension, the spectrum of local authority behaviours can span from creating close relationships with providers (for example, active provider forums and collaborative forms of commissioning) to taking a less interventionist approach in which it is left to providers and service-users to develop bilateral relationships. These four models allow the development of a typology of market shaping practices.

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 rule-driven and prescriptive. They may be appropriate for aspects of care markets (eg, the provision of aids and appliances, including technological supports, or ensuring rapid discharge from hospital), but are less likely to advance personalised outcomes and, hence, we consider these approaches to be less compatible with the Care Act.

Open market and **partnership** approaches differ in the extent to which they encourage close or distant relationships between local authorities and providers. Both approaches have the potential to deliver on aspects of the Care Act and could be **used in combination** for different parts of the market. However, local authorities need to understand and mitigate tensions between them, as discussed later in this report.

Figure 2: Market shaping typology

	DISTANT	CLOSE
HIGH	Care providers are multiple and dispersed. Local authority sets service specification. This can be described as a **PROCUREMENT** approach.	Local authority sets service specification for a small in-group of providers. This can be described as a **MANAGED MARKET** approach.
LOW	Care providers are multiple and dispersed with provision shaped by service users as much as by local authorities. This can be described as an **OPEN MARKET** approach.	Local authority works with a small in-group of providers to co-design care and support. This can be described as a **PARTNERSHIP** approach.

Degree to which local authority sets **rules**

Strengths of **relationships** between local authority and providers

3.1 Identifying market shaping approaches

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. However, rather than each site deploying one of the four approaches, we found that they were pursuing several types of market shaping simultaneously. This reflected how they interacted with the sub-markets in their locality, and their tendency to move between different types. Most of our local authority respondents talked about having different sub-markets according to the type of service, although some did recognise the artificial nature of these categories:

> *We have artificial financial constructs which are called home care, residential care, nursing care, extra care, temporary... You know, those are constructed by financial funding streams.* **Site 2, local stakeholder 2**

Due to separating out these different sub-markets, local authority commissioners found it difficult to talk about the market as a whole.

> *It's very difficult to think across the whole picture, isn't it? We'll end up with: market shaping for home care looks like this and your assets-based community shaping looks like that, but it's so difficult to bring it all together.* **Site 4, local authority interviewee 1**

> *[In residential care] we're talking about companies based in the Cayman Islands… it's a very different animal to say looking at befriending services which would be much more community/ voluntary sector response.* **Site 6, local authority interviewee 1**

Commissioners also reflected on the **difficulties of putting boundaries around 'their market'**, due to the influence of neighbouring authorities and other commissioners, including the NHS and self-funders. This might affect parts of a borough more than others and may influence provider capacity and workforce availability, if other commissioners pay higher wages. It may also distort the provision offered, detracting from the priorities and preferred market shaping strategy of that local authority.

‘

These four models allow the development of a typology of market shaping practices.

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> *[O]ur ability to market shape is very different in different areas… It's impacted a great deal by whether we are the main and/or sole commissioner or whether there are commissioners in health, in other authorities and self-funded.* **Site 3, local authority interviewee 1**

Some of our sites were **deliberately distinguishing their market** shaping approaches in different sub-markets, for example, developing a partnership-oriented approach to mental health services or developing the open market within learning disability support, and planning to address other parts of the market at a later date (*'Older people's care home market… we haven't got any bespoke plans around how we deal with that market'* – Site 1, local authority interviewee 1). Others were taking a less purposeful or explicit approach, and simply had in place a number of different and sometimes contradictory approaches to market shaping.

Figure 3: Market shaping typology and assigned practices

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Procurement approach
High control, distant relationships

Often used in residential and home care markets. Likely to be limited choice for individuals. May be tight controls in place for direct payment (DP) holders (eg, pre-payment cards). Self-funders are invisible but subsidise the LA market.

Example: spot purchasing

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Managed market approach
High control, close relationships

Often used in home care markets. Likely to be limited choice for individuals. DP holders may be steered towards framework providers. Self-funders may find choice limited as local authorities deliberately shrink the market.

Example: framework contract

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Open market approach
Low control, distant relationships

Characterised by high uptake of DPs and provider variety (including personal assistants). Likely to be used most for working age people with disabilities. Self-funders can benefit from the market diversity and from any market facilitation undertaken by the local authority.

Example: support for provider diversity, eg, PAs, micro-enterprises

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Partnership approach
Low control, close relationships

Some examples of this; most sites aimed to move in this direction. Providers co-design and work with local authorities over the long-term, with community input. This approach may limit provider choice for DP holders and self-funders.

Example: outcomes-based commissioning
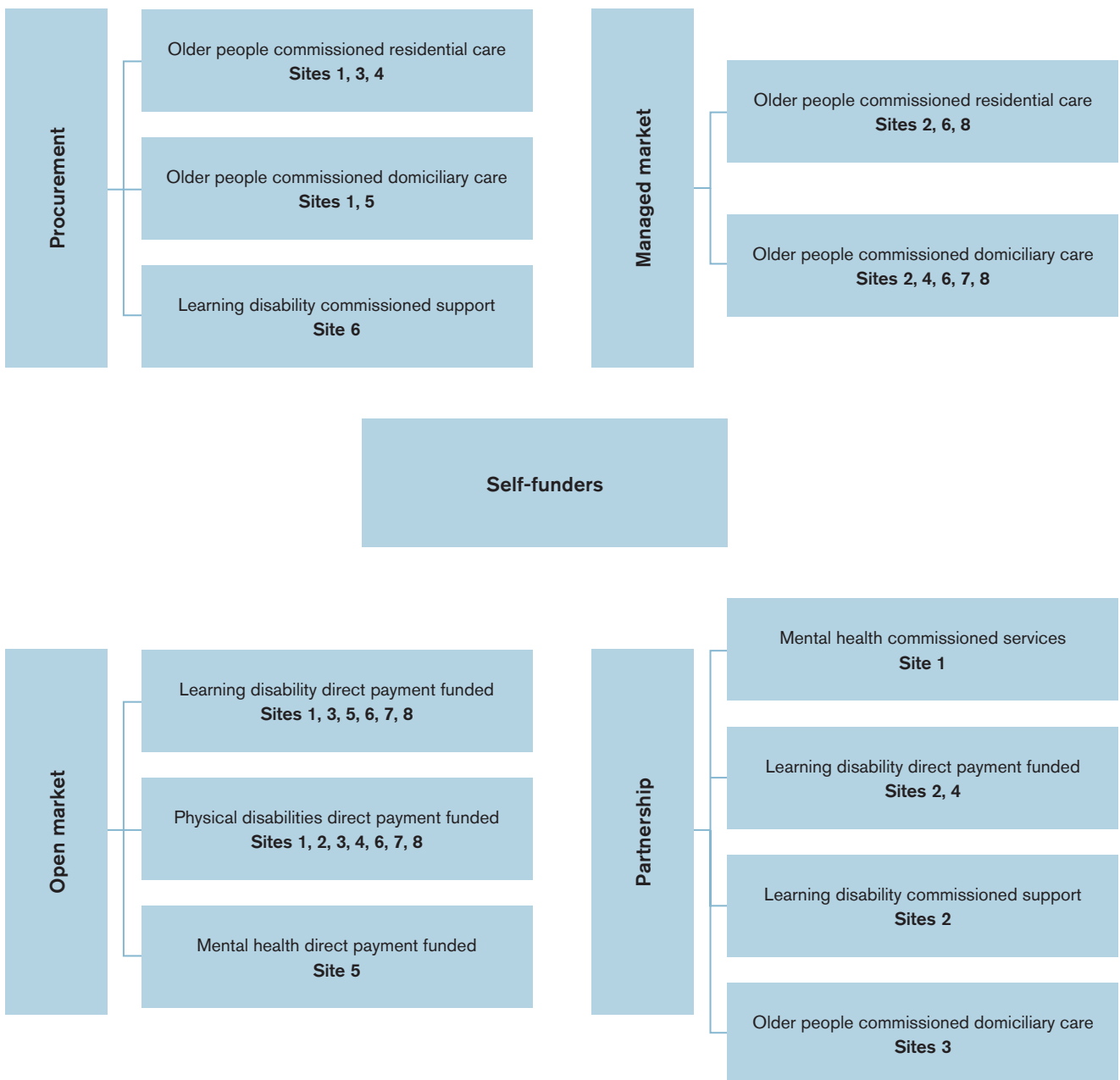
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Despite the intentions of the Care Act we found that self-funders continued to be treated largely as bystanders by local authority market shaping strategies (discussed in further detail in our earlier report on self-funders, Henwood et al., 2018). Figure 3 shows the types of sub-market that we identified, displaying the characteristics of the four quadrants.

Figure 4 shows the **allocation of sub-markets** within our eight local authorities – using the service labels that were used by local authority interviewees (whilst acknowledging that these labels are artificial and can be misleading (SCIE, 2004)). It shows those sub-markets where we had sufficient data to make an allocation. **Self-funders are shown as**

free-floating – in the middle of the diagram – influenced by but also impacting on the dominant approach in their locality and sub-market.

Figure 4: Allocation of sub-markets to types of market shaping

Procurement

- Older people commissioned residential care
  Sites 1, 3, 4
- Older people commissioned domiciliary care
  Sites 1, 5
- Learning disability commissioned support
  Site 6

Managed market

- Older people commissioned residential care
  Sites 2, 6, 8
- Older people commissioned domiciliary care
  Sites 2, 4, 6, 7, 8

Self-funders

Open market

- Learning disability direct payment funded
  Sites 1, 3, 5, 6, 7, 8
- Physical disabilities direct payment funded
  Sites 1, 2, 3, 4, 6, 7, 8
- Mental health direct payment funded
  Site 5

Partnership

- Mental health commissioned services
  Site 1
- Learning disability direct payment funded
  Sites 2, 4
- Learning disability commissioned support
  Sites 2
- Older people commissioned domiciliary care
  Sites 3

Part 4: Features and effectiveness of the four models
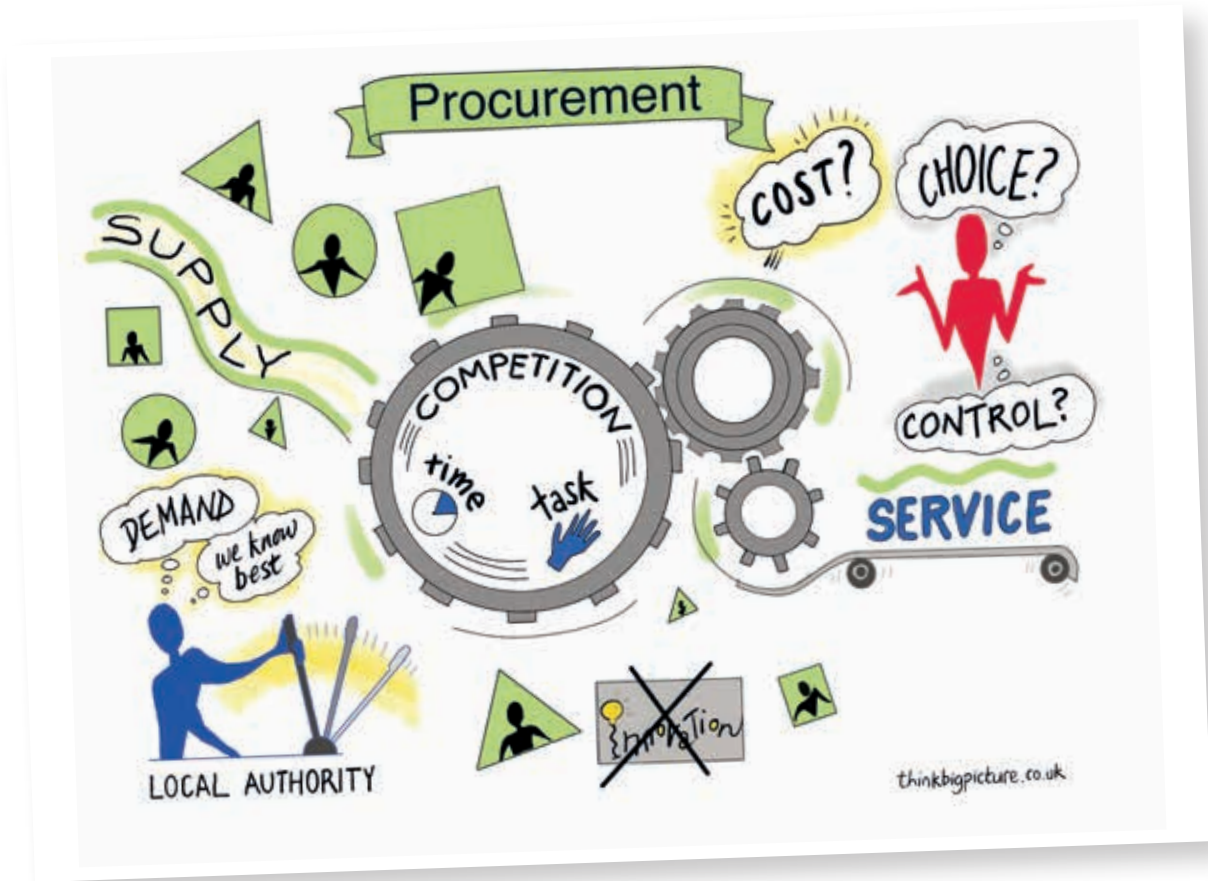
Through the fieldwork, we were able to identify **the features and effectiveness of each of the four approaches to market shaping**, to identify why they are expected to work, what are the contingent factors that affect how the approaches operate, and the implications for aspects such as integration with health and the self-funder experience. We also consider whether each model is likely to promote personalised outcomes as envisaged by the Care Act.

4.1 Procurement – high control, distant relationships

The procurement approach shapes the market through a combination of high local authority control and a dispersed market of providers who bid for contracts.

Shaping the market through procurement

In five of our eight sites, we found examples of the procurement approach, in which the local authority focused on **developing service specifications without involvement of providers**. The use of spot contracts and dynamic purchasing systems were examples of this approach, with an emphasis on what is sometimes called 'time and task' contracting. We found it to be particularly prevalent in older people's residential care, and it was also used in older people's home care and learning disability support in some sites.

The rationale for using a procurement approach was mixed. In some local authorities, it was seen as the best way to get **competitively priced care in a just-in-time way** – adhering to minimum care standards and stringent

budget constraints whilst also satisfying the requirements of procurement law. Market shaping, in this model, is mainly about cost-effectiveness.

My understanding of market shaping is that it's almost encouraging providers to be more competitive in terms of could they provide more value for money in care? And can [they] then provide higher standards of care? So if that provider didn't meet the standards we required, we could… potentially put it out to tender and ask another provider to take their place, so we can shape the market in terms of we can get better value for money and we can get competitive providers. **Site 1, local authority interviewee 5**

In other sites, it marked an **earlier era of commissioning activity**, which had been abandoned in some parts of the market but persisted in others. Some interviewees blamed their own procurement departments for refusing to move away from this approach:

> *[C]ommissioning is one side of a coin, procurement is another side of a coin… [W]e've had a lot of our historical contracts end up the way they are because the procurement department said you can only procure in this way.* **Site 5, local authority interviewee 4**

In the procurement approach, the emphasis is on matching supply and demand, rather than proactively shaping the market. Providers may be subject to local authority quality schemes to assure minimum standards, but local authorities maintain control rather than engaging in co-design. **Information, advice and advocacy** is a low priority, since primacy is given to placing people quickly and cost-effectively, rather than in facilitating individual choice.

Integration with other services, such as health, is hard to achieve in this model, due to the lack of external dialogue with other stakeholders and the just-in-time approach to commissioning. Clinical Commissioning Groups (CCG) (who are also commissioning care services) may themselves also be taking a procurement approach. For example, this care provider highlighted the problems of working with their local CCG:

> *I'm the only [provider] who's got any kind of communication with the CCG… [The CCG] had no idea what they had [commissioned], they didn't know what they bought, they didn't know how much they'd paid for it, they didn't know where it was. So they couldn't give an uplift, because they hadn't got a clue what they'd got.* **Site 2, provider 1**

The **procurement approach was highly unpopular with provider interviewees**, and seen as unlikely to stimulate a vibrant and sustainable care market. Providers saw it as coming from a local authority attitude of 'we know best': *'They make all the decisions before they enter into any kind of consultation with providers'* (Site 2, provider 1). It was seen as antithetical to the principles of the Care Act (*'We can't deliver personalisation properly if you're watching the clock'* – Site 2, provider 1), with no incentive to innovate. Providers saw it as being driven by short-termism within local authorities, which inhibited effective relationships and proper planning:

> *[W]e get phone calls every single week from the same commissioners, going, 'Can you do this for six people, and can you do it by, like, yesterday?' We're like, 'No, we can't, but we'd love to sit down with you and plan what you need for 12 months' time, and we can get that to happen.' 'Well, we need something for now'…* **Site 4, provider 1**

Nonetheless, 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. However, there remained limited collaboration between commissioners and providers, and minimal choice for the people using services.

Personalisation in the procurement approach

Under the Care Act, local authorities are expected to facilitate personalisation through encouraging market diversity and enabling people to make choices and take control of their support arrangements. In the procurement model, using time and task contracts for home care or spot purchasing of residential care placements, **choice and control for people using services is limited. Quality concerns were also raised** by interviewees. In all of our sites, we found variants of the following home

care experience, here reported by someone caring for her mother who has a diagnosis of dementia:

> *They're supposed to come in at 7.00 in the morning to see to her, but sometimes it was 11.00… They just send random people round, is the best way of describing it… They're okay, it's just that you know [mum] says she wishes she knew what time they were turning up and she wishes she knew who was turning up.* **Site 1, service user 3**

Time and task-based approaches were widely seen as antithetical to person-centred support, as this person who uses care services put it:

> *We haven't done anything wrong, so why are we imprisoned? Why are we left to have only four hours of care a week? Or 15 minutes twice a day? That's not social care, that's not social support, that's not even of any use to anyone. What's the point in having support with your shopping, if when the shopping arrives your care worker hasn't got time to put it away?* **Site 1, Service user 6**

The focus on local authority control means that even where forms of individual commissioning are used they may be subject to a high level of prescription and audit, which limit individual choice and control.

Although only one of the areas that we were working with had a **prepayment card for direct payment holders**, this is known to be increasing in prevalence as a way to re-establish local authority control over individual purchasing (In Control and Think Local Act Personal, 2019).

Self-funders are not explicitly in view of the local authority in the procurement approach and indeed the scale of their existence and their characteristics remain largely unknown to local authorities, even though their financial contribution may be crucial to sustaining a multiplicity of providers in the care sector (CMA, 2017; Henwood, 2018). Many of the providers we interviewed set out the need to continue to gain funding from both the state and from self-funders to ensure their viability.

Table 3 summarises the **features of the procurement approach** as we found it in the case sites.

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Many of the providers we interviewed set out the need to continue to gain funding from both the state and from self-funders to ensure their viability.

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Table 3: The procurement approach

Exemplar market shaping strategy	Spot purchasing of time and task-based contracts.
Logic	Best way to get competitively priced care in a just-in-time way, adhering to minimum standards, avoiding waste, and satisfying the requirements of procurement law.
Local authority attitudes	Five sites were using this approach within part of their care market. Seen by some as a cost-effective way to quickly set up a care package. Felt by others to be driven by procurement departments and short-termism. It was most common in older people's residential care. All sites had moved or were planning to move older people's home care away from this model.
Provider attitudes	Unpopular model of commissioning due to lack of provider involvement in service design and short-termism.
User attitudes	Unpopular model of commissioning, due to perceived lack of choice; poor quality; unreliable service.
Self-funders	Not directly involved, but their cross-subsidy will be vital in some areas to ensuring provider viability.
Personalised	Minimal scope for choice and control for people using services.
Integrated	Integration is not addressed.
Vibrant and sustainable market	Lack of engagement with providers to stimulate diversity. Price-driven contracting impedes sustainability.
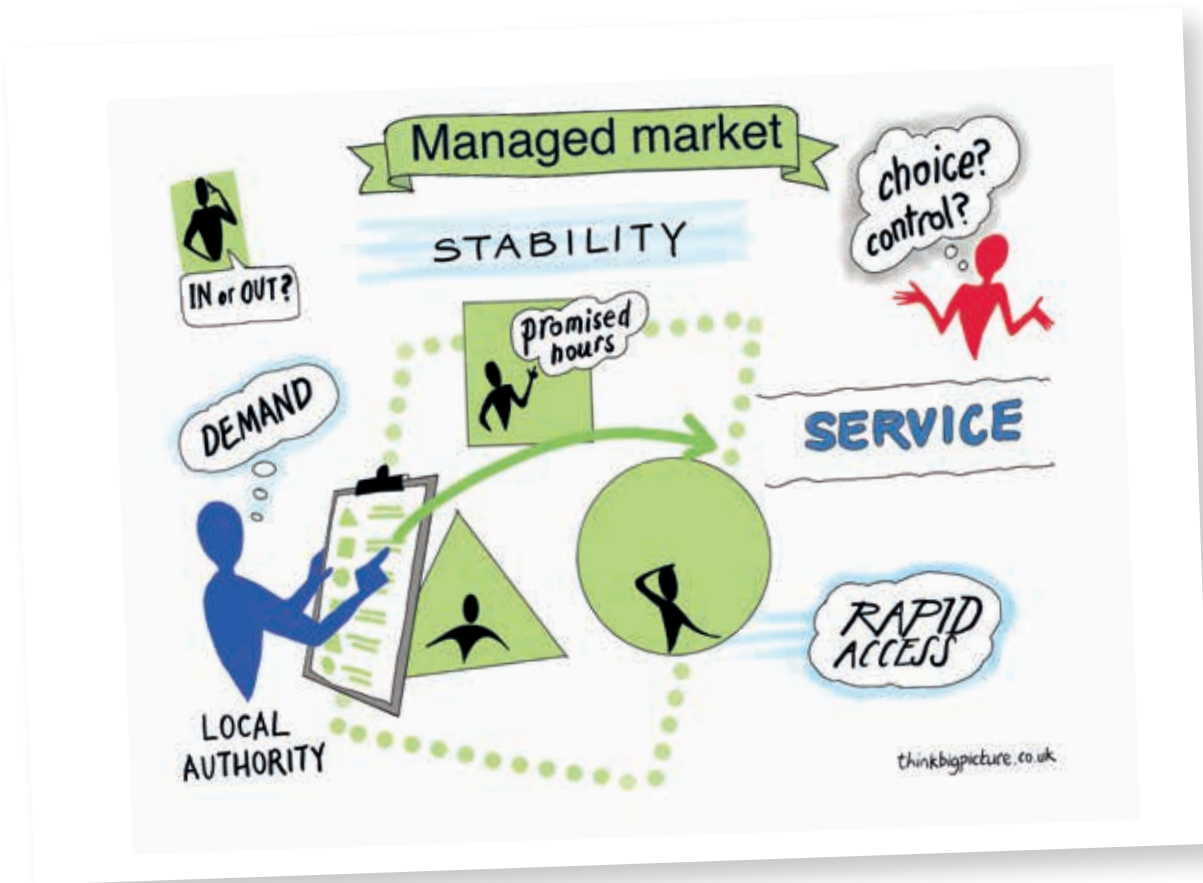
4.2 Managed market – high control, close relationships

The managed market approach is designed to secure sufficiency of supply through the use of block and framework contracts with a small number of providers.

Shaping the market through the managed market approach

The managed market approach may mark the next phase of development in local authority market shaping approaches: five of our local authority case sites had moved some of their sub-markets away from procurement-driven approaches to take a managed market approach with a smaller number of providers. This approach was seen to offer advantages to both the local authority and providers,

stabilising the market through guaranteed supply and facilitating rapid placements. In some sites, this had been done across a whole local authority area. In others, it was being done through a locality approach, in which providers were given guaranteed levels of hours within certain neighbourhoods – or in which a lead provider was appointed for an area who could sub-contract with other providers in a more flexible way.

This approach offers clear advantages over the procurement model, allowing local authorities to develop closer relationships with a small number of providers. There is also scope to use the framework to support better **integrated working** with health. For example, one of the local authorities in our study had addressed delayed hospital discharge by block contracting with three providers specifically to

do reablement work after a hospital stay. This service was also offered to **self-funders**, and some had continued to use the same provider after the reablement period had expired. However, in sites that were transitioning into this model by shrinking down the number of home care providers, we found little reflection by commissioners on the likely implications for self-funders of this change (which may drive out of business the providers that self-funders are also using).

The managed market approach is premised on **ensuring sufficiency of supply**. However, it had failed to do so in the five local authorities that were using it: issues of undersupply of staff or provider withdrawal meant that frameworks did not deliver the anticipated market stability. As one commissioner put it:

> *The intention was to try and take a stronger approach of shaping the market, by contracting agencies, rather than just doing spot purchases for people all the time. But trying to take that control back hasn't worked out as well as hoped.* **Site 7, local authority interviewee 4**

In this case, the attempt to establish a lead- and sub-provider model had fallen through when both lead providers **handed back their contracts** due to difficulties recruiting staff.

> *[T]hey appointed lead providers who would be the overall lead in the area and then they appointed market support providers, which is what we are on one of the locations. And then from that, we would then absorb 30% and the lead would absorb 70%. But both leads pulled out.* **Site 7, provider 4**

A local authority using a framework contract to **facilitate hospital discharge** found that staff shortages at weekends inhibited the effective working of the contractual arrangements. In another area, which has taken a more locality-based approach to commissioning, one of the providers described difficulties in how it is working:

> *Because fees aren't really covering the costs, [the neighbourhood] providers tend to say no to that care… [T]hey can't deliver it within the fee level, so then the local authority has to go to the wider [framework], which is, 'and other providers in the local authority area' who quite often then are able to negotiate a fee that they think they'll be able to do the work for. The commissioning framework doesn't really work in that respect.* **Site 5, provider 1**

Pressures on local authority capacity were particularly intense in areas with large self-funder markets where providers had other options and higher income streams:

> *[W]e said to [the local authority] at that time, we won't be signing up to [the framework], we'll keep what we've got. We've already been expanding our self-funder market, and we want to continue doing that. By doing that… the fortunes of the business have turned around quite considerably now.* **Site 5, provider 10**

Areas with fewer self-funders and greater workforce availability encountered a different problem. Here, providers were complaining that not enough of the promised hours were being given to them:

> *[T]hey work on a rota where there's two agencies in each locality roughly and each week they'll take everything that goes that week. And if anything, [the providers are] saying that they're not getting enough, rather than [too much]…* **Site 4, local authority interviewee 3**

In two of the sites, providers had been allocated a neighbourhood and number of hours on the framework, but had been able to increase this by encouraging their existing clients from other neighbourhoods to move onto a direct payment and continue using their services. This approach ensures continuity of provider (which may be a positive outcome in relation to personalisation), but it **undermines the logic of the neighbourhood commissioning approach**, which is that providers get guaranteed hours in their locality and plan their staffing accordingly.

A number of issues are at work here, all of which speak to the difficulties local authorities have in managing a market in which **they are not the only commissioner and have limited control over the workforce**. In more affluent sites, some providers were shifting to the self-funder market and capacity was limited as care staff were able to find better paid employment outside the sector. In less affluent sites, care providers lacked access to self-funder cross-subsidy and some were exiting the market altogether.

In a number of sites, a further worry for providers was that the local authority couldn't offer the long-term assurances that were needed for investment, particularly in building-based services.

One provider expressed their nervousness about local authority intentions to move to a lead- and sub-provider model:

> *Well, you know the demand's out there, it just depends what role you're going to play. Will we be a leader in delivering that and subcontracting [other providers]? Or will we miss out and have to be subcontracted to someone else and how will that work out?* **Site 1, provider 2**

In a number of sites, a further worry for providers was that the local authority couldn't offer the long-term assurances that were needed for investment, particularly in building-based services:

> *What do they want? Where do they want it? How much are they going to pay for it? That all enables us to put our hands in our pocket and invest in something… Local authorities… think well, we'll do something for a couple of years, any chance you could spend £3 million building it? Well, you can't build something for £3 million and two years later they change their mind.* **Site 2, provider 1**

Table 4: The managed market approach

Exemplar market shaping strategy	Framework contract, for whole borough or on a neighbourhood basis.
Logic	Stabilises the market through guaranteed supply and facilitates rapid placements.
Local authority attitudes	Several sites had recently established new framework contracts for home care, but found this had not been as effective as hoped due to lack of provider capacity.
Provider attitudes	Some providers unwilling to sign up to framework due to low fees. Others were attracted by the guaranteed hours but not getting the expected demand.
User attitudes	Users can be uncertain about how providers are allocated to them. Choice may be limited.
Self-funders	Not directly addressed. May inhibit choice through shrinking the market.
Personalised	Limited provider choice for individuals.
Integrated	Can be used alongside other partners, eg, to improve hospital discharge.
Vibrant and sustainable market	This approach emphasises sustainability but does not seem to be matching supply and demand in the way that commissioners had anticipated.

Personalisation in a managed market

This approach aims at stabilising the market through reducing the overall number of commissioned providers and/or using a lead- and sub-provider model to combine sufficiency of supply with flexibility. In the areas that were moving to this model, there was concern about **its impact on choice of provider**:

> *The way they commission that service is in geographical lots, so they will, I don't know, commission 5,000 hours of domiciliary care for a borough… The challenge really to the local authority, and I've had this with various people in the commissioning team is to say, 'Well, where is the choice there? That customer has no choice, you decide and that's a given'.* **Site 3, provider 1**

One person (a self-funder), whose mother had used a provider allocated through a hospital discharge scheme, described her lack of choice in the process:

> *Social services at the hospital said a care package needed to be put in place. [The care provider] employ assessors who work in the hospital to assess people's needs and get people home… We weren't given a choice of agency, we were just told we were having that one…* **Site 1, carer 6**

The scope for this model to enhance choice and control is limited. The guaranteeing of hours to providers, at the same time as purposefully shrinking the number of commissioned services, inhibits user choice.

4.3 Open market – low control, distant relationships

In the open market approach, commissioning is done by the person using the service, through a direct payment, or other kind of individualised funding model. This is the approach to care commissioning promoted by the Putting People First Concordat (HM Government, 2007), in which support would primarily be accessed using a personal budget, within a structure of improved access to universal services. The role of the local authority here is **to stimulate a diverse market of providers**, including non-regulated providers such as personal assistants and micro-enterprises. By encouraging individuals to commission their own care, the aim is to enhance choice and control and minimise waste. Local authorities

that are actively taking an **open market** approach, facilitating diverse supply and individualised commissioning, are also likely to provide a conducive environment for self-funders, who are already acting as micro-commissioners on their own behalf.

Shaping the market through the open market approach

All of our sites were adopting some elements of an open market approach. This was particularly the case in support for working age people holding a direct payment. In some sites, commissioners were explicit that this was not an approach that was appropriate for older people (despite clear sector guidance to the contrary):

> [P]articularly for older people, in my experience, people just want to know which service is local and if it's a good service that's local, that's fine. They don't necessarily want five good services that are local to choose from. **Site 7, local authority interviewee 1**

> [T]he issues around an individual employing a PA, for example, is just too difficult to manage, especially for an older person. **Site 8, local authority interviewee 6**

The proportion of people receiving direct payments, or part-direct payments, varied across the eight case study sites. The lowest proportion was a site where fewer than 10% of people accessing services were receiving a direct payment (either full or in part), compared to (at the higher end) a site where approximately 40% of people accessing long-term support received a direct payment (NHS Digital, 2018b). In most sites, a higher proportion of working age people (18–64 years) received a direct payment or part-direct payment than those aged 65 years or older. Across the sites, the proportion of working age people who received a direct payment, or part-direct payment, ranged between 12 and 60%. For those aged 65 years and older, this ranged between 5 to 40%.

In sites with a higher proportion of direct payments, **the development of an open market was a clear priority**. It was seen as linking well to other strategies such as Personal Health Budgets and Integrated Personalised Commissioning. Respondents emphasised the importance of people being the active *'integrators of their own care'*, although some expressed concern about how far health commissioners understand the personalisation agenda.

In other localities, local authority interviewees indicated that they had prioritised this model for several years after Putting People First when there had been strong national policy drivers, but that they had **now drifted away from it**.

This type of market shaping requires commissioners to let relationships develop bilaterally between users and providers. As a provider put it:

> *Local authorities have to get out of the way and allow providers and service users to develop the relationships between them… [T]heir role simply needs to be, 'Is everything proceeding as it should be? Is the customer happy, healthy? In that case, that's all we need to know.'* **Site 2, provider 3**

However, this requirement to 'get out of the way' was something that many local authorities struggled with.

> *[P]robably the most challenging bit is the bit where we don't actually commission with those providers, so it's shaping the market that we don't have a direct relationship with.* **Site 4, local authority interviewee 1**

In particular, there was uncertainty about what the role of the local authority should be in this type of market shaping:

> *We're still very much in the mind-set that we're the parent: we know all the services, we know what are the best ones, and we are the judges of quality. Something I hear regularly is, 'Well, you know, what quality framework does that third sector organisation follow?' Well, frankly, probably none. But does that mean that all of their service is no good? Quite often it doesn't mean that, but the risk aversion, the fear of being seen to recommend or support a service that isn't quality-assured, that limits the ability of the market to shape around social care and health, in my opinion, because we are too scared of what will happen if someone has a bad experience and we are somehow found to be accountable for that.* **Site 8, local authority interviewee 2**

The development of an open market was recognised to involve facilitation rather than simply assuming that supply would emerge to match demand. For example, one case study site had employed care coordinators who were tasked with proactively helping people find appropriate support, including community resources.

> *[I]t's meant having a coordinator out there to help develop some of those community businesses so people can go there before they come to us, or they go clutching their personal budget in whatever form that takes and they can buy what they need from the community and they're not coming into service land, if you like, before they ought.* **Site 8, authority interviewee 2**

> **❝…In the old days, there used to be leaflets. But now when we say, well, we need information, we are often signposted to online information websites. And we say well, we haven't got the computer skills.❞**

Personalisation in an open market

The open market approach is the one that most explicitly prioritises user choice and control. Many interviewees with direct payments reported positive experiences of being able to choose their own care, although they wanted much more local authority support and facilitation than they were currently getting. The informal nature of the open market approach often means that users and carers are left to their own devices to find providers through word of mouth. Personal assistants reported feeling isolated, with a lack of formal structures to match them to the people needing support:

You're left to struggle on your own. That's the only downside… Gumtree, I've used the Job Centre. Word of mouth, yeah. Advertising in shops, newsagents, that kind of thing. That's the main ones I've used. **Site 1, personal assistant 2**

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You're left to struggle on your own. That's the only downside… Gumtree, I've used the Job Centre. Word of mouth, yeah.

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Self-funders similarly reported being left to find their way around providers with only a care directory to guide them. Carers reported the difficulties of operationalising choice where they are only given a list of providers – or told to look online:

This [local authority] person said, 'It's online.' I said, 'Well, there's a lot online. I want to be able to focus on this area' … He rather grudgingly sent this really un-useful list. It was sort of 30 [agencies], and they were from all over. **Site 6, carer 1**

In a group of family carers for young people with disabilities, participants reflected on the difficulties of finding information in a language other than English, which had been exacerbated by the move away from printed leaflets:

There has been a change in how information is now conveyed to people. In the old days, there used to be leaflets. But now when we say, well, we need information, we are often signposted to online information websites. And we say well, we haven't got the computer skills. **Site 1, Carer focus group, translated from Urdu**

Table 5: Open market model

Exemplar market shaping strategy	Direct payments, Personal assistants, micro-enterprises.
Logic	Individuals can commission their own care to enhance choice and control and minimise waste.
Local authority attitudes	Fits with personalisation but can be seen as risky due to lack of control over quality.
Provider attitudes	Popular with some providers but can be seen as a threat to those on block/framework contracts, due to perception of lack of a level playing field around regulation.
User attitudes	Works well for people who can commission their own care but does need facilitation.
Self-funders	Most self-funders already commission their own care. They can benefit from the market diversity and facilitation.
Personalised	People can commission the support they want (subject to that being available, affordable and signed off by the local authority).
Integrated	Can fit into other initiatives such as Personal Health Budgets and Integrated Personalised Commissioning.
Vibrant and sustainable market	Emphasises vibrancy of the market. Some respondents saw a trade-off between diversity and sustainability, suggesting that the open market approach was unsustainable.

4.4 Partnership – low control, close relationships

In this approach, local authorities work with a small number of providers to co-design services and orient them to outcomes. This may also involve community co-design and a focus on asset-based approaches. The aim is to assure the long-term stability of the market, an appropriate service mix, and achievement of individual-level outcomes, which may include preventative interventions.

Shaping the market through the partnership approach

Four of our sites were undertaking approaches which fitted the partnership approach. In all eight of our sites, we found that this was a model that local authority commissioners aspired to move towards, feeling that it was consistent with the Care Act and likely to offer the combination of stability, quality and affordability that communities, providers and the local authority wanted. It could also create positive knock-on benefits for **self-funders** if there is more investment in long-term, preventative services, or in effective reablement and a mixed supply of residential options like extra care housing. It is a model in which Care Act principles of integration and prevention can be embedded:

We've got integrated neighbourhood teams, teams who have knowledge of their own locality and give support and activities, which is available for all individuals… We need to have lower-level support service, like volunteer drivers… befriending services, carer services, you know. This is low-level prevention, but this is really important, bringing the voluntary sector involved into… personalisation. **Site 4, local authority interviewee 5**

Taking a more long-term approach was also welcomed:

> *There used to be 30-odd, but there's nine main providers in [our area] now. So, that gives you the economy of scale… which is good. And it's a ten-year framework so it's a long-term framework as long as each party is satisfied with each other, it allows you to put some real roots down, you know.*
> **Site 4, provider 3**

However, a number of authorities reported slow progress in moving in this direction, which they attributed in part to a lack of appetite for new ways of working amongst health partners or care providers:

> *CCGs go into this kind of state where the clinical stuff becomes supreme over everything else and NICE guidance becomes everything. And they can't really understand what else there is that they need to think about and talk about.*
> **Site 2, local stakeholder 1**

> *I think if I was to go and do a tender and say that I want an outcome-based contract, [the providers] would have absolutely no idea what I'm talking about or where I'm starting from and I think that's because all of our care home markets [are] kind of [small to medium enterprises]. I think they'll deliver really good quality care, but they won't necessarily… understand, okay now, we want to pay you based on the outcomes that you deliver or even start talking about outcomes framework, because I think they would be… really lost.* **Site 7, local authority interviewee 2**

Another interviewee, from the voluntary sector, felt that local authorities themselves bear some of the blame for a lack of provider innovation:

> *[A] lot of [local authorities] have the providers that they deserve. They're the people who commissioned them over [the] years, and so that's what you've got…They're cut to the bone, they don't have any management… And now, they're saying to them in the new contract, of course, well, actually what we want you to do is something really totally different. And we're now going to start paying you a little better. And the homecare providers, of course, are finding it very hard to respond to that.*
> **Site 2, local stakeholder 1**

In some areas, new payment models were being developed to enable providers and local authorities to gain mutual benefit from a reduction in service due to, for example, taking a more recovery-oriented approach in mental health services:

> *…there's a selection of outcomes that they [people using the mental health service] choose from and then with the support of the support worker and the care coordinator, or any other agencies that are involved, we'll work together… to kind of move up the scale. Their package of hours will decrease, which means it will cost less and then that gap of savings is split 50/50 between ourselves and the local authority as a gains share.*
> **Site 1, provider 1**

However, in other areas, providers reported that commissioners were expecting outcomes-based approaches without having changed their financial models:

> *[Y]our aim is to get someone better, and reduce the amount of care, and get them, you know, out of the system and as independent as you possibly can down to a minimum level. You can't then pay me based on the amount of time that I'm delivering, because the sole purpose of what I'm doing is to reduce the amount of time I'm spending with the individual and make them more independent.*
> **Site 2, provider 3**

Although the importance of wellbeing was recognised by commissioners in all of our sites, the cultural shift necessary to drive different market shaping processes was harder to achieve. One provider described it as the need to take a holistic approach, focused on overall wellbeing rather than the services and processes:

> *It isn't a service; there isn't a service in place. It's about people leading activities, people learning new skills, developing people, sharing. And inevitably, it's by that networking, that connectedness, that people's health and wellbeing can improve, people's lives improve, people's employment rates can improve.*
> **Site 1, local authority interviewee 9**

Personalisation in a partnership approach

The partnership model brings service-users and families into a dialogue with providers and commissioners about the outcomes that they seek to achieve. The model of choice and control here may be one in which provider choice is limited, but choice and control is maximised over how people want to be supported and spend their time. Through the opportunity to set out and achieve outcomes, people may transition into less reliance on paid support, and we did find examples of that:

> *To put it bluntly, they've exceeded my expectations in a way. They've helped me get myself doing things that I wouldn't normally see myself doing… Not only has it built my confidence up but also, they've shown me what there really is out there.*
> **Site 4, service user 9**

However, it is worth noting that not all the people we interviewed saw a reduction in service as a positive outcome.

> *I mean, the council have tried to cut my hours… my shopping down and my washing and all that down to once every two or three weeks, you know, but I put up a bit of a stink and said I needed to have my washing done every week.*
> **Site 1, service user 4**

This is a reminder that outcomes-oriented conversations, which may lead to a reduction in service, need to include the priorities of the person being supported and not be contractual conversations between commissioners and providers.

Table 6: The partnership model

Exemplar market shaping strategy	Outcomes-oriented commissioning.
Logic	Assures the long-term stability of the market, appropriate service mix, achievement of outcomes.
Local authority attitudes	Fits with personalisation but requires local authorities to trust providers and to have sufficiently innovative providers.
Provider attitudes	Popular with some providers due to long-term assurances, but can be a threat to others eg, where financial incentives are not aligned with the new model.
User attitudes	Offers scope for user-defined outcomes, which might include reduction in formal services.
Self-funders	May benefit from development of services for the broader population, eg, relating to prevention or housing.
Personalised	Can be outcomes-driven in terms of commissioning (although those outcomes may be set by commissioners) and data-driven.
Integrated	Scope for population-level planning with health and other partners.
Vibrant and sustainable market	Emphasis is on sustainability, this may be at the expense of vibrancy/diversity.

‘

[A] lot of [local authorities] have the providers that they deserve. They're the people who commissioned them over [the] years, and so that's what you've got… They're cut to the bone, they don't have any management…

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Part 5: Linking market shaping to costs and outcomes

Two key questions to consider in examining different models of market shaping are: what are their associated costs; and what difference – if any – do they make to individual outcomes? We aimed to better understand what costs were generated by market shaping and the extent to which different approaches to market shaping generate different outcomes for people using services and for carers. As we discuss below, both identifying costs and attributing outcomes proved difficult and we weren't able to draw clear conclusions about cost-effectiveness from our data.

The following data sources are discussed in this section:

■ Local Authority Revenue Account Budget: Adult Social Care
■ Interviews with commissioners
■ Client Service Receipt Inventory (resource use) data from people using services
■ ASCOT, ICECAP and EQ-5D data on outcomes from people using services and carers

We looked at (i) what local authorities consider to be the costs of market shaping; (ii) whether there is a difference in resource use (eg, healthcare visits) depending on which of the four models of market shaping is being used; (iii) whether user outcomes are patterned by the type of market shaping in their locality.

There are two returns relating to market shaping activity in the Adult Social Care section of the annual Local Authority Revenue Account Budget, and we began with these as a measure of market shaping activity, given that it allows comparison between sites and over time in two categories (a) Information and Early Intervention and (b) Commissioning and Service Delivery.

However, the volatility of this data proves an unreliable measure of activity. Some sites had a zero return for one of these categories, whilst others showed high levels of variability between years. When the data was sense-checked with commissioners in the sites, the return was described as something 'done by finance' and not a reliable guide to spending on market shaping.

A second data source was interviews with commissioners in the eight sites, in which we asked what costs were incurred by the market shaping duty. Here we found substantial variance across the eight sites in relation to what was included in market shaping. Some focused on staff costs:

There isn't a lot of cost that's actually external to officer time. **Site 3, Local authority interviewee 1**

Others interpreted market shaping as a much broader category of activity and expenditure:

Your market shaping activity is everything other than your actual spend on services. **Site 8, Local authority interviewee 1**

It's not just about revenue costs for social care, we're talking about capital costs. **Site 6, Local authority interviewee 1**

You've got the impact of things like the Better Care Fund and stuff like that… which you could say has got large elements of market shaping in it because it's actually across the health and social care footprint. **Site 8, Local authority interviewee 1**

Some challenged the notion that it was possible to disaggregate market shaping activity from broader social care spend:

It would be much more difficult to separate that out… It's sort of part of everything we do. **Site 3, Local authority interviewee 1**

Interviewees had mixed perceptions when asked about whether the market shaping duty had increased or decreased local authority costs since the Care Act:

I don't think it costs any more… It's just doing it differently… it's just about best use of our resources really. **Site 1, Local authority interviewee 1**

By doing the market shaping and engaging with the market in the long run, it's actually more cost-effective to us because we end up buying services that are right rather than the services that we think we need in the way we think we need them. **Site 7, Local authority interviewee 2**

The cost of it is not on my radar because that's not important, it's got to be done, you know, it's non-negotiable. **Site 8, Local authority interviewee 1**

These qualitative responses highlighted the **difficulties of identifying discrete market shaping activities and costs**. The findings were discussed with the commissioners from each site who engaged in the peer-learning exercise. In particular, participants were asked to consider the likely differential spread of costs of undertaking one of the four types of market shaping (recognising that in practice most sites were utilising a combination of the four). The expected ratios of spending on different market shaping activities are shown in Table 7 below. It indicates that the 'distant relationship' approaches (procurement and open market) are seen as likely to have the lowest costs across all categories, largely because they are more short-term and require less senior staff involvement. The managed market and partnership were seen as incurring higher costs in most categories.

Box 1 shows the results of **analysing the individual survey responses to assess resource use and individual outcomes** of people using services and family carers in the eight sites. Interview participants were asked to complete an adapted version of the Client Service Receipt Inventory (CSRI) to collect resource use relating to health and social care use, and two outcome measures: the Adult Social Care Outcomes Toolkit (ASCOT) and the ICECAP-A. Respondents were assigned to one of the four models, based on how their 'sub-market' in that locality had been coded (as shown in Figure 4 on page 17). Given the relatively small sample size (we received baseline and follow up data from 49 service users and 54 carers) for each model, this part of the study combined the four models into two pairs – the 'low control' models (open market and partnership) which the stakeholder

interviews indicated were compatible with the underlying principles of the Care Act, and the 'high control' models (procurement and managed market) which the stakeholder interviews suggested were not compatible with the Care Act. Interview participants, recruited through the snowball approach described earlier, were asked to complete outcome and resource use data at baseline (face-to-face interview) and at six-month follow-up (primarily through postal methods). Costs were categorised as healthcare costs, social care costs or informal care time.[1] Quality of life measures were ICECAP-A score; ASCOT Social Care Related Quality of Life and EQ-5D score.[2]

[1] Informal care was valued using the proxy good method (van den Berg et al., 2004).

[2] The EQ-5D score was estimated from ASCOT using a recently published methodology (Stevens et al., 2018).

Table 7: Comparing expected local authority spending level on the four types of market shaping

	Procurement	Managed market	Open market	Partnership	Rationale
'For the following activities, please indicate whether you would expect spending in each column to be low, medium or high relative to each other'					
Provider engagement	LOW	MEDIUM	LOW	HIGH	Building relationships is key to the partnership approach, and requires more senior officer involvement than in the other approaches.
Community and user engagement	LOW	MEDIUM	LOW	HIGH	Coproduction and co-design is particularly a feature of the partnership model, although may also be used in shaping framework contracts under managed market.
Tendering/ Contracting	HIGH	HIGH	LOW	MEDIUM	High control approaches require tight specification of contracts. In other approaches, formal contracting is less central and time-intensive.
Monitoring performance/ outcomes	HIGH	HIGH	LOW	HIGH	All types (apart from open market) require high levels of oversight, although partnership is a learning/adaptive approach with providers rather than a monitoring process.
Use of data	LOW	MEDIUM	LOW	HIGH	In partnership model, long-term planning, based on good population and outcome data, is key to design and learning.
Provision of Information, Advice, Advocacy	LOW	LOW	HIGH	MEDIUM	Users have most choice in the open market model and require IAA to navigate that. In partnership model, IAA helps in identifying outcomes.
Facilitating access to direct payments	LOW	LOW	HIGH	LOW	The open market model prioritises individualised funding which may require brokerage and support.
Integration with health	LOW	MEDIUM	LOW	HIGH	Working closely with health system is most evident in the partnership model.

The data summarised in Box 1 suggests that the Care Act-compatible commissioning models (open market and partnership) may be linked to higher resource use than the non-compatible models (procurement and managed market). Not all of these costs will be incurred by the local authority (the sample includes self-funders and the CRSI includes health as well as care costs), but it may explain the continued appeal of the procurement and managed market models to local authorities. A limitation on this data is that there was wide variance in spend per individual given that we recruited a diverse sample of people with different levels of health and care needs. It is not clear why there is higher reliance on informal care in the open market and partnership models. Since they are 'low control' models, there may be a greater need for families to work with providers to purchase care or agree outcomes. The improvement in quality of life between baseline and follow-up for people using the open market and partnership models, may suggest that these models offer a better fit over time for people than the 'high control' options which are subject to local authority specification.

These inferences have to be heavily caveated, given the small sample size (particularly for the follow up survey), the variance in care spend per individual and the difficulties of attributing costs and outcomes to market shaping activity, which our qualitative work showed does not have the characteristics of an 'intervention', and in which there are many intervening variables which inhibit causal relationships. We conclude that assessment of the cost-effectiveness of market shaping is likely to remain elusive, and that commissioners would do better to see different types of market shaping as facilitative of interventions which themselves can be assessed for cost-effectiveness (eg, the provision of Extra Care Housing as part of a partnership approach (Holland et al., 2015)).

In the final section of the report, we consider how best to bring together the approaches that are most compatible with the Care Act – the open market and partnership types of market shaping – recognising that both are likely to be needed in a locality, but that potential tensions between them need to be addressed.

Box 1: Summary Findings from the Resource Use and Individual Outcomes Analysis

Overall, **total costs were slightly higher in the Care Act-compatible group,** *ie, for people in the sub-markets classed as open market or partnership compared to those in the non-Care Act compatible group (people classed as in procurement or managed market sub-markets). (See table A1 in the Appendix).*

Mean total costs, measured over a three-month period, were £1,361 per service-user in this open market/partnership group at baseline, compared to £1,112 per service-user in the procurement/managed market group.

At six-month follow-up, costs increased for both groups; mean total cost per service-user was £1,510 in the Care Act-compatible group compared to £1,334 per service-user in the non-compatible group. The size of the difference in mean total costs between the two groups decreased from baseline to follow-up (£249 vs. £175), however, this difference was not statistically significant at either time point.

At baseline, **the most sizeable difference in costs was in informal care,** *with this being higher in the Care Act-compatible group. There was a £663 difference in mean costs of informal care and this was the only statistically significant difference in the broad cost categories at baseline.*

Average quality of life (QoL) scores did not differ much between service-users within the two groups *(table A2 in the Appendix). At baseline, QoL scores were slightly higher in the non-Care Act compatible pair (procurement/management market) compared to the Care Act-compatible group (open market/partnership). However, at follow-up, this pattern was reversed.*

QoL scores were higher at follow-up than they were at baseline across all three measures for the Care Act-compatible group. *However, for the non-compatible group, QoL scores were lower than they were at baseline across all three measures.*

For carers, mean QoL scores were typically lower at follow-up than they were at baseline for both groups. *This was with the exception of mean ICECAP-A score in the Care Act-compatible group, which was slightly higher at follow-up than at baseline (0.640 vs. 0.626).*

When baseline and follow-up scores were used to generate QALY (Quality-Adjusted Life Years) changes for the three outcome measures, **differences between the two pairs were again very small and not statistically significantly different** *(table A3 on page 44).*

Part 6: Getting the best of both worlds

All of the sites in our study were in transition, moving between the four parts of the market shaping typology as they sought to discharge their duties more effectively. One of the elements we looked at in the research was **why local authorities were moving in particular directions**, or were stuck in a model of market shaping that they recognised to be sub-optimal. We developed this section of the report through the peer-learning exercise where we shared the four-part typology with commissioners from our case sites. This offered a 'member check' to validate our findings and scope to test out emerging recommendations (Koelsch, 2013).

Several interviewees talked about having moved from a procurement to a managed market to an open market approach, and then either **now attempting to move to the partnership approach, or going back to the managed market** to regain greater control over the market. One local authority interviewee described the rationale for retreating from the open market:

> *Everyone jumped on choice means more… more provision and more providers and you got all these organisations set up to kind of hit that… Actually, it diluted a market and… I think it's created unsustainable business models at the moment actually. So, we're looking to kind of reverse that a little bit…* **Site 1, local authority interviewee 1**

A provider reflected on watching the progression from open market back to a managed market:

> *Other local authorities in [the region] have gone very hard down the individual budgets route, which is great. Again, if it's accompanied by stimulation of the market to deliver what those people want to buy, but they're also now starting to kind of retract that offer a little bit. They're… starting to look back at commissioning blocks of service rather than allowing people to make their own decisions. That seemed counter-intuitive to me and… it goes against some of the stuff that we've been trying to do within our services to kind of liberate people and say, 'You do have a choice, you don't have to do, you don't have to purchase this particular service'.* **Site 3, provider 1**

Some local authorities were **purposefully deploying different market shaping strategies** in different sub-markets, but in others, there was a tendency to drift between quadrants as the limits of one became apparent.

There was little reflection on how the different market shaping approaches interacted with each other. For example, several sites were seeking to combine a managed market with an open market approach in home care – working with established providers at the same time as stimulating micro-enterprises and personal

assistant provision. However, this was antagonising some of the framework providers because of a perception of double standards:

> *The reaction from the traditional service providers has been very mixed… One of the fears for providers is that it's an attempt to kind of dismantle the current structure of the market and give people more choice. In so doing, undercutting traditional providers because micro-providers aren't subject to the same regulatory control, so their costs are lower.* **Site 5, provider 1**

This response highlights the **importance of working with providers** to communicate the different contexts and advantages of being located within either the open market or partnership approaches. It also requires clarity about the rationale for regulatory approaches being different. Local authorities need to be able to work with the CQC and national policy-makers to articulate for providers and for people using services why 'open market' providers operate with less regulatory scrutiny than other providers. There also needs to be recognition by the CQC of the implications of partnership working for regulatory oversight:

> *Our delivery models include… health and wellbeing workers, housing advisors. But, that didn't fit sort of CQC. How do you contract with that? Well, we don't. We work together differently. Yeah but, who's responsible for that? So, if you've got a housing input into a wider health and care provision, they couldn't get their heads [a]round… whether that was appropriately regulated or not.* **Site 4, local stakeholder 2**

Barriers to working in the partnership and open market approaches may also come from within the council. In the peer-learning exercise, several commissioners discussed how they had experimented with partnership approaches – including co-designing approaches with providers and other stakeholders – but had to abandon this approach due to **internal resistance from legal and procurement teams** and an inclination to emphasise contract price. Excessive focus on contractual terms and conditions led to provider caution and fear of breaching the rules. Despite these issues, the participants in the peer-learning exercise agreed with the imperative to **combine an open market with a more long-term partnership approach**, in order to get 'the best of both worlds'. Together, these approaches offer scope to support self-funders in different ways, and also to respond to demographic diversity amongst people using care services. However, there are tensions between these models which need to be openly discussed and managed.

Both of the approaches require sufficiency of supply and demand. Both **offer ways to incentivise providers to enter and stay in the market**, either through lowering barriers to entry and increasing micro-commissioning (open market) or by providing long-term stability and the opportunity to co-design new approaches (partnership). Potential risks of adopting both models side-by-side include so-called 'cannibalisation' between the two: will local authorities discourage direct payments and an open market if they have heavily invested in a long-term partnership approach? Alternatively, does the commitment to personalisation and micro-commissioning mean that partners will not get the security of demand that they need to invest in staff and facilities? We found evidence of both types of conflict in our case sites. In Table 8 we set out some of the distinguishing elements of the two models and how they can potentially complement but also clash with each other:

Table 8: Comparing the open market and partnership approaches

	Open market	Partnership
Rules	Low contract specification by LAs	
Relationships	Distant relationships between a large number of providers and local authority.	Close relationships between a small number of providers and local authority.
Outcomes	Outcomes are decided by individuals using services, and signed off by social worker/care manager.	Measurable outcomes are set by commissioners and providers. Providers may then work with users to identify their individual outcomes.
Local authority role	Key role of local authority is in providing information and advice, stimulating the market and possibly providing some quality assurance.	Key role of local authority is co-designing services with providers and communities, creating opportunities for learning.
Risk	Higher risk for providers.	Lower risk for providers.
Self-funders	Indirectly helps self-funders who already operate in this space.	May enhance self-funder access to a broader range of services, eg, prevention, housing.
Personalisation	Promotes personalisation, choice and control, building on existing direct payment support.	May reduce individual choice of provider but can create opportunities for services to be better oriented to individual outcomes.
Diversity	Can stimulate provision of small, culturally appropriate providers for communities.	Large providers may be able to employ a diverse staff base to support culturally diverse needs.
Target group	Suitable for people who can commission their own services (with support).	Suitable for building-based services and other high-investment projects; recovery-oriented services; prevention.

The skill-sets and relationships are different in these two models so care needs to be taken in combining them. Supporting open markets requires commissioners to have an **entrepreneurial understanding of the market**, including how to stimulate market entry, and how to support individuals, families and providers to manage the risk and complexity of individualised commissioning. The partnership approach requires building trust with providers and communities over the long-term, which may reduce individual choice of provider but enable people to make choices in relation to how their outcomes are achieved. The next two sections look at two elements of this: trust and outcomes.

Building Trust

The partnership approach requires high levels of trust between commissioners and providers, and a willingness to design the market for the long-term. On the whole, we found low levels of trust between commissioners and providers in all our sites. As this commissioner put it:

Fundamentally it's trust… Particularly financially if we're saying 'yes we'll give you that pot of money for that group of customers, here's x per year, just meet all their needs, we trust you to do that', but we don't… We want to measure it. We don't quite trust that those outcomes will be met for that money unless we can see what's been delivered minute by minute. Yeah and then it becomes a bureaucratic nightmare! We want to change things but carry on measuring it in the old way, because we're so paranoid. **Site 8, Local authority interviewee 4**

This local voluntary sector leader highlights the problems on both sides in relation to trust and transparency:

What [the local authority] do is they buy something… they monitor it, tell the organisation off for not doing it properly… The organisation itself (and I've been on the other side of this), we just tell the commissioner whatever it is that we think they need to hear to get them off our back. Why would we do anything else… because they are judging us on that monitoring, the monitoring doesn't make any sense. Because they haven't really understood what it is they're monitoring a lot of the time. **Site 2, local stakeholder 1**

Several local authorities expressed concern about risks of profit-extraction by large providers if more public money comes into the system. Some were unsure about the business models of some of their providers:

You don't understand how their business is structured. You don't understand the business that that overhead exists in. So, you don't know whether they've got a mortgage on an owned property, whether they're renting, the local rental fees. **Site 4, local authority interviewee 2**

One local authority had worked with providers on a more transparent basis to help understand their context and business model, and to improve staff wages:

We did a bit of work with those providers to understand, 'Okay, what kind of structure of a company are you? What's your profit margins? What can you really afford? What can you not?' On the whole, they were small, independent or sub-regional organisations that could demonstrate that, if we provided them with extra money, that would be passed on directly to staff… **Site 3, local authority interviewee 1**

From the provider perspective, **a key barrier to trust** was the high turnover of local authority commissioners, care managers and social workers, which inhibits communication, continuity and a coherent organisational long-term strategy. Commissioners themselves recognised that they often do not project a clear and consistent market shaping strategy that is needed to allow trust to develop:

When you talk about market management, market shaping, whatever you want to call it nowadays, I don't think we know what we want and we're not communicating it and it's not clear, which doesn't bode well for many local providers, small or large, to think about the work they're doing. **Site 1, local authority interviewee 9**

It was also clear that in some cases, **providers may not trust other providers** and that this was contributing to the vulnerability of approaches such as lead and sub-provider models.

> *So when you're in a formalised procurement exercise, you know, basically we don't even ask who they are in the room because some organisations don't want to give that information over… Even things which are less formalised, providers will sort of either use it as a sales pitch, even though it's not part of the procurement exercise, or become very very reticent to actually be open about what's happening for them and what works and whatever – because they have people round that table who might be bidding against them in six months' time.* **Site 6, local authority interviewee 1**

To outcomes and beyond

There was a sense in several of our case sites that commissioning for outcomes via partnerships was the desired destination of their market shaping approaches. However, there were a number of barriers to this, particularly in a low trust setting. **Early experiments with outcomes-based commissioning** have encountered some of these problems and suggest that moves to partnership arrangements require iterative adjustment rather than 'big bang' approaches (Bolton, 2019). Bolton argues that there should be realistic expectations of **the time it may take to develop agreements** to support outcomes-based commissioning and that continuing discussions between all parties are needed. Providers should not be held solely to account for the outcomes achieved.

Instead, all parties should work together to consider why certain targets may have been met and others have not, recognising that in complex systems attribution is difficult to establish. There needs to be scope for learning and adaptation, 'using monitoring data for reflection, rather than target-based performance management' and fostering a 'positive error' culture (Lowe and Plimmer, 2019, p.19).

> *So it's no longer us saying, 'This is what we want. Off you go, go and do it.' It's more about how do we as commissioners and you as the provider work together to deliver these outcomes but also drive up quality and drive down costs.* **Site 7, local authority interviewee 2**

There needs also to be an awareness of the **limits of defining outcomes in functional terms**. Good care which supports the Care Act principle of wellbeing is relational: good relationships between the people giving and receiving care are one of the outcomes that are valued most (Lewis and West, 2014; Eldh et al., 2016; Needham et al., 2017). **Sustained relationships are also essential to building trust with communities** so that local communities do not see a reduction in service as a violation of their entitlements. However, this can only succeed where there is a comprehensive asset-based and strengths-based approach to developing and linking community resources alongside care and support service provision (Tew et al., 2019). This then raises the importance of co-design and co-production with people using services, families and broader communities as well as providers so that care services support broader wellbeing.

Part 7: Conclusions and recommendations

The aspirations of the Care Act to improve market shaping and support personalised outcomes were endorsed by the people who took part in our study. There was no sense that the legislation was unhelpful or out of date. Rather, participants noted a **disjuncture between the aspirations of the Act and the practices in localities**. The complexity of local care markets makes market shaping a complex and fractured activity. There are multiple sub-markets in operation within a local authority. As local authorities attempt to shape them, their activities overlap with those of other commissioners (health authorities, neighbouring boroughs, self-funders and direct payment holders). The elements that underpin effective care markets – notably, long-term funding confidence, stability of providers, high-trust relationships with and between providers, choice and control for people using services – were not strongly evident in any of the sites. Instead, we found the case sites drifting between types of market shaping, often solving one issue but generating another. **Market shaping has not been done in a purposeful way, and has lacked recognition of interdependencies between different market shaping models**.

In the report, we have set out a four-fold typology of approaches to market shaping, all of which are being used by local authorities. National stakeholder interviewees told us that **low control approaches**, which we separated into open market and partnership, were the **most likely to support the personalisation and wellbeing** aspirations of the Care Act. 'High control' approaches (which we termed procurement and managed market), undermine the scope for innovation and trust which support personalised outcomes. The national interviewees highlighted the advantages of both distant and close relationships between local authorities and the market: **the open market (distant relationships) maximises diversity and choice, whereas the partnership approach (close relationships) helps to secure long-term stability and an outcome focus**.

In local sites, we found support for this positioning. **Procurement approaches** minimised scope for providers to innovate, pushed down quality and offered no choice and control for people using services. **Managed market** approaches were being used to stabilise the market but were stifling choice and were not able to match supply and demand in the way that was hoped. Open market approaches offered scope for innovation and choice, but were not being facilitated in a way that helped people with the risk and complexity of the open market. The **partnership** approach was popular with local authorities and providers but difficult to operationalise given funding constraints, high local authority turnover and workforce shortages.

Attention should focus on how local authorities can be supported to develop a **combination of open market and partnership approaches**. This combination facilitates the development of close relationships with a group of providers while also allowing other providers to enter the market, and therefore has the potential to maximise choice for people accessing services.

There are **strong pressures pushing local authorities towards the open market and partnership approaches** that are compatible with the Care Act. Providers, people using services and carers, other local and national stakeholders, and key sector bodies (eg, SCIE, Think Local Act Personal) all advocate the 'low control' approaches, albeit in different combinations. However, these two approaches (open market and partnership) require local authorities to cede control, and the difficult financial circumstances in which they find themselves alongside the statutory need to meet care needs, is a **countervailing force pulling them towards the high control approaches** (procurement and managed market). Rising demand, constraints on public spending, insufficient staffing, weak consumer power and poor flows of information can steer local authorities towards forms of market

shaping which stabilise care markets in their current form rather than moving to more person-centred approaches. There is a perceived trade-off between individual choice and market stability, and local authorities don't necessarily have the capacity and skills in market management and foresight planning to address this tension.

Designing local rules in ways that enhance diversity and choice rather than reduce it, combining the open market model or the partnership model, should be the aim. **Partnership models are best pursued in an iterative way** to build trust, enable providers, service-users, families and communities to adapt, and to see the effects of changes (including on self-funders and other commissioning partners such as health). Doing this well is more than a technical commissioning role – it requires relational skills and the acumen to build trust and learning within complex local systems. **Open markets already exist in many areas but are fragile** and need active local authority facilitation to work effectively. The mix of open market and partnership approaches requires local authorities to combine two sets of strategies and behaviours, and for national policy and regulatory requirements to support such endeavours.

7.1 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 market shaping. 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.

6. All of these elements require **support and training**. There are many existing tools available to support local authority market shaping (for example, the LGA/DHSC/ADASS's **Commissioning for Better Outcomes framework and Integrated Commissioning for Better Outcomes** and resources from the **Institute of Public Care**). There is also a number of improvement initiatives within the sector, such as the LGA's Peer Challenge scheme and the 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**. 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 but requires a sustained commitment by all stakeholders to deliver the Care Act's radical ambition of improving wellbeing.

For more information on the project, please visit the Shifting Shapes website: **www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/research/projects/2017/shaping-care-markets.aspx**, or contact Professor Catherine Needham, **c.needham.1@bham.ac.uk**.

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Appendix – Detailed findings from economic analysis

Sampling process for economic evaluation

Eight local authorities (LAs) were selected to represent LAs in geographical spread; prevalence of self-funding; political control and authority type. The sample LAs comprised social care users who receive LA funding (eg, managed personal budgets or direct payments), and self-funders. Service-users were recruited through providers to reflect the breakdown of users nationally. Carers were recruited through local community organisations.

Outcome measures

Social care-related outcomes were measured using ASCOT (Adult Social Care Outcomes Toolkit) and ICECAP-A in interviews (care recipients) and focus groups (carers). Respondents completed measures via postal survey at six-month follow-up. From ICECAP-A, years of full capability and years of sufficient capability were calculated. The difference between YFC and YSC is that full capability (ie, scoring of 44444) is substituted with sufficient capability (eg, scoring of 33333). The latter corresponds to individuals reporting that they have at least 'a lot' of capability for each domain, as opposed to full capability across all domains (as in YFC). To calculate YSC, the original values of ICECAP-A are rescaled so that 1 is equal to the threshold of sufficient capability (scoring of 33333). ICECAP-A and ASCOT (service user) data were scored using UK tariffs to generate scores on a 0-1 scale.

Resource use

An adapted version of the Client Service Receipt Inventory (CSRI) collected resource use relating to health and social care use, valued using published national unit costs and NHS Reference Costs. To value the costs of informal care, the proxy good method was used. This information was collected as part of the questions to both service-users and carers and enabled the valuation of time losses following this methodology.

Analysis

Statistical analyses were conducted to determine baseline differences between the sample LAs. Parametric (independent samples t-test) and non-parametric (Fisher's exact test; x^2-test; Mann-Whitney U-test) were conducted to compare socio-demographics (age and gender), social-care related quality of life (mean ASCOT scores), capability (mean ICECAP-A scores), and resource use at baseline between sites. Significant differences were controlled for using ordinary least squares (OLS) multiple regressions to adjust for baseline characteristics in all tests of differences in costs and outcomes.

Economic evaluation

Mean ICECAP index scores were calculated at baseline and follow-up for intervention and control groups. YFC and YSC were then estimated using the standard area under the curve approach, whereby quantity of time is adjusted for full or sufficient capability, in the case of YFC or YSC, respectively. ASCOT responses were translated into QALYs using recently published methodology that informs an exchange rate between ASCOT and EQ-5D-3L (QALYs).

For cost calculations, unit costs for individual resource items were combined with mean resource use and mean differences in cost per service-user were then compared. To assess whether these differences were statistically significant between intervention and control groups, we used 95% confidence intervals, estimated by 1,000 bootstrap replications.

An incremental cost-effectiveness analysis was conducted to compare relevant costs and outcomes for providers and service-users in sub-markets using high levels of Care Act compatible interventions (open market and partnership) with those observed in LAs using non-Care Act compatible interventions. For outcomes collected using the ICECAP-A,

we assessed the cost-effectiveness of the intervention in terms of its incremental cost per year of full capability (YFC) and year of sufficient capability (YSC), ie, the additional cost of producing one unit of additional benefit in terms of capability well-being. We also presented cost-effectiveness in terms of incremental cost per year of full SCRQoL. Additional costs and outcomes (well-being capabilities and SCRQoL) were calculated as the difference in costs and outcomes between LAs using Care Act compatible types of market shaping and those using non-Care Act compatible approaches. These differences were expressed in an incremental cost-effectiveness ratio (ICER). For each of the three QoL measures, we calculated and presented ICERs based upon only service users' QoL responses and ICERs calculated incorporating both service-user and carer QoL. Cost-effectiveness figures based upon both service-user and carer QoL combined were used for the main base case results, as market shaping is likely to impact upon carer QoL.

Results of economic evaluation

Sample

Seventy-five service-users were recruited at baseline. Forty-nine service-users completed follow-up surveys at six months, giving a response rate of 65%. For the main base case analysis we included only those respondents who had provided both baseline and six-month follow-up data. This was to isolate the effect of market shaping on resource use and QoL over time and avoid making any misleading conclusions that could be due to losses to follow-up. Ninety-two carers were recruited at baseline and 54 carers completed follow-up questionnaires at six months, giving a response rate of 59%.

Resource use

Three aggregate cost variables were compiled using the various resource use variables to reflect the different cost categories. Mean total costs per service-user for each of these three dimensions are presented in table A1. Overall mean total costs were higher for the

intervention group compared to the control group (£425 more). At baseline, mean cost per service-user for informal care was £664 higher in the intervention group compared to the control group; this was the only statistically significant difference. At follow-up, this difference in cost reduced significantly to just £199 more in the intervention group and was no longer statistically significantly different between groups.

Outcomes

Quality of life (QoL) scores did not differ much between service-users within the two groups. At baseline, QoL scores were slightly higher in the control group compared to the intervention group (table A2). However, at follow-up, QoL scores were slightly higher in the intervention group. These differences were not, however, statistically significant. Furthermore, QoL scores were higher at follow-up than they were at baseline across all four measures for the intervention group, however, for the control group, QoL scores were lower than they were at baseline across all measures. For carers, mean QoL scores were typically lower at follow-up than they were at baseline for both groups. This was with the exception of mean ICECAP-A score in the intervention group, which was slightly higher at follow-up than at baseline (0.640 vs. 0.626). When baseline and follow-up scores were combined for presenting benefits of market shaping in terms YFC, YSC and QALYs, table A3), differences in mean QoL scores were again very small and not statistically significantly different.

Table A1: Total costs (£s sterling)

Cost category	Non-compatible (n=22)	Care Act-compatible (n=27)	Bootstrap mean difference (95% CI)
	Mean (SD)	Mean (SD)	
Baseline costs			
Healthcare resources	323 (423)	279	-44 (-274 to 148)
Social services	670 (884)	299	-371 (-792.90 to 53)
Informal care	120 (292)	784	663 (124 to 1598)*
Total costs	1112 (952)	1361	249 (-526 to 1218)
Follow-up costs			
Healthcare resources	197.93 (230)	548.93	351 (107 to 621)*
Social services	750.32 (910)	375.63	-375 (-824.10 to 118)
Informal care	385.98 (1146)	585.14	199 (-504 to 863)
Total cost	1334.23 (1518)	1509.70	175 (-781 to 1098)
Aggregate cost	2447 (2100)	2872 (3649)	425 (-1084 to 2175)

Table A2: Mean outcomes (indexed scores)

Measure	Service-users		Bootstrap mean difference (95% CI)	Carers		Bootstrap mean difference (95% CI)
	Non-compatible (n=22)	CA compatible (n=27)		Non-compatible (n=19)	CA compatible (n=35)	
	Mean (SD)	Mean (SD)		Mean (SD)	Mean (SD)	
Baseline index scores						
ASCOT SCT4 (SCRQoL)	0.855 (0.140)	0.834 (0.1574)	-0.02 (-0.11 to 0.07)	0.597 (0.293)	0.627 (0.214)	0.025 (-0.122 to 0.203)
ICECAP-A (full capability)	0.762 (0.204)	0.761 (0.207)	-0.001 (-0.12 to 0.12)	0.648 (0.256)	0.626 (0.237)	-0.031 (-0.265 to 0.120)
ICECAP-A (sufficient capability)	0.826 (0.192)	0.827 (0.203)	0.001 (-0.129 to 0.117)	0.734 (0.275)	0.701 (0.244)	-0.033 (-0.168 to 0.135)
EQ-5D-5L	0.787 (0.137)	0.767 (0.150)	-0.02 (-0.11 to 0.07)	0.535 (0.286)	0.564 (0.210)	0.025 (-0.116 to 0.175)
Follow-up index scores						
ASCOT SCT4 (SCRQoL)	0.835 (0.138)	0.844 (0.148)	0.01 (-0.08 to 0.09)	0.589 (0.290)	0.605 (0.245)	0.005 (-0.144 to 0.168)
ICECAP-A (full capability)	0.651 (0.263)	0.80 (0.183)	0.15 (0.01 to 0.28)*	0.629 (0.255)	0.640 (0.243)	0.005 (-0.144 to 0.194)
ICECAP-A (sufficient capability)	0.723 (0.203)	0.867 (0.174)	0.14 (0.02 to 0.27)	0.717 (0.281)	0.722 (0.262)	0.005 (-0.146 to 0.165)
EQ-5D-5L	0.767 (0.135)	0.777 (0.145)	0.01 (-0.06 to 0.09)	0.527 (0.284)	0.543 (0.240)	0.005 (-0.149 to 0.176)

Table A3: Mean QoL outcomes

Measure	Service-users		Bootstrap mean difference (95% CI)	Carers		Bootstrap mean difference (95% CI)
	Non-compatible (n=22)	CA compatible (n=27)		Non-compatible (n=19)	CA compatible (n=35)	
	Mean (SD)	Mean (SD)		Mean (SD)	Mean (SD)	
YFC	0.369 (0.086)	0.391 (0.095)	0.02 (-0.04 to 0.07)	0.314 (0.129)	0.323 (0.107)	0.008 (-0.068 to 0.089)
YSC	0.405 (0.082)	0.424 (0.092)	0.02 (-0.03 to 0.07)	0.356 (0.139)	0.369 (0.114)	0.013 (-0.062 to 0.099)
QALYs	0.387 (0.056)	0.386 (0.069)	-0.001 (0.04 to 0.03)	0.269 (0.134)	0.279 (0.088)	0.01 (-0.065 to 0.086)

The following figures show, for reference, the distribution of resource use across control and intervention sites. There is clear right skew in healthcare and informal care resource use in both case and control service-users. In the following graphs, control group refers to people in sub-markets which we classed as non-Care Act compliant (procurement and managed market), and intervention refers to people in sub-markets which we classed as Care Act compliant (open market and partnership).

Figure A1: Distribution of healthcare costs incurred over the last three months in the 'intervention' sample at baseline
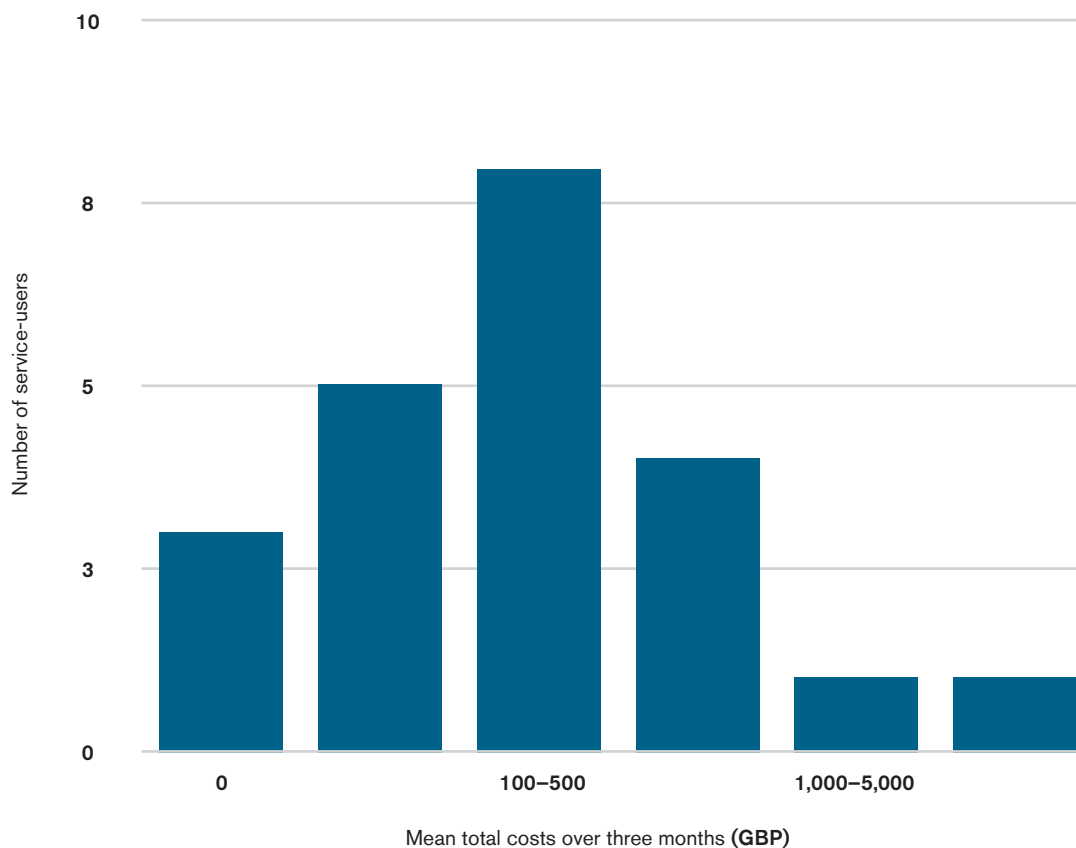
Figure A2: Distribution of healthcare costs incurred over the last three months in the 'control' sample at baseline
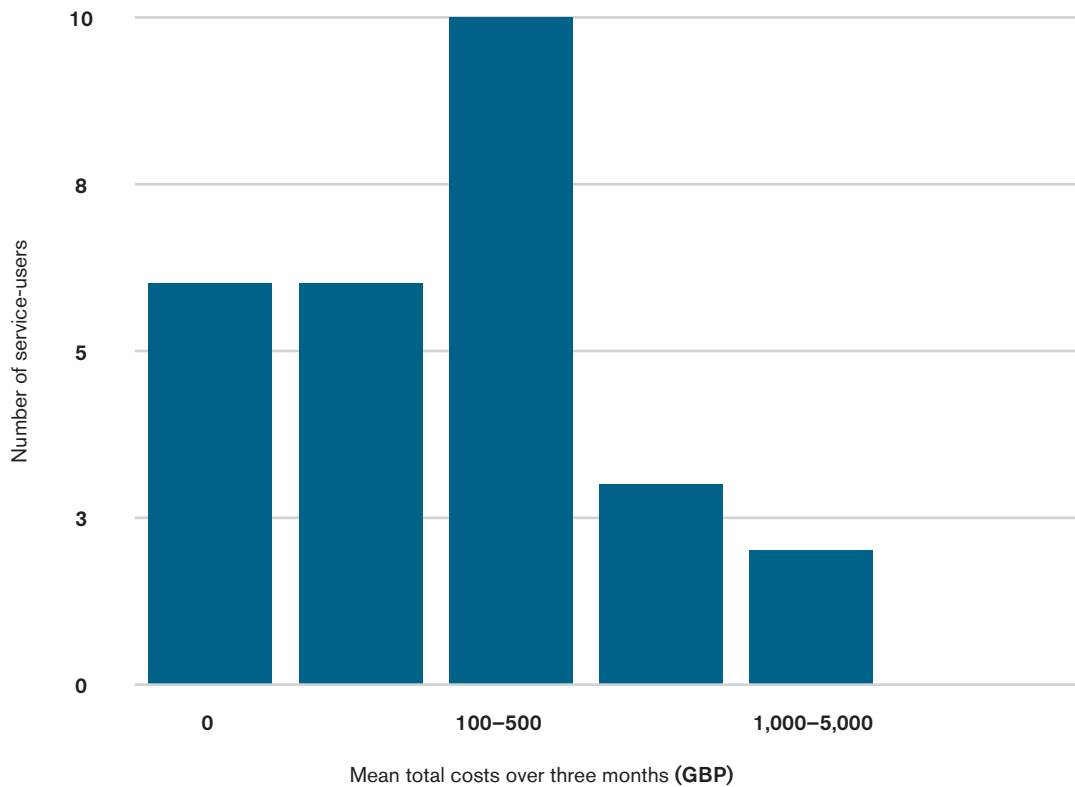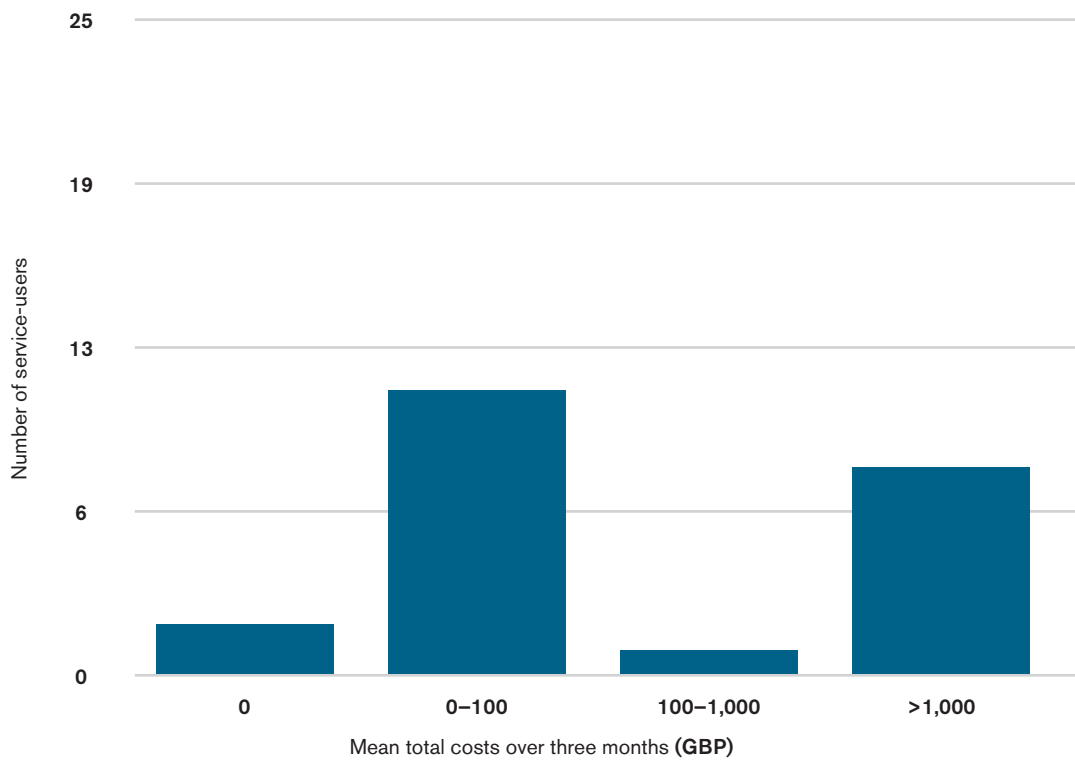

Number of service-users (y-axis)

Mean total costs over three months **(GBP)** (x-axis: 0, 100–500, 1,000–5,000)

Figure A3: Distribution of social care costs incurred over the last three months in the 'intervention' sample at baseline

Number of service-users (y-axis)

Mean total costs over three months **(GBP)** (x-axis: 0, 0–100, 100–1,000, >1,000)

Figure A4: Distribution of social care costs incurred over the last three months in the 'control' sample at baseline
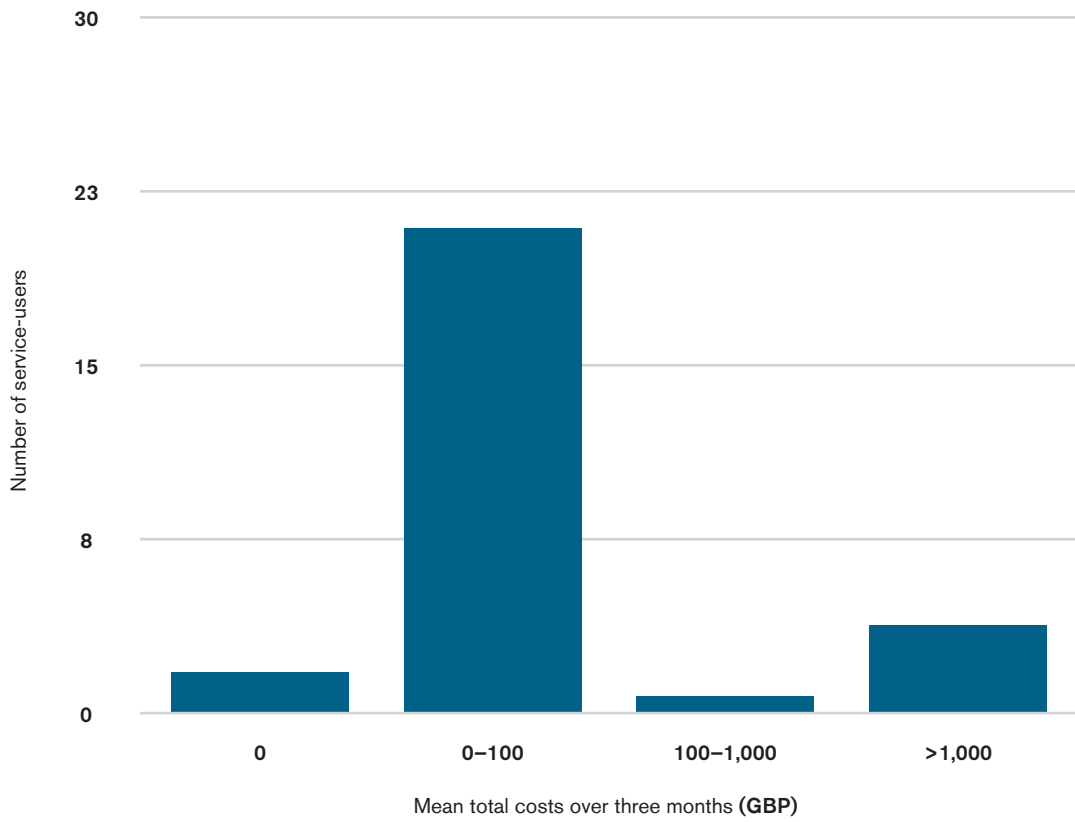
Figure A5: Distribution of informal care costs incurred over the last three months in the 'intervention' sample at baseline
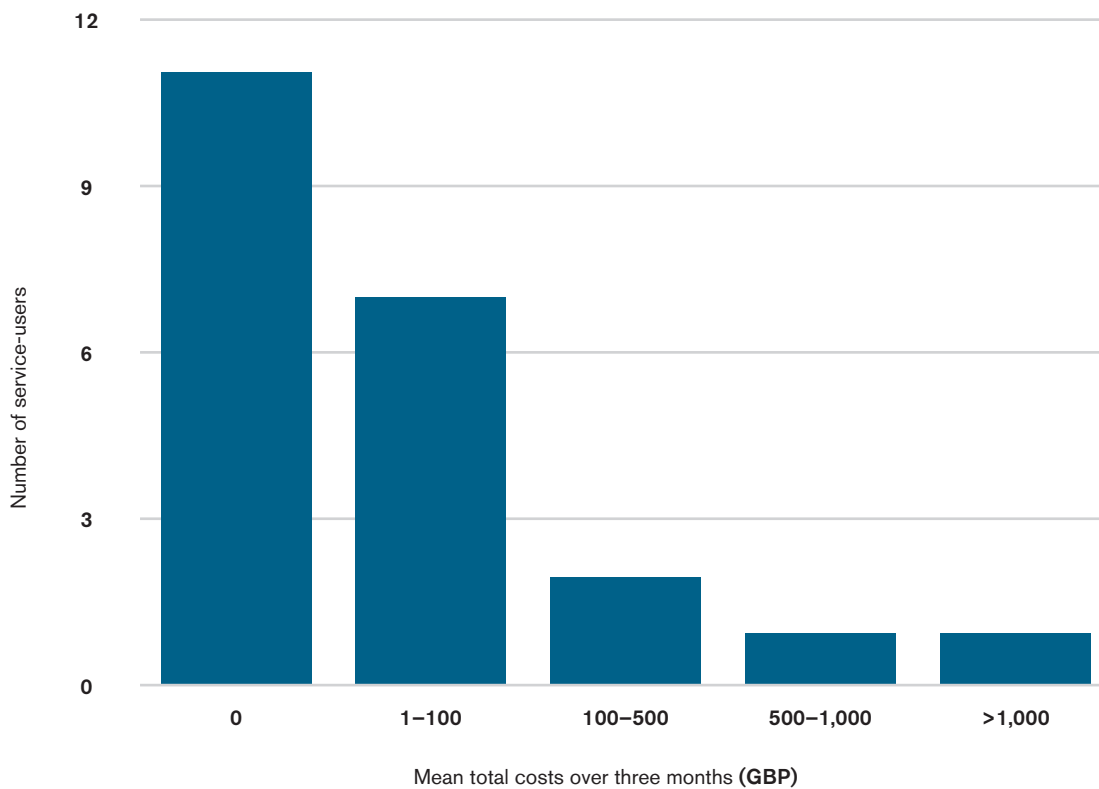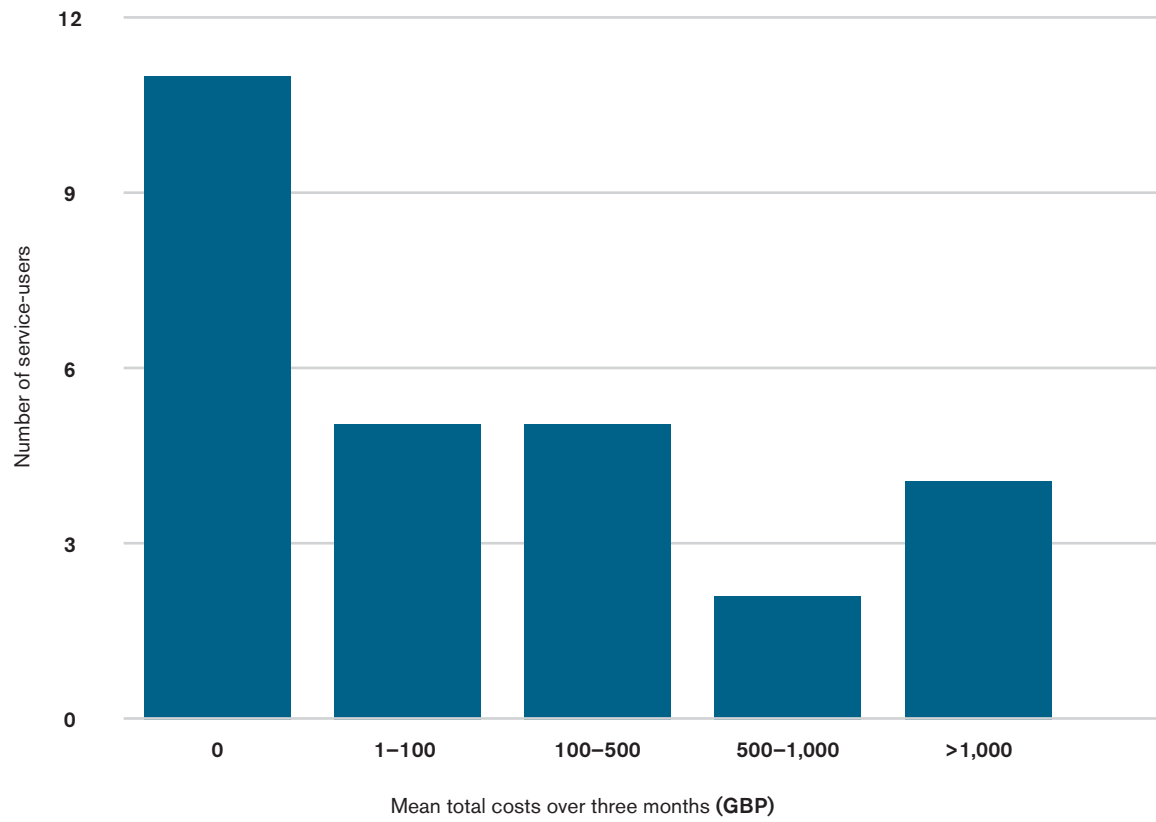
Figure A6: Distribution of informal care costs incurred over the last three months in the 'control' sample at baseline