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Department of Health

Final report on the DCMQC programme

Report

May 2014

OXFORD BROOKES UNIVERSITY

http://ipc.brookes.ac.uk

Developing Care Markets for Quality and Choice (DCMQC) – Final report

Overview

1. The DCMQC programme ran from the Autumn of 2012 through until March 2014, although most work with local authorities took place between January 2013 and March 2014. The programme was delivered by IPC in cooperation with the Association of Directors of Adult Social Services (ADASS) and the Care Provider Alliance (CPA).

2. Although the successful fulfilment of the programme has implications for Section 5 of the Care Act relating to promoting 'diversity and quality' in the care market, it also has implications for Section 3 in the approach to commissioning integrated preventative services and Section 4 in terms of the effective provision of consumer information.

3. The vast majority of local authorities took part in the programme either through their individual work with IPC or via a series of regional events. As a crude measure IPC estimates that some 22 local authorities had an MPS prior to the commencement of the programme and by its conclusion 126 authorities had either a published MPS or a document in draft awaiting publication.

4. Most local authorities recognised at the start of the DCMQC programme that their relationships with providers needed to improve, a view supported by the provider side and that developing and using an MPS as a basis for change was an important step forward.

5. The vast majority of authorities responded positively to the programme. However, that is not to say that the development of an MPS or ongoing work to facilitate the social care market is embedded within their organisations. Considerable thought needs to be given to how this area of activity may at least be sustained, let alone, grow and develop post implementation of the Care Act. There will be an ongoing need for training of commissioning staff in MPS development and market facilitation as staff turnover. There would be benefit in having a national depository of up to date MPSs which providers, consumers and other LAs could access. IPC will continue to make available, for a period of time, the materials developed for the programme.

6. In general, local authorities' knowledge of providers, their concerns and their potential for development in their local care markets is not strong. The skills required for effective facilitation of the market, for analysing demand and supply and how to commission to reduce demand are not part of any formal training for commissioning staff.

7. Real consumer research, despite the size of the care market, is still very much in its infancy for local authorities and providers alike. Consequently, direct payments are being given with little knowledge as to how the money is being used or whether this is cost effective, little is known about the behaviour and desires of self-funders and there is little evidence that the nature and type of care provision being funded is either cost-effective or evidence based. If the Care Act aspirations are to be delivered then better mechanisms need to be developed across health and social care for understanding the nature of consumer demand and how this may be met with better outcomes and in a more cost effective way.

1 Introduction

This final report reviews the activities undertaken by the Institute of Public Care (IPC) in delivering the Developing Care Markets for Quality and Choice (DCMQC) Programme. The original brief was described as to: "facilitate the social care market through the development of Market Position Statements as part of a wider support programme in connection with the forthcoming Social Care White Paper".

DCMQC was designed in cooperation with ADASS and managed externally through a programme group consisting of IPC, DH, ADASS and the Care Provider Alliance (CPA).

2 Project timeline

Date	Activity
May – August 2012	Background work on developing the programme
September 2012	Formal launch via two events. Followed by material sent to every Local Authority (LA)
September – December 2012	Planning and development meetings with each regional ADASS group. Identification of regional lead Director
September – December 2012	Initial questionaries' and materials sent to each LA.
October – December 2012	Follow up and planning time use with each LA and region
December 2012 – January 2014	Programme delivery

3 Planned v Delivered Activities

Planned activity	Activity	IPC planned days	IPC days delivered
A programme of support and mentoring available to each LA and region in England towards the development of a Market Position Statement with time allocated through the ADASS regions.	A programme for every local authority and each region planned and delivered	720	690
A half-day launch + development of briefing materials for use at the above event and for distribution to Directors for reproduction locally.	Completed but two launches – one with minister and one with ADASS. Briefing and background papers developed	7	9

Planned activity	Activity	IPC planned days	IPC days delivered
The development of programme materials to be made publicly available.	5 papers produced, four published on website.	38	39
At the programme's midpoint and at its conclusion, IPC would offer a statistical summary of activities, an analysis of the quality of Market Position Statements produced by LAs and suggestions for future development to the programme steering group.	An initial web based questionnaire developed and reported on to the steering group. Production of final report	15	20
Additional days to report regularly, liaise with and respond to requirements from the programme steering group.	Attendance at programme group and reference group, together with increased reporting requirements.	12	36
Further meetings with national ADASS group.		0	2
Development of website		0	10
Support to provider organisations		0	10
Assistance with developing Care Act Guidance		0	22
Total resources planned and delivered in days		**792**	**838**

4 Quantitative assessment

4.1 IPC Activity

IPC used a total of fourteen staff and associates to manage and deliver the programme together with three administrative and computer staff. Internally IPC had a monthly project planning and review meeting which allocated project time and reviewed progress.

There have so far been twelve project programme group meetings and three reference group meetings. Two meetings were held to report on progress to ADASS. Three provider only meetings were delivered with participants being recruited by the Care Provider Alliance. A presentation was made to the Five Nations Care Forum.

Of the 149 Local Authorities that responded to the initial survey 114 identified that they wanted to use the Market Intelligence options that offered one of three choices; (a) Preparing an MPS (b) Data use and analysis or (c) Mentoring support to the MPS.

The remainder indicated a range of different types of support required and 14 had at the time of the questionnaire not decided how they wanted to use their time.

Particular points to note:

- In delivering the programme not all authorities used all their time. A few authorities did not wish to, or were unable to engage with the programme (see Appendix 1). Some authorities did not use all the time allocated to them (in some instances this may be no more than a ¼ day). Some authorities requested additional help. Time was re-allocated roughly in the following order, (a) to other authorities within the region (b) back to the regional programme (c) back into the national pot for related activities.
- There were more programme group meetings than were budgeted for.
- Most LAs were slow to start, consequently there were far more days delivered towards the end of the programme than at the beginning.
- Basic 'how to' materials were seen as those most likely to be used.

4.2 Regional and sub-regional activities

All regions had an initial regional starter session and each region nominated an ADASS lead Director. Following on from this, regions used their allocation of days in a variety of different ways:

London

- Consortium of West London authorities ran workshops and had an evaluation looking at comparative similarities and differences in MPSs.
- Three pan London workshops – MPS master class, Self-funders, Advice and Information services.

West Midlands

- Regional Learning Disability MPS developed and workshops run (significance of work recognised by NHS clinical lead and Joint Improvement Team).

North West

- In addition to a region wide workshop. Sub regions ran a variety of projects, eg:

- Merseyside sub region - Estimating self-funders
- Greater Manchester - Project and Workshop on Learning Disability - Included a survey of LD providers
- Cumbria, Lancashire, Blackpool – Analysis of care resources.

South West

- Regional days mainly got re-allocated to LAs although a regional workshop was run.

East Midlands

- Development of self-funders toolkit.
- Regional provider workshop (each LA nominated five providers).

North East

- Regional MPS on Learning Disability.
- Series of monthly workshops covering LD, Service users, Providers, NHS links.

South East

- Attendance/presentations at 2 regional commissioning/market development leads meetings.
- Workshop on self-funders and the implications of the Care Act. One further regional event in March 2014 on the market and personalisation.

4.3 Papers and Website

IPC developed and offered via the DCMQC section of the IPC website some five papers in support of the programme. There were 5,321 unique users [1]of the DCMQC pages on the website and there were 233 unique viewers of the videos. As might be expected the greatest usage occurred within the first month of the programme at 1,177 unique users. However, even towards the end of the programme there were still new users viewing the material, eg, January 2014 197 new people came to the site.

From IPCs work with LAs and regions it is clear that the support materials were widely printed off and used. Anecdotally, we believe the two papers on What is a 'Market Position Statement' and the 'Exemplar' were the most widely used. They were visible and in use at many of the planning meetings IPC attended.

[1] A unique user constitutes the registering of a computers address. Obviously more than one person may use a computer, equally one person may log on from more than one machine

4.4 Market Position Statements

By the start of May 2014 to IPC's knowledge

- 77 authorities had an MPS publicly available.
- 49 authorities stated that they had a draft MPS.
- 13 authorities reported that they were still in the process of writing.
- 49 authorities had clear evidence of provider involvement in developing, or in presentations of, their MPS.

A full list of Authorities is contained in Appendix 1. Prior to the DCMQC programme commencing IPC were able to identify some twenty two authorities that had an MPS. These are indicated by an asterisk in Appendix 1. Some of these authorities decided to use their DCMQC days in revising and reworking their MPS. Some authorities have produced more than one MPS for different groups of care users.

The vast majority of IPCs involvement with adult social care fell into three categories:

- Getting people started either through meetings with senior management teams or commissioning teams; sometimes both.
- Reviewing and commenting on MPSs and acting as a critical friend.
- Helping to set up, participating in, or facilitating meetings with providers.

Minority activities consisted of:

- Administering and analysing mini-questionnaires to providers.
- Attending meetings with a public health market brief.
- Attending joint health and social care meetings.
- Attending meetings involving housing and supporting people.
- Attending meetings with a wider LA audience.
- Providing help and workshops on how to identify self-funder populations.
- Providing mini-research reviews.

5 Qualitative assessment of the programme

5.1 Local authority perspective

At the conclusion of the DCMQC programme some brief questions were sent to a sample of participating local authorities. In total some thirty participating LAs were contacted with replies being received from twenty-two. Appendix 2 has the detailed responses that were received. These are summarised below:

Local authorities' perspective on the main use of, and benefits from, the DCMQC programme?

- Providing examples from other sources of information and other LA's and making documents available.
- Receiving comments on drafts.
- Discussions with and support for MPS authors.
- Help in structuring the approach the authority was taking.
- Facilitating workshops and events with providers.
- Sometimes just assurance that the path that was being followed was the right one.

What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?

Responses can be summarised into four areas:

- Using the MPS as a vehicle to improve relationships with providers.
- Moving onto develop MPS materials for other markets (some in other areas of adult social care some in a more council wide approach).
- Linking thinking around care markets into the authorities approach to the Care Act.
- Gaining a better understanding of self-funders in older peoples care.

5.2 Provider perspective

In May 2014 and towards the end of the programme a series of three seminars were held in Leeds, Birmingham and London with provider organisations. The events were broadly divided into two seminars for smaller providers and one (in London) with larger organisations. Each seminar used a similar format of; presentations about the programme with a response from providers looking at their understanding of Market Position Statements and what they would ideally seek form their own local authorities. In total, some sixty providers were represented from a wide range of care organisations. Appendix 3 contains greater detail on their comments but the substantive points made were:

- There were lots of comments on the process of relationships between LAs and providers. Clearly providers don't feel that it is recognised this is a relationship of equals where both parties, albeit for different reasons, have a mutual interest in the sustainability of the care market.
- The MPS needs to be easy to read, far less jargon laden, written for providers (having asked what information they might find beneficial) and contain real commitments.
- If providers are asked for information the LA needs to be clear about how this might be used and what benefit it would also offer providers.

- In general, and fairly understandably, smaller providers feel they gain more from the overview that an MPS offers than larger providers (who potentially have greater resources for market research).
- Providers agree with LAs that consumer research in relation to care is a very underdeveloped area and needs considerable improvement.

5.3 IPCs perspective

The following list has been compiled based on the views of the IPCs consultants conducting the work with local authorities and regions:

5.3.1 Most authorities:

- Readily embraced the concept of market facilitation and developing a Market Position Statement.
- Recognised areas where they needed to improve or where they were short of information.
- Wanted to change the nature of their relationship with providers.

5.3.2 Most authorities struggled with:

- Writing a concise document.
- Being analytical about their data and information.
- Producing a document that was market facing.
- Quantitatively being able to show the value of the care market to local economies.
- Producing knowledge backed information of the strategic direction the LA would be encouraging through its commissioning activities.
- Intelligence about self-funders and how direct payments were being spent.
- Any useful and qualitative consumer research.
- Having an understanding of where and how they could be innovative towards the market.
- Having a clear plan for market engagement post MPS development.

5.3.3 Some authorities struggled because:

- Three days help was not seen as significant enough to warrant investment and because some needed more help than the time available.
- They were trying to deliver the programme at a time when LAs were undergoing major financial problems and staff changes meant some found it hard to get going.

- The development of an MPS was seen as simply a task to be got through. Consequently, it was not seen as significant and its authorship got pushed down the chain of command.

5.3.4 A few authorities struggled because:

- They do still not easily embrace the concept of a market and some have difficulties accepting a facilitative role towards the market as compared to a controlling role.
- In facing financial problems they did not see that the market could be engaged with as part of the solution rather than being perceived as part of the problem.

5.3.5 Some authorities were innovative:

- In going to the market and constructing exercises to find out what providers would benefit from the most.
- In extending the MPS concept to other parts of their authority such as housing, supporting people and Public Health.
- In recognising that even if the time was not quite yet right they need to bring their local CCGs on board with their market activities.
- In re-defining roles within the authority and developing a market lead person.

6 The way ahead

6.1 Most authorities recognise that the programme has been a valuable start. However, IPC is conscious that its benefits can equally as soon be lost. For example in the region that originally pioneered some of this work (Yorkshire and the Humber), two years on there was only one or two of the same commissioning staff still in post and working on market development. Therefore, there is uncertainty as to how much of this activity is embedded as a routine part of a LAs responsibility.

IPC would suggest it is important to look at what are the best mechanisms for ensuring that the development work that DCMQC has offered can be sustained until it is embedded as part of adult social care commissioning practice.

6.2 In line with the above, consideration needs to be given to training and development for commissioning staff in terms of market facilitation and shaping. For example typical skills might include; business planning, commercial awareness, how to create innovation and what might businesses respond to, conducting market research and assessing stability in local care markets.

There could be benefit in encouraging secondment arrangements between LA commissioners and major providers as well as joint training (this could equally be appropriate for CQC).

6.3 There is an considerable need to help authorities develop capacity which can translate general policy ideas into scenarios that would benefit the whole market, ie, you might be able to show how many people would have dementia in the future alongside a policy of using less residential care. But what might this mean in terms of how many fewer people would be in residential care year on year, what kinds of needs would this present, what alternatives might be needed at what kind of price point to effect that change, how might risk be managed?

It would be helpful to work with ADASS on defining how these activities can best be understood and encouraged by senior management teams and the necessary skills developed amongst commissioning staff.

6.4 IPC will continue to make available, for a period of time, the tools that have been developed as part of the programme.

There could be benefit in adding to these, in terms of how to assess the numbers of self-funders within the care market, how to conduct consumer research and the wider skills needed in evaluating and analysing data.

6.5 The care market is made up of some large providers but is dominated by small and medium sized businesses and organisations. From the provider consultations undertaken as part of DCMQC it is clear that many of these smaller providers find it difficult to engage in discussions with Local Authorities, to be able to make a convincing business case and in particular to evaluate and present what they do in terms of the outcomes it achieves. Yet if innovation is to be introduced into the care market then that is exactly the change needs to occur.

There could be considerable value in developing a support programme, to work alongside the national umbrella groups and local provider forums, in order to offer help and support to smaller organisations in developing innovative and preventative practice.

6.6 Whilst some authorities have recognised the need to develop their MPS work into broader issues around accommodation, particularly for people with a learning disability and older people, examples of this work are still few and far between. If the involvement of DH in the housing agenda is to bear fruit this needs a combined approach across DH, DCLG and the Homes & Communities agency to look at the market in specialist accommodation for older people, both social and private housing and in particular how the sheltered housing estate can best be stimulated in order to provide accommodation into which community health and social care services can be delivered. Sheltered housing is, at least financially, probably the most significant market influencing care and support, given that it comprises the single biggest asset held in trust for older people. Yet there is no clear view of what this market can achieve or needs to deliver if older people are to remain within the community.

It would be beneficial to work across the two government departments and the umbrella bodies of housing providers in order to produce a template for evaluating local housing markets for actual and potential care consumers.

6.7 Consumer research in the care market is still in its infancy and one where the local authority as the biggest purchaser / funder of care still has little expertise. This is not just about what types of care might be available and their location but what should the person who needs care be looking for and why, what outcomes might they expect it to achieve for them and how? In terms of other sectors, such as the grocery business, as consumers, we know about the different types of providers, about differential pricing, about the trade-off between price, size and geographical proximity. The need to change this this is threefold:

- To know if the care market is working well and money being spent to best effect then authorities need to be able to sample and understand consumer opinion.
- In a market dominated by small organisations and with a growth in micro enterprises the capacity of such organisations to conduct any effective market research is limited.
- Consumers, in making care choices, need to have access to good market information. Is not only about what is on offer and have others thought of the services they have received, but also what might be possible, how does the LA respond when we go to them with questions, how do we judge the quality and take up of the information the LA makes available, etc.

It is important that Local Authorities have the tools and funding available to develop appropriate consumer orientated market analysis as part of their changed role towards the market.

6.8 Finally, we have suggested elsewhere that the market could be aided by Local Authorities and CQC working closer together. This would be greatly helped by:

- Market position statements having at least some standardised information that they collect in order to enable information to be pooled across regions and nationally.
- CQC developing their website so that an instant view of any LAs given care market could be generated by LA's providers and consumers.
- A mechanism by which local information about providers in difficulties could be fed back to the regulator.
- Working together to delineate and coordinate information capture between contracting arrangements and quality assessment.

The use and development of MPSs could be aided by local authorities and CQC establishing some elements of a common template for their joint understanding of local care markets.

Appendix 1: Local authorities and MPS completion

The table below represents the last position identified by IPC at the start of May 2014, (this also included a web search:

- Some authorities where 'Not known' is indicated may mean that we have not worked with them or we do not know how far they have reached in developing an MPS, ie Their time may have been used in a planning workshop.
- 'Draft' normally means we have seen a draft or we have been told the council has published a draft.
- 'Evidence of provider involvement' means either we have been involved with the authority in meeting providers or we know a meeting has taken place'. Clearly there will be authorities that have engaged with providers around their MPS where we have not participated in this.
- Where it says 'did not participate in programme' this maybe because the authority already has an MPS or did not feel they needed support. Their days were re-allocated either to another authority, to the region or to the national programme. Several of these authorities still participated in regional and sub-regional work.
- An * indicates an authority that had developed an MPS prior to the commencement of the DCMQC programme.

Council	Market Position Statement status
London Borough of Barking & Dagenham	Draft
London Borough of Barnet	Available
Barnsley Metropolitan Borough Council*	Available
Bath & North East Somerset	Draft
Bedford Borough Council	Draft
Central Bedfordshire Council	Available
Bexley Council	Available
Birmingham City Council*	Available
Blackburn with Darwen Borough Council	Draft
Blackpool Borough Council	Draft
Bolton Metropolitan Borough Council	Draft
Bournemouth Borough Council	Draft
Bracknell Forest Council	Available
City of Bradford Metropolitan District Council*	Available
London Borough of Brent	Available
Brighton & Hove Council	Writing

Council	Market Position Statement status
Bristol City Council	Draft
London Borough of Bromley	Writing
Buckinghamshire County Council	Writing
Bury Metropolitan Borough Council*	Available
Calderdale Metropolitan Borough Council*	Available
Cambridgeshire County Council	Draft
London Borough of Camden	Available
Cheshire East Council	Not known
Cheshire West and Chester Council	Available
City of London	Writing
Cornwall County Council	Draft
Coventry Metropolitan Borough Council	Available
London Borough of Croydon	Draft
Cumbria County Council	Draft
Darlington Borough Council	Draft
Derby City Council	Available
Derbyshire County Council	Available
Devon County Council	Available
Doncaster Metropolitan Borough Council	Available
Dorset County Council	Draft
Dudley Metropolitan Borough Council	Available
Durham County Council	Available
London Borough of Ealing	Draft
East Riding of Yorkshire Council	Available
East Sussex County Council*	Available
London Borough of Enfield	Not known
Essex County Council*	Available
Gateshead Metropolitan Borough Council	Available
Gloucestershire County Council	Draft
Royal Borough of Greenwich	Available
London Borough of Hackney*	Available
Halton Borough Council	Available
London Borough of Hammersmith and Fulham	Available
Hampshire County Council	Draft
London Borough of Haringey	Draft
London Borough of Harrow	Draft
Hartlepool Borough Council	Writing

Council	Market Position Statement status
London Borough of Havering	Available
Herefordshire Council	Available
Hertfordshire County Council	Available
London Borough of Hillingdon	Draft
London Borough of Hounslow	Draft
Isle of Wight Council	Not known
Isles of Scilly	Writing
London Borough of Islington	Available
Royal Borough of Kensington and Chelsea	Available
Kent County Council	Draft
Kingston-Upon-Hull City Council	Not known
Royal Borough of Kingston Upon Thames	Not known
Kirklees Council*	Available
Knowsley Metropolitan Borough Council	Available
London Borough of Lambeth	Writing
Lancashire County Council*	Draft
Leeds City Council*	Available
Leicester City Council	Available
Leicestershire County Council*	Available
London Borough of Lewisham	Not known
Lincolnshire County Council	Available
Liverpool City Council	Available
Luton Borough Council	Available
Manchester City Council	Available
Medway Council	Draft
London Borough of Merton	Not known
Middlesbrough Council	Draft
Milton Keynes Council	Not known
Newcastle Upon Tyne Council	Available
London Borough of Newham	Available
Norfolk County Council*	Available
North East Lincolnshire Council	Writing
North Lincolnshire Council	Available
North Somerset Council	Available
North Tyneside Council*	Available
North Yorkshire County Council*	Available
Northamptonshire County Council*	Available

Council	Market Position Statement status
Northumberland County Council	Draft
Nottingham City Council	Available
Nottinghamshire County Council	Available
Oldham Metropolitan Borough Council	Available
Oxfordshire County Council	Available
Peterborough City Council	Draft
Plymouth City Council*	Available
Borough of Poole	Draft
Portsmouth City Council	Not known
Reading Borough Council	Draft
London Borough of Redbridge	Not known
Redcar & Cleveland Borough Council	Available
London Borough of Richmond on Thames	Draft
Rochdale Metropolitan Borough Council	Draft
Rotherham Metropolitan Borough Council	Available
Rutland County Council	Available
St Helens Metropolitan Borough Council	Draft
Salford City Council	Available
Sandwell Metropolitan Borough Council	Draft
Sefton Council	Draft
Sheffield City Council	Draft
Shropshire County Council	Draft
Slough Borough Council	Writing
Solihull Metropolitan Borough Council	Available
Somerset County Council*	Available
South Gloucestershire Council	Available
South Tyneside Metropolitan Borough Council	Writing
Southampton City Council	Draft
Southend-on-Sea Borough Council	Draft
London Borough of Southwark	Not known
Staffordshire County Council	Draft
Stockport Metropolitan Borough Council	Available
Stockton-on-Tees Borough Council	Draft
Stoke-on-Trent City Council	Writing
Suffolk County Council	Draft
Sunderland City Council	Draft
Surrey County Council	Draft

Council	Market Position Statement status
London Borough of Sutton	Available
Swindon Borough Council	Draft
Tameside Metropolitan Borough Council*	Available
Telford & Wrekin Council	Available
Thurrock Council	Available
Torbay Council	Draft
London Borough of Tower Hamlets	Available
Trafford Metropolitan Borough Council	Available
City of Wakefield Metropolitan District Council*	Available
Walsall Council	Available
London Borough of Waltham Forest	Writing
Wandsworth Borough Council	Not known
Warrington Borough Council	Draft
Warwickshire County Council	Available
West Berkshire Council	Available
West Sussex County Council	Not known
Westminster City Council	Available
Wigan Metropolitan Borough Council	Draft
Wiltshire County Council	Writing
Royal Borough of Windsor and Maidenhead	Available
Metropolitan Borough of Wirral	Draft
Wokingham Borough Council	Available
Wolverhampton Council	Available
Worcestershire County Council	Draft
City of York Council	Available

Appendix 2: Comments on the DCMQC Programme from a sample of Local Authorities

The following table has been complied following a brief set of questions to local authorities, sent at the end of the programme. In total some thirty participating LAs were contacted with replies being received from twenty-two. The responses are in the order they were received.

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
Swindon	We used the programme to support our development of a Market Position Statement for learning disability in Swindon.	We found the support offered was invaluable in helping us focus on the detail and plan what data to include. Good examples were shared from other local authorities and a 'show and tell' session was arranged for the south west. It also helped us focus on who the document was for, what needed to be included and how we could use this as a tool to develop our market further in line with commissioning intentions.	Further work is needed to develop our learning disability market, this will include retendering of provisions, redesign etc. We also intend on writing an MPS for older people residential and nursing services. Further work is planned to consult with our providers on developing this market
York	Support to structure and compile first MPS. Attended all the regional workshops. Comments on first draft from IPC and planning and facilitation of an event for providers to introduce the draft of our MPS.	Very helpful support for a small authority where one person doing most of the work on the MPS. Good guidance re sample documents, discussions with IPC and critical feedback. Very useful to benchmark the work against other MPSs.	This is only the start of the process in changing our role to be a facilitator of the market. MPS will need to be updated and be a 'live' document. Work planned to develop relationships with providers through forums/events.

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
Bradford	We used the programme to gain knowledge of MPS and develop our next version for Bradford.	Not that many because we had a good insight into what needed to happen to develop it.	Lots!
East Midlands	Regionally we identified a need for a self-funders toolkit which IPC developed for us. In addition we held a regional providers meeting in January 2014 which was facilitated by IPC. LAs have shared information about MPS through the regional meetings.	A self-funders toolkit and sharing of good practice re MPSs. Building a network around MPSs.	This will form the basis of ongoing work which will need to be done to prepare for the implementation of the Care Bill, eg identification of self-funders.
Wirral	As a Council we received professional support, advice and input from the IPC designated lead for the North West Region. This was in the form of email exchanges, advice regarding exemplars to be utilised, sharing MPS drafts for comment and face to face engagement with key Council Officers to enable progression of MPS. In essence seeking to draw down experience to enable Wirral MPS development. Again useful to be able to access sounding board, to afford challenge.	As indicated in question one, the programme afforded structure and a framework to progress Market Position Statement by affording professional backdrop and wider context of access to other experiences. This avoided drift and set realistic timelines to aid delivery and a meaningful product.	
ADASS Eastern Region	The East of England made good use of the regional support offer	The sharing of best practice and the ability to take stock	We had a recent AD Forum meeting which highlighted a number

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
	delivering three sessions, one focusing on sharing best practice on Market Position Statements and progress to date. One on Self Funders and the future requirements on local authorities. One on Market Position Statements in the context of the Care Bill.	has been really valuable for local authorities. It has encouraged mutual support and exchange of intelligence in order to further improve and develop market positions statements and plan for the future. It also helped to improve relationships with providers.	of areas for the region to consider under the umbrella of Care Quality, Markets and Commissioning (there will be more areas for development I'm sure as we implement the Care Bill requirements and Better Care): Ways of sharing intelligence about larger provider's performance across the country. Suite of MPS's across the region with one executive summary Identifying opportunities for joint commissioning and further best practice across the region in relation to MPS's Regional standards for supported living Regional market gap analysis linked to workforce development - what isn't out there that might be needed? The sharing of gaps. Hard to commission risk register and solutions plan Shared commissioning on specialised services
Wokingham	We used the toolkits and guidance documents from the website and attended	The toolkits and documents provided clarity of the nature and purpose of the MPS and how it might	We now want to work on updating the MPS in a modular way focussing those areas where we feel the

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
	Regional Events. In addition we benefitted from direct support from IPC which included facilitating a workshop for providers.	be structured. Input from IPC then enabled us to get specific feedback on the structure and content of our MPS as well as the extent to which it achieved its purpose of clarifying our needs and commissioning intentions to match our vision of our local care market.	market most needs to be developed and facilitated. This will involve more detailed work and greater involvement of customers and providers.
Bromley	Bromley have used the support to help us deliver: A facilitated day with our community sector strategic partners To get feedback on our first draft MPS for adult social care	Writing an MPS is an interesting piece of work as it focuses commissioners thinking around their longer term commissioning strategies and translating that into to something practical and informative for the provider market. It also develops the role of a LA as a market facilitator as opposed to simply a buyer of services. It was a benefit to use the MSP project as a useful point in time to sit down with our strategic providers to set out how main drivers such as funding, care bill and integration are going to radically transform the way we commission and procure services going forward	Lots, but first priority is to agree the messages in the draft MPS and get it out in a digestible format to local providers. There is a special focus on the community sector where we hope to use the MPS to reset the way that we work and commission from this particular sector. The main output to date is a MPS for adult social care which we plan to take through I'll internal approvals processes over the next two months before publishing with providers in the Autumn. We have already shared our draft with health colleagues at the CCG and received positive feedback. We want to now see how the commissioning

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			actions set out in the MSP which include a new carers support, dementia and self-management strategy can be linked into the joint commissioning work which is starting to take place under the Better Care Fund
Birmingham	Birmingham used the DCMQC programme to review our existing Market Position Statement for Adult Social Care, and to help us produce a better product for our second go at an MPS. We applied for additional hours of support when it became apparent that the region hadn't used its quota of hours. These additional hours of support were used to attempt to bring Public Health and Housing Directorates on board; to demonstrate to them the principles of an MPS, and to attempt to produce some cohesive messages and analysis across the different departments.	IPC were excellent at giving us some perspective on where our initial MPS was lacking, and how we could go about putting it right the second time around. IPCs subsequent workshop/ presentations to Housing and Public Health colleagues were really useful in setting the ball rolling for these departments to engage in producing their own MPS documents, and linking in with ourselves in Adult Social Care.	My view is that there's huge potential for significant pieces of work to be done regionally that could produce huge efficiency savings, innovation and quality improvements in commissioning. One that I advocate wherever possible is that of a regional development and purchase of e-Marketing software and an associated quality monitoring framework. The North-East has made progress in this area, and whilst Birmingham have made great strides in terms of micro-tendering, quality monitoring, and have an online presence in 'MyCareInBirmingham', there are all sorts of benefits to be had if we were to collaborate as a region on this.
Leicestershire	Leicestershire used the programme to plan and facilitate a providers/stakeholder	We were able to build on partnership work that had already been undertaken in relation	Continuing to improve market intelligence to better understand and predict market gaps

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
	workshop to explore the notion of place based markets and how this might be reflected in the MPS.	to place based work and move this on to specifically look at social care markets in this context; The Programme will directly help to shape and inform the next iteration of Leicestershire's MPS; ensuring it continues to be a meaningful and relevant documents for providers; Specifically the workshop generated: ▪ Useful discussion about how social care markets relate to and interact with other service provision ▪ Added to our market intelligence about local need and gaps in the market ▪ Contributed to wider commissioning discussions eg, how to support and encourage innovation in the marketplace, supporting provider collaboration, quality and professionalism;	and opportunities; Supporting/facilitating the domiciliary care market to meet growing need; Supporting/facilitating the integration of health and social care services; Responding to the requirements/implications of the Care Bill.
Bolton	Undertaking consultation work with providers to	Comprehensive advice on the options to develop the MPS.	Review content with providers to ensure the MPS contains

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	understand their requirements from the Bolton MPS. This included help with facilitating an event and delivering a presentation. Support and advice in developing the outline document and contents. Coordinating Greater Manchester sub regional work on cross authority market issues.	Provided independent facilitation of local MPS event. Collated survey findings and produced summarised report used to develop the local MPS. Great Manchester report and intelligence produced.	useful and up to date information for business planning purposes. Undertake a Healthwatch and service user group brief consultation process to produce clear market shaping requirements such as improvements in quality. Update needs/demand and market data and ensure correct strategic direction of MPS.
LB of Brent	IPC jointly facilitated (with our Head of Commissioning) a workshop with the Departmental Management Team, and IPC provided comments on the first draft of the document.	The jointly facilitated session was helpful in setting the context, pointing out examples of good practice and providing a sounding board for ideas. IPC involvement provided additional credibility to the session. The comments on the draft were helpful, but were largely positive, so didn't really lead to any substantive changes.	I think the additional help needs to come in two types: Specific topics – self funders was an area of particular interest, which London benefitted from additional workshops and there is still work to do on this. There are also other specific areas, e.g. high needs learning disability provision, which Boroughs like ours would benefit from subject matter expertise Next steps and making it real – the point I have been making is that the Market Position Statement is only the first step. It needs to be the basis for

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
			further engagement and for real and quantifiable change. The London ADASS group wanted to know how could we measure impact, as part of TEASC how could we do more than just say 18 out of 33 Boroughs have an MPS, how can we articulate the progress that Boroughs are making to deliver their MPSs?
Salford	We received 'critical friend' support for developing our Market Position Statement, and we also received support in understanding how to determine self-funders in the area both residential care and domiciliary care.	We felt that it provided us with some assurance around the processes we were following.	We need to do further work now in engaging the care market to understand the requirements of personalisation and the care bill.
Rotherham	Rotherham Council attended the group workshops and we also accessed some 1 to 1 consultation to support us in the development of our MPS.	The workshops were useful in that we were able to see what other LAs were doing in relation to their market facilitation plans, They were also useful for networking, looking at best practice examples and discussing different approaches. The 1 to 1 help was useful in that it gave us very specific guidance which helped us focus on the messages we	The next key piece of work will be in relation to the Care Bill and meeting the challenges that the legislation will present.

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
		were giving the market in the MPS.	
Camden	We arranged for IPC to facilitate a discussion on the use of MPS's with senior managers here at Camden.	It clarified the requirements and enabled us to consider our approach in light of these.	As the Care Bill requirements become clear and guidance is issued we will need support to re-interpret what's required locally and to see what opportunities there are for regional and national joint work.
Manchester	Received support from the DCMQC programme to help us to refocus our Market Position Statement to make it more relevant for our local provider market. To better understand self-funders through our participation in the Self-Funders Workshop in January 2014. Used support from DCMQC to explore innovation for the LD market	A more concise and relevant Market Position Statement is now in draft form. This will help Manchester City Council identify what the future demand for care and support might look like and to act as a starting point for discussions between the local authority and those who provide services. Manchester City Council are now better equipped to understand the self-funders market. The Manchester City Council Self Funders Strategy group intends to adopt the use of the DCMQC Self-Funder Toolkit.	Publish and regular updating of the Market Position Statement. Embedding it in our structures and making it a key part of our relationship with those who provide services or are interested in doing so in the future. Continued work to understand current self-funders and to establish improved data gathering on self-funders in future. Conduct modelling of the implications of the Care Bill. Better understand the impact of the Care Bill on carers. Further explore ways to improve Self Funders' experience when in contact with Manchester City Council. i.e better signposting and links to financial support.

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
Warwickshire	We used the programme for 1 x full day of commissioning training. The remaining days were used to support with the development of our market position statements. This time was split up as follows:- 1 x half day session with internal stakeholders and chaired by IPC. This reviewed best practice for MPS development and helped further shape our draft statement. The remaining time was used by IPC reading/ giving comment on draft MPS's. This was around half a day.	It benefited Warwickshire in understanding how other authorities have developed their MPS's and in understanding what best practice looks like. It was useful to have an independent person reviewing the MPS who is experienced in doing this as it became difficult to view it impartially when we had been working on it non-stop. It is worth noting that the MPS is clearly a developing concept and it would be useful to understand from IPC what impact the MPS's are having upon commissioning and the market nationally.	There is a significant amount of market development work required locally during the next year. Do you need me to give any information about this or are you asking us what support we require from IPC in delivering the work?
Richmond	Of the 3 days allocated we used the programme for facilitated early workshops in Richmond	We found the workshops useful in shaping our thinking on how we approach developing our MPS. We have now completed our MPS testing event with providers, circulated early drafts and launched it with a major event which was well received.	We are now beginning work on the care bill and developing the market in partnership/collaboration with the market and service users. This is a very big programme of work across the LA and Adult Social Care overseen by a senior level programme board.
Somerset	We had about 4 days consultancy time which we focussed on reviewing our old MPS, helping us think	Having input from IPC at the events with providers was particularly valuable in providing a national	We have already started to develop more in depth focussed briefing sheets on particular

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
	about how to structure a new MPS, feedback on our new MPS, and support in designing and delivering two sessions to home care providers.	perspective on how the market for home care is developing and changing. IPC's advice was invaluable in getting us to think differently about what the MPS needed to say and how to best structure it. It also gave us some useful leads to information sources and ideas of different ways about how to structure the information.	areas of delivery. We do need to better understand the self-funding market and are having difficulty in getting the required intelligence.
Leicester	As we already had a statement in place we used the days to better understand the self-funder market and how we could improve our understanding and what actions we now need to take, noting that it is more likely going to be estimates initially given that information about self-funders is limited.	It gave staff not directly involved a fuller understanding of and a confidence in what we've been able to estimate so far. We had already begun to introduce clauses in contracts that allow us to gather intelligence around self-funders through contracted services. However, we have a clearer idea on what actions we need to take.	Establishing how we can better gather data around self-funders given the duties being introduced as part of the care bill
Nottingham City	Obtain feedback on the MPS drawn up by Nottingham City and review next steps Plan a stakeholder event for LA, Public Health and CCG Focus on the joint health and social care markets within the city and how inter-	To receive feedback and advice on future improvements to MPS's and approach to markets Deliver a Stakeholder event for LA, PH and CCG Sharing the messages within teams	To develop a joint Market Development Strategy between health and social care partners. Identification of current/future markets for accelerated support Draft joint messages to the market

Responding organisation	How did you / your authority use the DCMQC programme?	What were the benefits that you felt it delivered for you?	What further work do you consider will need to be done over the coming year in relation to your authority / region and the care market?
	agency working in Nottingham City may improve this influence.	Agreed programme/timeline for joint working	
Coventry	We used our allocation (and the extra available) to work with IPC in developing our MPS. IPC helped with structure and format and we also did a provider workshop and an internal management team session.	It helped to give some guidance and work towards the objectives of what the MPS should do	We are currently undertaking a range of MPS workshops with providers (new and current) in shaping our care and support market. These are all as a result of the MPS launch event that we did and we will use this to look at commissioning options going forward.

Appendix 3: Provider feedback on the role and function of the Market Position Statement (MPS) and market facilitation

1 Introduction

The comments below are summaries of a series of points made by providers at three seminars held in Leeds, Birmingham and London during May 2014. This was part of the Developing Care Markets for Quality and Choice Programme (DCMQC). The events were funded by the Department of Health and organised by the Institute of Public Care in cooperation with the Care Provider Alliance.

In total, some sixty providers were represented from a wide range of care organisations. Several of the comments included, were made by more than one group.

2 Approach and Process Issues

- Some thought needs to be given to how providers know an MPS exists. It would be helpful to have one place where all provider organisations could look. LAs should also let people know when an MPS is released. This is not just to providers with whom they contract, but all providers in their area. It is also important that LAs recognise not all providers belong to local care associations.
- There is a need for the MPS to be regularly reviewed if it is to be useful.
- Where this is not the first MPS an LA has developed, then subsequent MPSs should offer a review of progress and comment against any commitments made.
- There needs to be effective consultation and feedback from providers - pre-consultation rather than letting providers know after the event. Local Authorities need to move from a gamekeeper approach to a more trusting developmental relationship. For example; comments included ‘authorities need to recognise that providers are in it for the long term too’, ‘we need more mutual respect’, ‘authorities should not always start from an assumption of power’ ‘there is considerable scope for joint fixing of problems’.
- An MPS should be easy to read. If they are long or cover a range of provider groups then there should be an index. There should be less local authority jargon.

- Commissioning staff who write an MPS need to have experience of running businesses or at least need to better understand how businesses work and function.
- Where procurement is handled by more than one part of the LA there could be a description of how the central procurement function is engaged with adult social care commissioning.
- There needs to be ground rules for future LA / provider meetings if they are to give comfort & offer trust to providers and these could be described in the MPS. Currently it feels to providers as if engagement is often dictated by the local authority, it occurs when they have a problem or when they want an answer quickly.
- If providers are asked for information, then the LA should be clear about why it wants it. Providers don't always feel safe handing over their information and they also want to be asked in the right way.
- The MPS should contain information about where to go for redress if a provider is unhappy about local commissioning arrangements.
- The MPS needs to be part of a process with providers not a replacement for it. "Where you have personal contact, you can have the conversations, sometimes difficult conversations, but without those relationships this doesn't happen".

3 The MPS Content

- MPSs need to be more analytical, focussing on how commissioning intentions will affect providers. Some of current documents are too vague and woolly, some can be overly aspirational and hence not so useful.
- Some MPSs stated that innovation was wanted, yet those authorities didn't seem to recognise (or be receptive to) innovation, when presented with it.
- The information in the MPS needs to include information that a provider would want if they were thinking of developing and investing in an area.
- The MPS could start with a combined statement about values shared between the LA and providers. It could state what together we are trying to achieve.
- Some key data examples: How many providers are retained on contracts, CQC ratings, which organisations the LA has agreements with, profiling the size of providers, type of providers, volume of service use, from which sector.
- MPSs need to be very clear about outcomes and why those outcomes are important. What is the evidence underneath them?
- Better use of consumer information. More user voice in the content and how user feedback has contributed to the MPS.

- The MPS might need to be embedded in wider policies and change agendas across the LA and linked into health commissioning. These links and intentions should be made explicit.
- The MPS should say who won contracts and why.
- The MPS should be honest about acceptable standards of quality there could also be examples of other LAs good practice and a description of how might this LA move to that standard.

4 Managing the money

- Given the extent of self-funders and personal budgets, who is the buyer needs to be clearer in the MPS.
- There needs to be more transparency in terms of how personal budgets are being implemented and on how direct payments are being spent.
- Information on investment by LAs, eg, why particular contracts were awarded (not naming providers but being clear on decisions).
- Where budget cuts have to be made genuinely engaging providers in how budgets could be reduced.
- The impact of the care cap and care accounts should be reflected in future MPSs.