South West Regional Improvement and Efficiency Partnership

Developing a Market Position Statement for Adult Social Care: A TOOLKIT FOR COMMISSIONERS

Final Report

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South West Regional Improvement and Efficiency Partnership

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1 Introduction

The Institute of Public Care (IPC) at Oxford Brookes University has developed this document as part of on-going support by the South West Regional Improvement and Efficiency Partnership to the region’s commissioners and providers in their task of transforming services and practice that meet the needs and preferences of service users and their carers.

The document has three main parts: Section One looks how market facilitation can be defined; Section Two describes the purpose of a market position statement (MPS) and how information can be brought together into a single document; and Section Three provides an example MPS structure and data sets. The document ends with a list of useful resources.

We wish to acknowledge the specific contributions of Denise Fardon and Graham Varley at Devon County Council (Developing a Market Position Statement: The experience of Devon Adult and Community Services Directorate at Annex A) and Dr Carol Robinson (Self Directed Support: What we know about the use of personal budgets - a focus on the user’s experience at Annex B), as well as commissioners in Kirklees, North Yorkshire, South Gloucestershire and Bradford for use of their MPS materials.
Section One

2 Defining Market Facilitation

Increasing demand, greater numbers of self-funders and personal budget holders, and restrictions in local government expenditure will mean significant change to the social care market in the coming years.

The previous government identified that if social care was to be transformed then those eligible for social care provision should have greater choice and control over the services they might use. However, it was also recognised that the achievement of greater choice required the creation of a more diverse social care market. Consequently, if local authorities were to relinquish some of their role as purchasers of services then they would need to exercise a greater responsibility to ensure that a range of services would be available. Two successive government circulars identified the task for local authorities:

‘Work to shape and develop local and regional markets with the capacity and the variety to offer the range of options the population demands.’

Department of Health (2008) Transforming Social Care, Local Authority Circular 1, p.12

‘Councils will also be expected to have started, either locally or in their regions, to develop a market development and stimulation strategy, either individually or on a wider regional basis with others, with actions identified to deliver the necessary changes.’

Department of Health (2009) Transforming Social Care, Local Authority Circular 1, para.16

Consequently, the coalition Government has continued this theme by stating that if local authorities were to relinquish some of their role as purchasers of services then they would need to exercise a greater responsibility to ensure that a range of services would be available.

‘Social care already involves a diverse range of providers, including the voluntary and private sectors. But more can be done to make a reality of our vision of a thriving social market in which innovation flourishes. Councils have a role in stimulating, managing and shaping this market, supporting communities, voluntary organisations, social enterprises and mutuals to flourish and develop innovative and creative ways of addressing care needs... To build on this they will need robust evidence about what local markets offer and how they operate.’

Department of Health (2010) A Vision for Adult Social Care: Capable communities and active citizens, para. 5.2

Recent work led by IPC for the National Market Development Forum has produced a series of papers designed to explore key challenges and develop

1 The National Market Development Forum is a short life group comprising commissioners and providers from across the public, private and voluntary sectors. Its purpose is to explore some of the challenges of market development in adult social care, and to propose practical ways in which partners can work together to address them in the future. The Forum has been established and resourced by the Putting People First Social Care Consortium, and involves around 50 leaders from local authorities, voluntary organisations, major private service providers and national umbrella bodies. It is supported by the Department of Health, the Association of Directors of Adult Social Services, the Local Government Association, and I&DeA. For further information visit http://www.puttingpeoplefirst.org.uk/Topics/Browse/Milestones/Localcommissioning/Providerdevelopment/?parent=7800&child=7959 and
approaches to improving the social care market, the content of which is reflected in this document.

Facilitation of the social care market requires local authorities to engage in three distinct tasks, as Figure 1 illustrates. This document is primarily concerned with the first of these activities: the understanding of market intelligence through the development of market position statements.

**Figure 1: The tasks of market facilitation**

![Figure 1: The tasks of market facilitation](image)

*Market intelligence* - The development of a common and shared perspective of supply and demand, leading to an evidenced, published, market position statement for a given market.  
*Market structuring* - The activities designed to give the market shape and structure, where commissioner behaviour is visible and the outcomes they are trying to achieve agreed, or at least accepted.  
*Market intervention* - The interventions commissioners make in order to deliver the kind of market believed to be necessary for any given community.

### 3  Developing Market Intelligence

Local authorities have not always been good at capturing market intelligence. Thirty years ago there would have appeared to be little need, given that the sector was dominated by local authorities as providers of services. Even after the community care reforms of the 1980s, which forced authorities to buy in from the private and voluntary sectors, they remained the most significant purchaser in most communities and hence controlled the market through managing a mixture of price and quality.

However, that process is now changing - not only through the introduction of personal budgets and the transformation agenda but also through the considerable increase in the number of self-funders. (For a detailed discussion,
see Carol Robinson’s paper *Self Directed Support: What we know about the use of personal budgets - a focus on the user’s experience* at Annex B to this report. Given the future potential changes to the funding of social care, the marketisation of provision looks likely to continue and increase. If local authorities are to facilitate and influence that market, they will need to rapidly improve their knowledge and information about such markets, *i.e.* develop market intelligence.

The diagram below introduces a section that explores the meaning of social care market intelligence from the differing perspectives of the local authority, service users and providers.

**Figure 2: Differentiating market intelligence**

3.1 **What does the local authority need to know?**

- Who provides what, where and at what price?
- What is the perceived quality of services provided?
- What is the relationship between activity, outcome and cost?
- What are the financial and business challenges facing different services and what are the key factors influencing success and viability?
- What do providers know about demand and how can this information best be used?
- What does an overall model of good practice look like and what would it cost to achieve? How close/far away is existing provision from that model?
- What are the key drivers behind demand and how can these be stopped, lessened or deferred?
- What are people saying about current services and their priorities for the future and what approaches are successful in enabling people with support needs to drive changes in the market?
3.2 What do service users/the public need to know?

- Who provides what, where and at what price?
- Are there good reviews (from a number of sources including other users) of the quality of service provision and does this have a strong user input?
- How can I get involved to ensure that the services that are available locally meet my aspirations for the future?
- What is meant by choice and control – and what choices might I have available to me in terms of choice of service, delivery or worker?
- What choices have other people made and how successful have they been in meeting their outcomes (including direct feedback from other users)?
- How flexible is the service I am being offered and does it remain under my control regardless of the purchase/payment mechanism?
- If you are a carer at the start of a caring role, what degree and what flexibility of support will be available to you?
- Do I have enough money (either from my own pocket or via my council’s personal budget) to buy the type of care I need, and what other personal or community resources might I need to draw upon?

3.3 What do providers need to know?

- What does future demand look like and how reliable is this projection?
- What is the future balance of the market likely to be between self-funders, personal budget holders and those where the local authority intervenes more directly?
- What is the expected pace and scope of personal budget implementation and what impact will this have on the market?
- What are people (consumers) saying about current services and their aspirations for the future?
- Will there be consistency by the local authority towards price and support? What will the attitude be to transaction costs?
- Will the local authority be clear about what it considers to be a reasonable margin of profit?
- What will the attitude of planning authorities be to the development of new care facilities?
- Will the local authority support or incentivise innovation, and at what price?
- Does the local authority plan changes in its tendering processes or specification requirements that will promote or support change?
- Will the local authority incentivise diversification or start-up, for example through training, secondment of personnel, or provision of back office services?
- Will the local authority incentivise quality, how, and at what price?
Section Two

4 The Role of a Market Position Statement

Central to the use of improved market intelligence is the development by the local authority of a market position statement (MPS) - which in effect represents the end product of market intelligence activity.

This development process should bring together data from the Joint Strategic Needs Analysis (JSNA), commissioning strategies, and market and customer surveys into a single document. It should be market facing, i.e. contain information the authority believes, and can substantiate, would be of benefit to care providers. As the table below illustrates, an MPS is not a repetition of a JSNA or a commissioning strategy but a practical document that is focused on delivering a specific product to benefit the market.

Table 1: Comparative characteristics of a JSNA, Commissioning strategy and MPS

<table>
<thead>
<tr>
<th>JSNA</th>
<th>Commissioning Strategy</th>
<th>Market Position Statement</th>
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</thead>
</table>
| Defines demand across health, housing and social care. Essentially a broad based statement of current and future trends. May help to identify and target key populations, using predictive risk modelling. Looks at long term patterns of need and demand. | Normally based around groups of service users, commissioning strategies should:   
  - Build on the view of demand presented by the JSNA.  
  - Identify current practice and future use of public resources.  
  - Look at the resources the local authority has available and how these may be allocated or re-allocated in the future. | An analytical, ‘market facing’ document that brings together material from the JSNA and commissioning strategies into a document that presents the data the market needs to know if they are to plan their future role and function. Identifies the needs and preferences of different service user groups in the market, e.g. older people, learning disability, etc. and covers local authority and privately funded users of care. Indicates the necessary changes, characteristics and innovation to service design and delivery the local authority would like to see in the market to meet the needs and preferences of the whole population, and how the local authority will support and intervene in local markets. |

Other characteristics of the MPS are that it should:

- Cover the whole provider market, not just that part which the local authority currently funds.
- Indicate how the local authority intends to behave towards the market in the future.
- Be a brief and analytical rather than descriptive document.
• Be evidence-informed, in that each statement it makes has a rationale that underpins it, based on population estimates, market surveys, research etc.

• Take into account and (as relevant to the user group) consider the role of the wider local authority - for example, housing, education, leisure services and the PCT. The MPS should also take into account the current role and capacity for development of generic community services and resources. However, the MPS is aimed primarily at the social care market, so should retain focus on considering these other functions in terms of their impact on that market.

• Draw on commissioning strategies, the JSNA, policy reviews, inspection reports etc., but differ from these documents by virtue of its brevity and readability, and the fact it is a document designed solely to inform and facilitate the social care market. It is a document that is essentially addressed to providers and citizens (current and potential service users and carers).

An MPS should not be seen as the end product of the commissioner’s work, but as the start of an evolving constructive and creative dialogue between the local authority and its public, private and voluntary sector providers. An MPS should not be seen as an onerous task, because it should define what much of the future role of the social care function of the local authority will be.

5 The Content of a Market Position Statement

As a first step, the local authority will need to define the population(s) and market segment(s) the MPS aims to address. Some current MPS examples address ‘Adult Social Care’ while others comprise a series of linked documents for ‘Older People’, ‘Physical/Sensory Impairments and Long Term Conditions’, ‘Learning Disabilities’, ‘Mental Health’, ‘Extra Care Housing’, etc. Some authorities may wish to address the social care market as a whole, and this could be particularly appropriate – for example - in rural areas, and/or areas with small populations, and/or where there are unlikely to be many providers.

At this point it should be noted that, while the messages in this document are for the most part generic, and relevant to whatever market segment the MPS needs to address, the remaining sections of this document have been written very much with the adult social care market in mind.

The content of the MPS should convey clear messages for providers about:

• The direction of travel.
• Future demand.
• Current supply, identifying strengths and weaknesses.
• Models of practice.
• Future resourcing.
• Support for choice, innovation and development.

These are discussed in more detail below.
5.1 **Summary of the direction the local authority and its partners wish to take - the purpose of the document**

- Summarises the key care and wellbeing objectives for the local community, the principles of policy, legislation and regulation that will have an impact on the market.
- Summarises the key elements of the analysis presented in the individual sections below.

5.2 **The local authority’s predictions of future demand, identifying key pressure points**

- Analyses the current population and anticipated projections for the coming five, ten and fifteen years for the relevant market sector and the authority’s analysis of the impact population change may have on future demand for health, housing and care services.
- Offers an analysis concerned with the whole care and wellbeing market, including - for example - self-funders and those funded by the local authority either in part or in total. Consumer perspectives should be represented in here.
- Highlights particular aspects of demand now and in the future - for example by geography (which wards have high density) and by nature of particular problems, e.g. dementia, profound and multiple disabilities, etc. This will include the rationale on which such estimates are being made.
- Covers aspects of service demand which the local authority thinks might diminish.
- Differentiates between self-funders and those funded by the local authority.
- Looks at and interprets trends over time.

5.3 **The local authority’s picture of the current state of supply covering both strengths and weaknesses within the market**

- Review current spend - by whom on particular market sectors.
- Provides a quantitative picture of current supply, looking at what services are provided, to whom, where and in what volume. Particular questions discussed might be: does the profile of service provision match likely future demand, are services located in the areas of highest need, and - in the case of learning disability - what is the proportion of out of authority placements compared to in house, and how does this benchmark against other authorities?
- Provides a qualitative picture of current supply indicating those areas where services appear not to be meeting required standards or users’ requirements or outcomes. This might include taking evidence from Care Quality Council (CQC) reports of complaints, user surveys, mystery shopper exercises, etc.

5.4 **Identified models of practice the local authority and its partners will encourage**

- Reviews how the local authority sees the supply side delivering in the future in terms of the approaches and methodologies they might use.
• Analyses the extent to which desired models of care are matched by current provision, and whether they would require increased funding to deliver a different approach.

• Suggests how the market might deliver change.

• Makes a statement about whether the local authority will continue to provide or directly purchase any services, whether it will seek framework agreements with providers or seek only to influence the CQC, service users, carers, government in particular directions.

5.5 The likely future level of resourcing

• States which areas of supply the local authority will see as a high priority, where it wishes to see services develop, and where it would be less likely to purchase or encourage service users to purchase in the future. Describes the vision and options for future resourcing, and how this matches with the shift in resources that may be desired by the previous section.

• Provides - if cuts are to be made - an analysis of the likely targets, an analysis of the services which might be decommissioned or discouraged, and says how the local authority will seek to achieve changes.

5.6 The support the local authority will offer towards providing choice as well as innovation and development

• Gives an analysis of what the authority anticipates will be the impact of more service users purchasing or negotiating their own care, and suggests what impact this might have on transaction costs.

• Describes any particular offers and incentives available to providers if they develop certain types of provision, e.g. outcome based contracts and changes in reporting requirements, land availability and/or help with planning consent, guaranteed or underwritten take-up of services via framework agreements, training and development (including bursaries to visit other services/areas and report back to provider fora, and competitions with prizes for innovative ideas), secondment of personnel, back office services and other forms of business and management support.

6 The Style of a Market Position Statement

As a document that seeks to influence the market, the look of the MPS should encourage and not discourage reading. It should make clear in its opening words which population(s) and market segment(s) it is written for, and what the purpose of the document is. The use of a contents page, sections and subsections, bullets, etc. will all help busy providers to quickly find the parts that are relevant for them. Key messages should stand out from the rest of the document. Tables of numerical data should be used with caution: instead, the commissioner should articulate the key messages of a table of figures, and then consider whether inclusion of the table will still add anything to the messages. In the interests of clarity and brevity, it may be preferable simply to reference more detailed data and publish these in a separate Data Report. Consider whether to publish an Executive Summary separately.
For the Main Report, consider the use of photographs, maps, graphics and colour to enliven the document and extend readership (see, for example, City of Bradford MDC’s MPS\(^2\)). Use font sizes and colour contrasts that take forms of visual impairment into account, and make it clear that the MPS is available in alternative formats and languages.

7 **Beyond the Market Position Statement**

Local authorities developing an MPS should be mindful that the finished product should act as a ‘calling card’ or a starting point. To that end, it should represent a summary and statement of local authority intent towards the market. It should:

- Adopt a market facing/engagement approach.
- Analyse future demand, the current size, shape and performance of the market.
- Address how the quality and standards of service available to people can be driven forwards.
- Estimate the likely level of resources that will encourage this and the wider role the local authority will play in helping to achieving this.

Beyond the MPS are a number of tasks to be identified and completed.

7.1 **Market structuring activities**

- Publish, launch and disseminate the MPS and use it as a ‘calling card’ for meetings and discussions with current and potential future providers.
- Actively promote the model of what the range of care should look like based on good practice, both within and external to the authority.
- Develop an awareness of providers’ long term business plans and where future support might be needed. Identify business cycles across provider sectors.
- Discuss whether support to strategic business planning is needed.
- Work with providers to assess the impact that greater choice, via personal budgets and direct payments, might have on costs and availability of service provision.
- Where demand for a service exists and where the provider is vulnerable, identify how commissioners can reduce that vulnerability.
- Identify where there are barriers to market entry where new resources are needed and identify with providers how these might be overcome.
- Look for potential diversification amongst existing organisations’, *e.g.* Can Registered Social Landlords do care and repair? Can home care agencies deliver assistive technology?
- Work with providers on an open book accounting model to cost out new developments and innovations.

• If there is in house service provision, be clear about where and why the local authority is a provider. Diminish differences between in house and external systems where these potentially compete in the same market.
• Open up discussions across the local authority with planning, business support and regeneration departments.
• Review tendering and procurement processes, evaluate their impact on provider communities and explore how improvements can be made that will help to drive the market forward.

7.2 Market intervention
• Refocus local authority business support initiatives on to the health and social care market.
• Explore how local projects can attract capital investment and what guarantees may be needed.
• Develop social enterprise organisations.
• Explore where planning barriers exist and negotiate how that process can be improved for providers.
• Offer access to training that commissioners and providers agree can improve performance and is focused on delivering the model of care.
• Promote local Which-type care guides that adopt a consumer perspective.
Section Three

8 Example Market Position Statement and Data Set for Adult Social Care

When considering what to include and what to exclude, the local authority should ask itself: What are the key characteristics of the market locally, and are these important? What do current and potential service users and their carers and families need to know, and what are their aspirations? What do providers need to know – what trends and key messages should we include and emphasise – so that they can respond and proactively develop their business activities? Where we have a clear sense of where we wish the market to reshape, have we conveyed this, and have we said how we will support and encourage providers to respond?

The remainder of Section Three makes detailed suggestions for data collection and analysis in relation to Adult Social Care. However, these suggestions are neither relevant in all cases nor necessarily exhaustive. Relevance will depend on the target population(s) and market segments for whom the MPS is being written, and on characteristics of the local demographic and economy.

Between the stages of data collection and analysis on the one hand and drafting of the MPS document on the other, there is an important intervening process in which the writer needs to review the evidence so far and consider: out of all this information, what is really relevant to the purpose at hand? Have we captured the key characteristics and trends in the local market for this segment? Is there other information that needs to be gathered and analysed, and does it call for any primary research? Have we taken a broad enough view of current and future developments that will impact on our target market, for example by checking with colleagues in planning, business support and regeneration? Where we lack information, will we acknowledge this in the MPS and invite providers to contribute their intelligence? Have we made a clear and succinct statement of intent to the provider market? How does the structure and style of the MPS promote readability and ensure key messages stand out? In the interests of brevity, can some supporting information and analysis be referenced and published separately?

8.1 Introduction

The MPS document should make it clear at the outset which population(s) and market segment(s) it is written for and what the purpose of the document is.

Example statement

Who this document is for
This document is aimed at existing and potential providers of adult social care and support. It represents the start of a dialogue between the council, people who use services, carers, providers and others, about the vision for the future of local social care markets. We are committed to stimulating a diverse, active market where innovation and energy is encouraged and rewarded and where poor practice is actively discouraged. This is an important role for the council, and a key part of shaping what kind of place Borchester is, namely a place where people with care and support needs, their families and carers, are included and involved in community, economic, and social life.
Providers of adult social care can learn about the council’s intentions as a purchaser of services, and our vision for how services might respond to the personalisation of adult social care and support. Voluntary and community organisations can learn about future opportunities and what would enable you to build on your knowledge of local needs in order to develop new activities and services. People interested in local business development and social enterprise can read about new opportunities in the market and tell us what would help you to come into social care markets and offer innovative services. Social care providers and organisations not currently active in Borchester could find opportunities to use your strengths and skills to benefit local people and develop your business.

8.2 Exploring demand

This section of the MPS could draw on the materials suggested below. While it is important to describe the data, this section of the MPS should provide a narrative of the analysis of the data (see comments in Section Two about the potential for a separate Data Report). The section of the MPS should focus on commentating on trends, comparisons and projections, in particular drawing attention to key characteristics of the local demographic.

Example

Using information drawn from our JSNA (etc.) we have summarised here some of the key messages relating to the current and likely future community support needs of adults in Borchester:

- Based on these projections, if we continued with the same model of care as we have currently, there would need to be an additional 1,250 care home places for older people by 2025 (an increase of approximately 50 per cent).
- By 2030 we expect to see approximately X informal carers who will themselves be aged over 65 and have their own care needs alongside those of the person they care for.
- The number of people with dementia is expected to rise to 16,000 by 2021 – an increase of 36 per cent.

Example Table 1: Potential population growth of older people

<table>
<thead>
<tr>
<th></th>
<th>2010 current figure</th>
<th>2015 figures and % increase</th>
<th>2020 figures and % increase</th>
<th>2025 figures and % increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people aged 65 plus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People aged 85 plus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: POPPI³

Quantitative data available to commissioners often comes in table format, requiring analysis and interpretation. The examples provided in this document should not be seen as items for cutting and pasting into an MPS document; instead, the commissioner should draw out and articulate the key messages, then consider whether inclusion of the table itself in the MPS would add anything to these messages. Where the preference is to include the hard data, consider whether a graph or chart would convey key messages more clearly than a table. Use numbers sparingly: in the interests of clarity and brevity, it may be preferable simply to reference more detailed data and publish these in a separate Data Report.

³ Projecting Older People Population Information at http://www.poppi.org.uk/
Example Table 2: Key factors that may influence potential changes in demand for health and social care in people aged 65 and over

<table>
<thead>
<tr>
<th></th>
<th>2010 current figure</th>
<th>2015 figures and % increase</th>
<th>2020 figures and % increase</th>
<th>2025 figures and % increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with dementia</td>
<td></td>
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<tr>
<td>People with a limiting long-term illness</td>
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<td></td>
<td></td>
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<tr>
<td>People unable to manage at least one personal care task</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People unable to manage at least one domestic care task</td>
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<tr>
<td>People aged 75 and over providing more than 50 hours care per week</td>
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</tbody>
</table>

Source: POPPI

Note that data tables in Poppi and Pansi can be downloaded into Excel for analysis and charting.

Example Table 3: Predicted population of people aged 18-64 with a physical disability or mental health problem

<table>
<thead>
<tr>
<th></th>
<th>2010 current figure</th>
<th>2015 population % increase</th>
<th>2020 population % increase</th>
<th>2025 population % increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with a moderate or severe learning disability</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with moderate physical disability</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>People with a severe physical disability</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>People with a moderate or severe personal care disability</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>People with a mental health problem</td>
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<td></td>
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</tbody>
</table>

Source PANSI

Maps with the following data are useful to align population and provision:

- Proportion of population estimates per ward - people age 65-84.
- Proportion of population estimates per ward - people age 85plus.

Example Table 4: Distribution of older people by top [x number] wards compared with those in receipt of council support

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Ward by total population 2006-07 ONS</th>
<th>Ward by population aged over 65</th>
<th>Ward by number of council funded packages of day care (2009-10 RAP return)</th>
<th>Ward by number of council funded packages of domiciliary care (2009-10 RAP return)</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>5</td>
<td></td>
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</tbody>
</table>


A table that explores migration may pick up patterns of population flows that should be articulated in the MPS. Is the younger population leaving the authority area, or are there significant factors in the local economy – current or planned – that may attract particular socio-economic groups and influence the balance of demand – for example, for schools and healthcare, or rehabilitation? Does the locality attract people on retirement or is there an exodus of the physically fit and better off at that point?

### Example Table 5: Migration flows

<table>
<thead>
<tr>
<th></th>
<th>Internal (UK) migration</th>
<th>International migration</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Inflow</td>
<td>Outflow</td>
</tr>
<tr>
<td>MPS authority</td>
<td></td>
<td></td>
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<tr>
<td>OLA</td>
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<td>OLA</td>
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</tbody>
</table>

*Source: ONS Migration and Internal Migration by Local Authority in England and Wales*

### 8.3 Summary of current and future expectations

The population data provide only part of the demand picture. What are consumers saying about current services and their aspirations for the future? Understanding current and future expectations among relevant groups gives definition or colour to the population data. However, engaging service users and carers in making a contribution towards strategic commissioning decisions is an activity often fraught with difficulties. For many authorities, consultation has centred on discussions with organisations or individuals with whom there is regular discussion about provision: however, their views may not always be representative. It is particularly hard to get the pre-retirement age group, or service users in early old age, to envisage what life may be like in older old age. (For an alternative approach, see [Anticipating Future Needs](#).) Notwithstanding these difficulties, there are potentially useful sources of information that may help in developing a picture of future need. For example:

- General estimates of demand, e.g. housing needs surveys.
- MORI polls and other national surveys which explore attitudes towards health and social care.
- Research which looks at general population perspectives on services or future provision.
- Local surveys. Some authorities have standing groups that offer representative samples of the population for consultation.

The example on the next page illustrates how relatively small pieces of local research can provide valuable insights. Ideally, commissioners should use a twin approach, supplementing findings from national research with locally based work. In recent years the Joseph Rowntree Foundation, the Economic and Social Research Council and Help the Aged have sponsored a considerable amount of research.

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Example

A recent survey of council staff and partner organisations highlighted the expectations of people within the district and their future housing and funding options for retirement. In our sample, 23 per cent of 50-59 year olds said they would prefer to live in a retirement development, sheltered housing or an extra care facility. When asked about how they expected to fund their retirement, 73 per cent of 50-59 year olds said that an employer’s or private pension would be used, while 29 per cent said they would use their savings. Although this gives a local snapshot of opinion, it is nevertheless an interesting indication as to how some local people approaching retirement age are thinking about how to fund their future care and housing needs. Where there are a possible growing number of people prepared to self fund some or all of their care and support needs, the market needs to be able to respond to this and deal with people self referring or wanting information and support to make choices about their needs.

research work with older people. These studies have looked at, for example, older people’s attitudes to their housing, to inheritance and to illness and frailty. Commissioners of older people’s services would be well advised to build on this information in conducting their own studies. For example, the ESRC study on quality of life offers some important indications beyond health and care that will influence whether older people are to remain within the community.

8.4 Exploring current supply

This section of the MPS should describe the characteristics of the current market - for example where it is growing or slowing down, where there are voids, waiting lists, gaps or unmet need. Which areas of the local authority have over/under provision based on what you know of the current population and predicting future populations? Is there anything significant in terms of migration that will impact on this picture? This section of the MPS should also include a statement about the quality of current provision. For example, it could start with a summary that focuses on some of the following:

Example

- We are experiencing an increasing demand for domiciliary care, with people’s needs becoming more complex and their care packages becoming larger.
- There is a shortage of high quality nursing home care for older people with dementia, and demand is growing.
- Some areas of Borchester – particularly the rural ones - have a lack of choice of provision of all types of care. Poor access to transport, particularly in these rural areas, is an issue for a number of older and disabled people.
- There is a general lack of choice of living options (e.g. Extra Care, Supported Living choices) in all areas and for all care groups – older people, disabled people, people with learning disabilities.
- We have an over-reliance on registered care for adults aged under 65.

Suggested headings and data include:

Residential Care

- Number of residential care establishments
- Number of beds
- Breakdown of provision by sector including local authority owned
- Breakdown by specialism (e.g. dementia)
- Number of care beds per 1,000 population aged 65plus (compare with national/regional/comparator group)
- Similar approach for registered care homes with nursing beds (older people or dementia).
- Number of specialist establishments for people with learning disabilities, mental health problems or a physical disability etc.
- How many out of authority learning disability placements, and how many within authority placements (residential and nursing).
- What is the lowest older people/learning disability cost per week and the highest? How does this stack up against any local authority provision?
- What percentage of residential and nursing home beds are occupied by people funding all or part of their own care?
- Volume and distribution of residential homes compared to where people live.

Example Table 6: Registered care homes by provider and client group

<table>
<thead>
<tr>
<th>Client type</th>
<th>Residential /with nursing</th>
<th>Number of homes</th>
<th>Number of places</th>
<th>Number of homes LA run</th>
<th>Number of LA places</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old age registered for dementia care</td>
<td>Residential With Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old age only</td>
<td>Residential With Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example Table 7: Number of residents supported by the local authority who are in residential care or residential care with nursing by type of admission and age group

<table>
<thead>
<tr>
<th></th>
<th>Age 65-74</th>
<th>Age 75-84</th>
<th>Age 85 and over</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care</td>
<td>Permanent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Temporary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential care</td>
<td>Permanent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Temporary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: NASCIS, ASC-CAR S2^6.

Example Table 8: Number of older people permanently admitted to registered accommodation per 100,000 population

<table>
<thead>
<tr>
<th></th>
<th>Residential Care</th>
<th>Nursing Care</th>
<th>Total of residential care plus nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>07-08</td>
<td>08-09</td>
<td>09-10</td>
</tr>
<tr>
<td></td>
<td>07-08</td>
<td>08-09</td>
<td>09-10</td>
</tr>
<tr>
<td></td>
<td>07-08</td>
<td>08-09</td>
<td>09-10</td>
</tr>
<tr>
<td>England</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIPFA group avg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MPS authority</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: NASCIS ASC-CAR S3

Example Table 9: Registered care homes by provider and client group

<table>
<thead>
<tr>
<th>Client type</th>
<th>Residential / with nursing</th>
<th>No of homes</th>
<th>Spaces</th>
<th>No of homes LA run</th>
<th>No of LA spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability</td>
<td>Residential</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>With Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Care Quality Commission

Example Table 10: Current placements

<table>
<thead>
<tr>
<th></th>
<th>Total providers in market</th>
<th>Number currently commission with within LA (number in brackets = number of in-house providers)</th>
<th>Of residents as at 30.09.10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>% placed in house</td>
</tr>
<tr>
<td>Residential care 18-64</td>
<td>167</td>
<td>131 (5)</td>
<td>1</td>
</tr>
<tr>
<td>Residential care 65plus</td>
<td>212</td>
<td>210 (24)</td>
<td>28</td>
</tr>
<tr>
<td>Nursing care 18-64</td>
<td>10</td>
<td>8 (0)</td>
<td>0</td>
</tr>
<tr>
<td>Nursing care 65plus</td>
<td>71</td>
<td>66 (0)</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Capturing Regulatory Information at a Local Level (CRILL)

Extra Care Housing/Housing with Care

- Numbers of ECH, how many apartments purchasable/rentable?
- Provision by voluntary sector private sector

Domiciliary Care – Older People and Adults with Physical Disabilities

- Total number of care hours provided by LA
- Number of hours purchased from registered private/voluntary providers hours per week.
- Number of hours supplied by the in house service hours per week.
- Unit costs of domiciliary care - spot contracts: £average hourly rate, £lowest rate, £highest rate.
- Unit cost for in house provision
- Average cost of domiciliary care across the area.

Domiciliary Care – Adults with Learning Disabilities

- Hours of care to people with learning disabilities.

Housing Related Support

Sheltered Accommodation

- Range, distribution and mean rental cost per person/unit cost per person.
- Mean service charge.
- Number in sheltered accommodation within borough (broken down by fully funded by council, part-funded, any specialist needs).
- Number in sheltered accommodation out of borough (broken down by fully funded by council, part-funded, any specialist needs).
- Performance information collected in the last two years.
Example Table 11: Proportion of spend per client group on housing related support

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Proportion of annual spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td></td>
</tr>
<tr>
<td>Young people at risk</td>
<td></td>
</tr>
<tr>
<td>Generic support</td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td></td>
</tr>
<tr>
<td>Single homeless</td>
<td></td>
</tr>
<tr>
<td>Offenders</td>
<td></td>
</tr>
<tr>
<td>Homeless families</td>
<td></td>
</tr>
<tr>
<td>Complex needs</td>
<td></td>
</tr>
<tr>
<td>All other client groups</td>
<td></td>
</tr>
</tbody>
</table>

Grant-funding for Older People’s Preventive Support

- Amount allocated to support voluntary and community sector groups across the area who are working with older people.

Community services and resources

The mapping of supply should not focus exclusively on services for people with social care needs and the resources of the local authority. Attention should be given to factoring in the current impact and potential of generic community services and resources – from citizens’ advice and adult education services to outdoor activity centres and community choirs. How far are these currently used by people with health and social care needs? What are the barriers to access, and how can these be overcome? How can social capital be made to grow and flourish?

8.5 Exploring quality

Overall, the end product of this section of the MPS should be a clear view of the qualitative aspects of current supply, including saying on what this view is based. This may mean making clear statements for each service about what quality is to be expected, on what this is based, and how it is/was to be tested. Are there divergent views between commissioners, users/carers and providers? Are there any particular factors affecting quality - temporary or permanent? Is there clarity about what the service is trying to achieve and is this based on outcomes or outputs? It may not be possible to analyse the quality of all aspects of all the services relevant to the market segment being addressed, and commissioners may need to identify priorities. They may decide to focus, for example, on one or some of the following:

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7 See, for example, the Community Empowerment Toolkit at http://www.puttingpeoplefirst.org.uk/BCC/topics/Browse/Usefulresources/PracticalTools/?parent=6633&child=6692. Links to other resources can be found at http://www.coproduction.org.uk/content/resources.
- Effectiveness: What are the service outcomes for consumers and do they meet assessed need?
- Acceptability: Are consumers satisfied with these services?
- Equity: Is there unwarranted exclusion?
- Efficiency: Are there significant waiting times?
- Coordination: Do services provide effectively coordinated packages of care, and what is the pathway between services like for the consumer?
- Appropriateness: Do any services deliver to a higher or lower standard than necessary to achieve strategic priorities? How well do they align with overall strategy?

Typical information sources for this section include:

- CQC inspections.
- Complaints and letters of support about individual services.
- Anecdotal accounts from services users, carers and members of staff.
- Local and national surveys.

These sources should be supplemented with conversations with service users/carers and providers about what they believe constitutes good quality and whether it has been achieved. Suggested headings and data include:

**Residential Care**

- CQC ratings across private/voluntary care homes/local authority homes.
- Comparison with England.
- Number and nature of complaints.

**Domiciliary Care**

- CQC ratings across private/voluntary/local authority provision.
- Comparison with England.
- Number and nature of complaints.

### 8.6 Exploring funding

The MPS should include a statement of the authority’s current financing and funding arrangements, *e.g.* Where are you spending your money – client group, service provision. Has this changed over the last five years? How does it compare with other local (comparator) authorities?

<table>
<thead>
<tr>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>The council currently spends £x million a year on care and support (based on 2009-10 figures). A breakdown of this spend is provided in Table X and Figure Z. In 2008-09, the council spent x per cent of its overall spend for older people’s care services on residential and nursing care; a decrease from X per cent in the previous year, <em>i.e.</em> a majority share but a decreasing one. This is a very significant level of resource, which we would wish to see diverted as far as possible, in innovative ways, to helping people achieve wellbeing, safety and security, and good quality of life at home.</td>
</tr>
</tbody>
</table>
Example Table 12: Net expenditure by social care including grants for year 2009-10

<table>
<thead>
<tr>
<th>Item</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for people with physical disabilities</td>
<td></td>
</tr>
<tr>
<td>Services for people with mental health needs</td>
<td></td>
</tr>
<tr>
<td>Services for people with learning difficulties</td>
<td></td>
</tr>
<tr>
<td>Services for older people</td>
<td></td>
</tr>
<tr>
<td>Other adults</td>
<td></td>
</tr>
<tr>
<td>Supporting people</td>
<td></td>
</tr>
<tr>
<td>Asylum seekers</td>
<td></td>
</tr>
<tr>
<td>Voluntary sector grants (broken down by client group if possible)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

Example Figure 1 - Percentage distribution of social care funding

The table below compares the MPS authority with other authorities in terms of percentage distribution of total gross expenditure on adult social services by client group.

Example Table 13: Comparison of total gross adult social care expenditure across shires, etc.

<table>
<thead>
<tr>
<th>MPS authority</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>Comparator group</th>
<th>England average %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people (65 plus)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with a learning disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with a physical disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with mental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8.7 The local authority’s vision of the future market

This should cover not only how the local authority sees the market in the future, but the level of resourcing and why the authority sees the vision as it is: What is the evidence? And how will the LA influence the market? This section of the MPS should be led by the analysis of the above narrative, with a clear link between the direction being described here and the market conditions above.

It may be useful to start with a section that helps you to draw it all together, as in the example below. (As mentioned earlier, note that these statements are an illustration only. They are not universally relevant.)

Example Table 14: Reviewing the evidence – delivering change

<table>
<thead>
<tr>
<th>Reviewing the evidence</th>
<th>Delivering change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic growth means that the current pattern of services and investment is unsustainable; a growth upwards of X per cent in older people and younger adults with disabilities in the next 15 years will not be matched by public funding.</td>
<td>The market will need to be ready to respond to budgetary pressures that are being faced nationally. This may mean providers being able to offer sustainable value for money and quality services at a lower cost regardless of whether service users are spending their own or allocated funding. We will be keen to do business with flexible providers who can demonstrate that their services are able to diversify into areas of provision where they may not have provided in the past.</td>
</tr>
<tr>
<td>The current care and support market offers a range of providers who provide good quality services. There is sufficient capacity in the market as it stands and a good labour market to support the industry. However, the current profile of service provision is unlikely to match the expected rise in demand in care and support services across the district.</td>
<td>Additional capacity may be required to meet the expected demand for residential and domiciliary care. The council’s view is that investment and growth in prevention, early intervention and social capital is vital. We will work closely with our NHS partners to deliver these types of services and reduce any duplication of services over the coming years.</td>
</tr>
<tr>
<td>An increasing number of people (notwithstanding any government proposals with regard to the future funding of social care) fund their own care. Currently we estimate that approximately 12 per cent of service users who receive support funding via the council also augment their care, or purchase other services directly from the same provider. The figure for those funding their own care outright is estimated at around 8 per cent of the total market.</td>
<td>People who do not require the local authority to fund their care should still benefit greatly from improved health and social care information and expertise regarding e.g. the alternatives to care homes, assessing needs, maximising independence, managing risks, and supporting carers.</td>
</tr>
</tbody>
</table>
8.8 Describing the future

In this section, the aim is to provide clarity in terms of what the future model of service provision the commissioning authority is looking for. Once the local authority has been able to build a clear picture of what future service provision will look like, it should develop a clear action plan that sets out, over the time period of the MPS, how it will move from the current situation to where it needs to be in the future, and how such change may be stimulated, managed and funded. The following table outlines the market development issues that will need to be considered at this stage so that the local authority is clear, not just about the services it is intending to develop, but also about how it intends to work with other agencies and providers to achieve the change.

Example Table 15: Planning for long term market development

<table>
<thead>
<tr>
<th>Area</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market growth</td>
<td>● Which sections of the market need to grow, by how much and with form of provision?</td>
</tr>
<tr>
<td></td>
<td>● Who will be the potential suppliers?</td>
</tr>
<tr>
<td></td>
<td>● What will be the balance between in house and external provision?</td>
</tr>
<tr>
<td></td>
<td>● Where will funding come from to fuel developments?</td>
</tr>
<tr>
<td>Market diversification</td>
<td>● Is there a need to encourage new suppliers into a sector or to help assist smaller but specialist or high quality providers to survive?</td>
</tr>
<tr>
<td></td>
<td>● What kinds of new supply need to be supported?</td>
</tr>
<tr>
<td></td>
<td>● Have there been discussions with the independent and voluntary sector about widening forms of provision?</td>
</tr>
<tr>
<td></td>
<td>● Are changes needed to existing procurement arrangements?</td>
</tr>
<tr>
<td>Procurement practice</td>
<td>● Are specifications, tendering and contracting arrangements fair and cost effective for providers?</td>
</tr>
<tr>
<td></td>
<td>● What demands are being placed on providers by tender processes?</td>
</tr>
<tr>
<td></td>
<td>● Are there procedures and processes that would allow for a shift in service description from quantity and quality to outcomes?</td>
</tr>
<tr>
<td>Decommissioning</td>
<td>● What services either in house or external may no longer be required, either in the same amount or at all?</td>
</tr>
<tr>
<td></td>
<td>● When will decommissioning need to take place?</td>
</tr>
<tr>
<td></td>
<td>● What processes need to be put in place to support service users through changes?</td>
</tr>
<tr>
<td></td>
<td>● Have the transition costs of changing provision been fully taken into account?</td>
</tr>
</tbody>
</table>

The local authority may wish to make it explicit where and why it will continue to directly provide services, as this example illustrates:

Example

Increasingly, the council’s in house services across all care groups are focusing on those people with the most complex needs, while the majority of straightforward provision is commissioned from the independent sector. We will be continuing this approach in the future, with a reducing market share for the council across all service areas – more details of this are provided within the care group sections. Our overall principles are that we will only provide direct services ourselves where:

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8 CSIP Extra Care Housing Toolkit at http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/AboutHousingLIN/HowdoIusetheHousingLIN/KeyDocuments/?parent=1648&child=1508
The needs of service users are very complex and quality of service relies on highly trained staff (though we will also contract for some very specialist provision).

The independent sector is not willing or able to provide services.

An element of the service offered includes assessment which we feel needs to be undertaken by in house staff to remain independent.

The service relies on close partnership working, which is easier to achieve successfully if staff are directly employed by us.

We believe we need to retain an element of provision to enable us to try out new approaches which the independent sector would be unable or unwilling to undertake.

**Domiciliary care services**

In line with this policy, the council’s domiciliary care service will continue to reduce its share of the regular market down to zero over the next three years and will instead focus on the provision of:

- Rapid Response (24 hour urgent support to avoid hospital admission, respond to emergencies, etc.).
- Specialist support for people with long term conditions, working in partnership with NHS colleagues.
- The establishment of an intake/reablement service offered to everyone who is new to service. This period of up to six weeks of support will aim to increase people’s independence and to stabilise or refine the care package that is subsequently commissioned from independent sector providers in the longer term, either by the individual themselves or via a block contract arrangement on their behalf.

This section of the MPS should also describe the local authority’s mechanisms for ensuring that it has the most appropriate contracting mechanisms in place to facilitate the provision of its desire future model of provision. For example:

**Example**

To make sure that there is a thriving independent sector social care market, the council will continue to work with providers and potential providers to support them in a range of ways.

**Block contracts and future contract models**

We are continuing to block contract for some services for a number of reasons:

- To ensure that there is an adequate supply of services.
- To obtain best value for money.
- To provide security for existing providers whilst the transition to personal budgets takes place.

At present we have a number of block contracts in place, including for:

- Domiciliary care.
- Daytime activities for learning disabilities, older people and people with physical/sensory impairments.
- Transport.

We will keep reviewing the situation on these as the contracts are due for renewal. As more people opt for personal budgets we are likely to establish reducing contracts within which block payments will be made for time limited periods and providers will be expected to gradually shift over towards individual arrangements with people using their personal budgets. A number of these type of contracts are now in place.
In some areas of provision (daily living support for working age adults for example) we are developing framework agreements, where agreed payment bandings will be established with providers, based on the needs of the person using services. The aim of these arrangements is to offer a fair price for care to providers, whilst ensuring that people using services receive best value from their personal budgets.

8.9 Facilitating the market

This part of the document should bring together all the narrative and analysis and describe the methods of developing and facilitating the social care market required – for example, How to use market intelligence? How to help providers change/shape their services, investments, support, and training? What type of providers do you need to see in the local authority to grow, consolidate the market – large/small/medium sized, private, social enterprises, etc? How will you share risk, reduce costs, improve outcomes? What development grants will you be pursuing? Do you want to support voluntary sector providers via infrastructure organisations to come together to build more social capital in the local authority? How will you encourage providers in this dialogue?

9 Conclusion

Local authorities will continue to shift away from providing services and move towards a role which focuses more on assessing overall need within a locality and ensuring there is sufficient appropriate care provision available. Individuals will increasingly have control over purchasing their own services, using their personal budget, while providers are likely to see a steady decrease in block contracts. These changes will require local authorities, providers and citizens (current and potential service users and carers) to have a much better understanding – and ideally, a common perspective - of how the social care market operates. An important step towards achieving this common understanding is the development of a market position statement (MPS).

The MPS is a practical tool. While it draws on commissioning strategies, the JSNA, policy reviews, inspection reports etc., it differs from these documents in that it is a document designed solely to inform and facilitate the local social care market. It comprises a brief, readable summary and statement of local authority intent towards the market, and at the same time clearly articulates key messages that can help providers to be more proactive as well as responsive in the marketplace, using market intelligence to shape their business activities. As a product, it acts as a ‘calling card’ or a starting point, opening a dialogue between the local authority, providers, service users, carers and others about the vision for the future of local social care markets.

10 Useful Resources


commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20100218-underpressure-nationalstudy.pdf

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http://www.puttingpeoplefirst.org.uk/Topics/Browse/Milestones/Localcommissioning/Provid erdevelopment/?parent=7800&child=7959

http://www.northwestjip.co.uk/resources/downloads/programmes/category/14-commissioning

http://www.puttingpeoplefirst.org.uk/_library/Resources/Personalisation/Localmilestones/Market_Shaping_Review.pdf
Annex A

Developing a Market Position Statement: The Experience of Devon Adult and Community Services Directorate

1 Market Management: Demand Methodology

The figure below shows the target populations addressed in the market position statement (MPS):
2 Content of the Market Position Statement

We summarise the main content of the MPS as follows:

- The Future Operating Model – Helping People to Help Themselves - outlines the Council’s future ‘offer’ of services.
- The Commissioning Environment sets out how the Council intends to commission services.
- The Role of Voluntary and Community Sector Organisations identifies the particular contribution of voluntary sector providers.
- Representation underlines the need for recipients and their carers to be consulted.
- Future contracting arrangements introduces the move to different forms contracting.
- Financial Context.
- Characteristics of the provider of the future indicates the expectations the Council will have of providers.
- Major shifts in approaches to service delivery summarises some of the main changes affecting services.

3 Statement of Commitment to the Voluntary and Community Sector

The MPS included the following statement of commitment to the voluntary and community sector:

‘The Council recognises that VCOs are able to make a distinctive contribution to the needs of service users because of their:

- Responsiveness
- Flexibility
- Independence
- Capacity for innovation
- Ability to develop self help groups
- Ability to reach those organisations and individuals who are easy to overlook for a variety of reasons
- Capacity to lever in additional human and financial resources.

‘Given this distinctive role, the Council anticipates that in future, there will be a number of areas of provision that will be developed specifically in partnership with the Devon Consortium (representing the Voluntary and Community Sector).’

4 Market Shaping

Launch event

We launched the MPS at a conference Care is Our Business, held on 28 September 2010. This led care providers to think about the role of social care services across the county and how they might respond to changes to the way the Council provides services.
ANNUAL CYCLE FOR REVISION OF MARKET POSITION STATEMENT - DRAFT 3 JUNE 2010

June

July

August

September

October

November

December

January

February

March

April

May

Identify budget amendments

JSNA first draft

JSNA Final draft

Market Position Statement
Review principles, assumptions and previous year’s experience

Update Commissioning Strategies

User dialogue

Provider dialogue

Identify new providers

Budget finalised

Revise contracts

Strategic Plan refresh

TCS refresh

LAA refresh

Timing confirmed

Timing unconfirmed

Brendan Hurley
June 2010

JSNA first draft

JSNA Final draft

Market Position Statement
Review principles, assumptions and previous year’s experience

Update Commissioning Strategies

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TCS refresh

LAA refresh

Timing confirmed

Timing unconfirmed

Brendan Hurley
June 2010
Framework agreements
As a county we are planning to change the way services are purchased and the arrangements for contracting with suppliers. Thus the MPS is an important tool in shaping the market. The development is taking place in dialogue with providers.

5 Challenges
We faced a number of challenges during the process of preparing the MPS, and hindsight reveals the following learning points:

- Ensure the target audience understands the purpose of the document.
- To be clearer regarding high level messages and how they are drawn from the demand analysis.
- To identify gaps in the market and voids and to appropriately describe current characteristics of the market.
- Describing gaps, shortfall in need without guaranteeing commissioning of those services.
- Comparisons with other Local authorities in terms of supply.
- Comparison of cost information.
- Statements re current financial and funding arrangements, how and where we will invest to shape provision in the current changing financial climate.
- Accurate information and appropriate description regarding self-funders
- Difficulty in estimating numbers of individuals wishing to take up direct payments and utilise choice regarding personal budgets.
- Need to find an appropriate way of presenting our response to supply and demand intelligence that allows us to effectively describe our review of the evidence in respect of our analysis and link logically to proposals for delivering required change.
- Need to find appropriate statements to describe the method we will apply to develop and facilitate changes within the Devon social care market.

6 Balance sheet of progress
Despite the challenges above, considerable progress has been made. Briefly:

Achievements

- Have met providers expectations in producing the MPS on time.
- Established a firmer relationship with the VCS as providers.
- Confirmed a process/cycle for regular revision of MPS linked to commissioning/budget cycle.
- Established purposeful dialogue with an increasing number of providers.
- Dialogue in developing the MPS led to revising the PEN network and ongoing commitment to the MPS through a strategic commissioning sub-group.
- An increasing dialogue with the voluntary sector both with Devon County Council and for them with independent providers.
- An increased link between our market relationships and our service user and carer framework which has led to work on service user and carer involvement in service monitoring and the development of a single specification for involvement.
• The focus on procurement within the MPS has facilitated mutual collaboration on the introduction of framework agreements and has enabled a responsive dialogue with mutual accommodation.
• Changes to the approach and processes and content of framework as a result of listening to providers.

Still to be done

• Finalise document (Feb 2011) in context of emerging financial position.
• Be clearer about our role in future market shaping.
• Develop linkage between MPS, commissioning intentions and commissioning managers’ roles (IPC facilitated workshop Nov 2010).
• A more generic cross-cutting approach from the Strategic Commissioning Team
• Obtain more information on the total care market.
• Improve our information base relating to providers.
• Change of emphasis in style of MPS, e.g. towards the category management approach.
• A changing role in emphasis of the Management Information function within ACS along with the re-focus of the local government reporting framework – now more outward-facing influenced by the requirements of the MPS and more oriented towards market intelligence.

7 Read More Online!

If this brief summary of our experience of developing an MPS has been of interest, you may want to read more at www.devon.gov.uk/providerengagement and www.devon.gov.uk/market-position-statement.
Annex B

Self Directed Support: What we know about the use of personal budgets – a focus on the user’s experience

1 Introduction

This document provides a brief overview of the research that has been conducted with adults on personal budgets in the UK. It is intended to provide information and context for commissioners, providers and others who plan services and support. The term personal budgets is used to mean budgets largely allocated from social care sources as opposed to individual budgets which specifically bring together more than one funding source. Direct payments are generally mentioned as one sort of funding arrangement within self directed support, and are referred to specifically only where there is no more recent research on personal budgets.

Within the section on the user’s experiences, there is information on people’s aspirations, their need for information and support, the way they received their allocation of money, how they spent it, what people want from staff, information on good practice in support planning and the role of user led organisations.

The paper then moves on to consider what research tells us about outcomes both for the person in receipt of the money and family carers. It then touches on the research on cost effectiveness before moving onto a summary of the main messages and the final section where there is a discussion of the implications of the findings.

2 What We Know About People’s Aspirations

Recent work by Demos (Wood 2010) suggests that there is an appetite for change in social care with 55 per cent of people who are funded by councils keen to change their care arrangements when they receive a personal budget. Of those in receipt of a personal budget, 59 per cent had changed their care arrangements but 45 per cent of people currently using council services said they would not change anything. Self funders comprised 18 per cent of the sample and were the most satisfied with their package of support although 42 per cent would change some aspect of it, if they could.

This study of 770 adults from four main client groups and 10 local authorities also revealed that the five areas that they most wanted to change were:

- Their physical health (41 per cent)
- Opportunities for holidays (37 per cent)
- What they do on weekdays (32 per cent)
- The amount of control over their lives (29 per cent)
- Their financial situation (29 per cent).
The black Caribbean group (4 per cent of the total sample) were most likely to be concerned about their finances. Their six major concerns were: keeping healthy (77 per cent), having a good quality of life (64.5 per cent), having dignity and respect (50 per cent), having choice and control (48 per cent), economic wellbeing (25 per cent) and freedom from discrimination (19 per cent). In terms of help that people would need to make to change their lives, over half (54 per cent) said they would need help to know what they can (and cannot) do and 52 per cent said they would need face to face advice. Forty six percent also said they would need help in an emergency.

3 How People Get Information About Personal Budgets and the Processes Involved

There seems to be a low awareness of personal budgets in the general population and in the most recent DEMOS study of personalisation, many potential recipients had no knowledge of personal budgets. Some of the small scale evaluations that have taken place in Coventry, Worcestershire and elsewhere have suggested that accessing good quality information about personal budgets may be difficult. For example, in Worcestershire, the information packs provided were found to be complex and used too much jargon for the people with learning disabilities to understand and whilst good information existed on the internet, not everyone could access it. In the IBSEN research project on the impact of individual budgets on carers, it is clear that there was no consistency about how carers were informed about self directed support and what it might mean for them (Glendinning et al. 2009).

According to the Demos study (Wood 2010), the amount of help people need appears to differ according to the client group: over half of the people receiving funding from the council for their care said they would need information on what to spend their budget on whereas one quarter said they would need no help. People with learning disabilities were most likely to need information and people with sensory or physical impairments least likely to need it.

By April 2010, all councils should have had a strategy for delivering information and advice about care and support choices in place. But only 60 per cent had achieved this by June (Community Care 2010).

4 How People Received Their Personal Budget

In the IBSEN pilots, just over half of personal budgets were paid directly to the client, 20 per cent were held by the local authority, 16 per cent by friends or relatives (sometimes in a joint account), 12 per cent were held by an agent and fewer than 1 per cent were held in Trust and then only for the people with learning disabilities. As might be expected, there were significant differences between groups in terms of who had control of the money but the nature of the arrangements is just as likely to be influenced by the local authority area.

Looking at four small scale evaluations, it is clear that the amount of flexibility offered varies. In Hertfordshire, about half of all payments are paid directly to either the recipient or the family - but sometimes the local authority was commissioning services on behalf of the person, sometimes not. In addition,
there were examples of the money being managed by a service provider and the service being commissioned by the council as well as people having individual trusts and examples where the whole of the money was residing with the local authority. In contrast, only two main arrangements seemed to exist in Cambridgeshire with about two thirds of people having a direct payment and the remainder having money held by the local authority. In Worcestershire and Barnsley, the arrangements appeared to be split 3 and 4 ways respectively. In Worcestershire (N=56), all the people had learning disabilities and direct payments were paid to only three people, 25 arrangements involved payments to friends or family and for the remainder, an independent social care provider held the funds although some mixing of these approaches also occurred. In Barnsley, direct payments accounted for 23 per cent of budgets, independent agents were used in 22 per cent of cases and 54 per cent of budgets were held by the local authority. A trust arrangement was in place for less than one percent of the study group.

5 Support Planning – Good Practice

In Coventry, a local evaluation of the individual budget pilot found there were communication issues both between the individual/family and the local authority and between the agencies involved, which meant that families were not sure what was happening with the planning nor were they always confident that their aims would be met.

Recent research by Ward (internal report for ODI 2010) suggests that there is often no distinction in the minds of service users between local authority support planning and assessment and resource allocation, a point made previously by Simon Duffy (2007) and expressed succinctly by one recipient: ‘They listen to what we want, and give us what they want’. This lends weight to the view, endorsed by government, that independent brokerage and support from user led organisations is the way forward.

Whilst the importance of user led organisations has been recognised in several key government policy documents, particularly in relation to their potential role to support people to make the most of self-directed support, there appears to be little research on how well these arrangements work for people using them. However, we do know from work into the experience of people with learning disabilities receiving direct payments that they draw on lots of sources of support including family, friends and user-led organisations such as self advocacy groups, especially if they themselves are involved in them (Gramlich et al. 2002). Given the national roll-out of personal budgets, and the promotion of user led organisations to support this9, it is an area in need of further research.

There is useful information on the steps involved in the process of getting a personal budget on the In Control website and good practice guidance around

9 The development of ULOs has been supported by ADASS and the Local Government Association who formed an agreement with the National Centre for Independent living to promote their development for local implementation of SDS. To see this agreement go to: http://www.ncil.org.uk/categoryid20.html
the process of assessment and support planning is available from the Putting People First website at http://www.puttingpeoplefirst.org.uk/_library/Resources/Personalisation/Personalisation_advice/Good_Practice_in_Support_Planing_and_Brokerage.pdf. Phase 1 of In Control and the Coventry report on individual budgets highlighted the need for people to have information on where they could spend their money and some difficulties they experienced in recruiting staff. In response to such difficulties, the website shop4support enables people to choose the type of support they want in a virtual marketplace. The website aims to make it an easier and more effective way for service users to spend their individual budgets. They can also manage their budget and billing online. There are many personal accounts about the experience of receiving a personal budget on the Putting People First website: www.puttingpeoplefirst.org.uk/Topics/Browse/Milestones/Partnershipswithpeople/Workingwithpeopleusingservices/.

6 How People Spend the Money

The DEMOS study (2010) asked people to think about how they would spend their money if they had a personal budget. (It should be noted that two thirds of the respondents had no knowledge of personal budgets prior to the study). The most popular responses to this question were:

- Holidays (44 per cent)
- Personal assistants or home care (both 38 per cent)
- Leisure activities (42 per cent)
- Transport (36 per cent)
- Day centres (36 per cent).

However, use of personal assistants was found to have increased to 76 per cent once people had a personal budget or direct payment. In Barnsley, where there was basic data on 921 people, 45 per cent were purchasing support through a care agency and 27 per cent were directly employing personal assistants. There is further evidence from the IBSEN study and a range of small scale evaluations to suggest that people are most likely to spend their personal budgets (or individual budgets) on personal supporters (about 75 per cent overall). Most people seem to want to be as independent as possible and have access to local facilities such as leisure services. As might be expected, there are differences between the client groups with people who have mental health difficulties most likely to spend on leisure pursuits and older people least likely to do so, (IBSEN report 2008).

The early work by In Control with people with learning disabilities in six areas (2003-05) showed that there was a shift away from residential care into supported living and this was again seen in the IBSEN report (2008) although less markedly. However, demand for more ‘traditional’ services such as domiciliary care, day centres and to a lesser extent, residential care, seems to be remaining steady although there are regional variations. These trends are likely to change over time as more people receive personal budgets, and data needs to be gathered regularly to provide reliable evidence.
7 What Do People Who Purchase Support Want from Staff?

The Demos study (2010) concluded that amongst the 770 people consulted, there were four main priorities relating to staff. These were that they should:

- Have professional training
- Be locally based
- Have personal knowledge of the individual receiving support
- Provide continuity of service.

The self funders were less concerned about whether a person had any qualifications or training and instead preferred to rely on recommendations from friends. This latter view concurs with work by Skills for Care that states that 'people who use services often value the PA’s background and competence more than whether the PA holds any social care qualifications. Character, adaptability, empathy and strong communication skills are key.'

A separate study by Skills for Care (IFF Research 2008) on personal assistants found that 48 per cent of people employing personal assistants did not carry out Criminal Records Bureau checks on them but at the same time found that services users were experiencing less abuse than they were when receiving support through agencies commissioned by local authorities. Currently in England, Wales and Northern Ireland (not Scotland) personal assistants are excluded from the vetting system in place for staff working with vulnerable people. Widespread debate continues about whether personal assistants should be registered but 9 out of 10 of the 486 personal assistants questioned in this large study thought it should be compulsory to register. Their employers (n=526) tended to agree that a register would be useful but opinions were split on whether it should be compulsory to use it.

Opportunities for peer support for direct employers to share their experiences are recommended by Skills for Care as a cost effective way of promoting good working relationships with personal assistants (Patel and Pridmore 2010).

8 Research on Outcomes

The In Control evaluation of Phase 2 of the personal budget roll-out and local evaluations have used a similar format to each other so that it has been possible to gain information from up to 528 people about their experiences (not all questions were included in all evaluations). Satisfaction ratings were available in relation to eight domains including health, quality of life, involvement in community, personal dignity, sense of control over support and personal safety. The findings are that two thirds of people using personal budgets (66 per cent) reported that the control they had over their support and their overall quality of life had improved (68 per cent). Similarly, there was an improvement in the amount of time people were able to spend with people they wanted to (58 per cent), 55 per cent felt they were supported with more dignity and 51 per cent said they felt in better health since they took up a personal budget. There was no change in standard of living for most people (52 per cent) and 58 per cent said they felt there was no difference in their level of personal safety. In all domains, less than 10 per cent said that their lives had deteriorated since taking up a personal budget. These findings confirm the early findings from the IBSEN report in relation to people feeling in control of their lives but not in relation to
other aspects. The findings from the IBSEN report were very tentative owing to the fact that all the people in the study were interviewed after only six months of receiving an individual budget. Separately reported data on the impact on people with mental health problems, states that the people in receipt of individual budgets were found to have a significantly higher quality of life than those in the control group (Manthorpe et al. 2008).

In addition to these two studies, there is confirmation of the positive impact of individual budgets from the evaluation of their implementation in Coventry (Daly and Roebuck 2008). This work also found that amongst 30 users (aged 16-50), there was a greater sense of control over their own lives, an ability to have greater choice and autonomy, to consider new options and to be more involved in community activities. In particular, there were more opportunities to consider a wider range of housing and employment options. The previous DEMOS study (Bartlett 2009) also highlighted the fact that people with learning disabilities were much more likely to want to change their living arrangements and to want to work than people with physical disabilities and older people.

From the Barnsley analysis of 100 cases of people aged 18-97 years, there appeared to be no difference in outcomes by age but men were more likely to report improvements in quality of life than women. In addition, people with mental health problems were more likely to report improvements in health and community involvement than older people or people with physical disabilities.

9 What Are the Outcomes for Family Carers?

There are two main sources of information about the effect of personal budgets on family carers. The first of these is the IBSEN study of carers (Glendinning et al. 2009) and the In Control aggregated data from the phase 2 study and the local evaluations, reported in the Phase 3 document. The IBSEN study based on 129 qualitative interviews concluded: 'Individual budgets are associated with a positive impact on carer outcomes and if we allow for other factors, social care outcomes. There was no evidence of negative impacts on outcomes ....’ The study found there was no link between the psychological wellbeing of family carers and receipt of individual budgets but there was a greater sense of choice and control over how they spent their time.

The In Control data relate to up to 74 carers from five local authorities as the original evaluation framework did not include the section on family carer views. There were 10 domains included covering leisure and social life, capacity to take paid work, health and wellbeing, quality of life, ability to continue caring and stay well, equal partner in planning, choice and control, relationship with significant other, relationship with person you care for and finances. Most respondents said there was no change in the capacity to undertake paid work (60 per cent) and 19 per cent said this had become worse but in every other domain, fewer than 11 per cent reported their lives worsening after their relative took up a personal budget. In some areas, such as being a partner in planning, 77 per cent said there was an improvement and 63 per cent said their quality of life had improved. Overall, there was either improvement or no change in all areas apart from the domain relating to employment.
The Cost Effectiveness of Personalisation

Whilst it has been argued that there are significant cost efficiencies to be made through the transformation to self directed support (Tyson 2009), the majority of personal budget studies were of local authority pilots with specific local conditions or including particular user groups (such as those in the In Control pilots). It is therefore difficult to generalise about any efficiency findings. However, individual local authorities did report estimated savings of between 16 per cent (Worcestershire) and 18.7 per cent in Northamptonshire. The City of London also reported lower average per capita allocations compared to the costs of providing the traditional services previously received by seven people.

The IBSEN study provides the most reliable evidence to date and this too reported a small cost-effectiveness advantage over standard support arrangements for younger physically disabled people and people with mental health problems.

In addition, the national evaluation of POPPs demonstrated cost savings and improved productivity could be achieved through taking a more person centred and integrated approach to transformation of services to older people (PSSRU 2008).

The Care Service Efficiency and Delivery programme (CSED) has been actively supporting councils to transform the way they work and has argued for the personalisation process to be at the core of changes to the user experience of social care. They have made a number of suggestions about areas for creating efficiencies including the brokerage process (CSED 2007a and 2007b). A good account of the issues and current knowledge about personal budgets and efficiencies has recently been written by Carr for the SCIE (2010). This can be found at [http://www.scie.org.uk/publications/reports/report37.asp](http://www.scie.org.uk/publications/reports/report37.asp).

Summary of the Key Messages from the Literature

The key messages from the literature on users’ experiences of personalisation through the use of individual budgets, personal budgets and direct payments can be summarised as:

- There is low awareness of personal budgets amongst the general population and amongst people likely to be eligible for them.
- People with learning disabilities and older people are more likely to need advice and support to spend their personal budgets than people with physical disabilities or sensory impairments.
- How people receive their personal budget appears to be as much dependent on the local systems as on the client group to which they belong.
- People who are eligible to receive a personal budget said they would spend the money on one or more of the following things: holidays (44 per cent), leisure activities (42 per cent), personal assistants or home care (both 38 per cent), transport (36 per cent) and day centres (36 per cent).
- People (approximately 75 per cent) who are in receipt of a personal budget tend to spend at least some of their money on individualised support either personal assistants, care staff through an agency or by paying family or friends.
• The things that people valued most about staff is that they should have professional training, be locally based, have personal knowledge of the individual receiving support and provide continuity of service.
• Some people experienced difficulty recruiting staff or experienced delays in receiving information from an agency about potential candidates.
• Most people receiving personal budgets expressed greater levels of overall satisfaction with the care received and a greater sense of choice and control.
• There were positive outcomes for most family carers.
• Personal budgets can improve outcomes, and in some cases, reduce costs because resources are targeted better.
• Further work is required on the cost effectiveness of personal budgets and local authorities need to develop robust systems to monitor the number and costs of personal budget as well as the outcomes.

12 Discussion and Conclusions

12.1 Importance of information
The low awareness of personal budgets is a concern that local authorities, provider organisations and other relevant agencies must address urgently if they are to deliver the policy agenda of the government and the sector (see the Vision for Adult Social Care at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508. The partnership agreement Think Local, Act Personal (see http://www.puttingpeoplefirst.org.uk/_library/PPF/NCAS/Partnership_Agreement_final_29_October_2010.pdf) states that all service users eligible for an ongoing service should receive this by way of a personal budget with direct payments as the preferred model for most by 2013. Some providers will need support and encouragement to be more outward looking, more brand conscious and flexible in order to make themselves more attractive to individuals with their own budgets to spend. Individuals need to know where they can spend their money locally, so local marketing is key.

12.2 Changing Preferences
The literature on the way people spend their budgets indicates a shift away from many of the traditional services such as residential care to more mainstream community based activities and holidays. However, there still appears to be a steady demand for some types of service such as day centres and home care and this implies that commissioners need to do a tricky balancing act whereby they stimulate new types of activities and opportunities while simultaneously responding to the demand for more traditional services albeit more personalised and flexible.

12.3 Co-production
At the same time, research suggests that a one-size-fits-all approach will not meet the varying needs and preferences of different client groups, age groups and ethnic groups. It will be a challenge to ensure that there is a good understanding of the range of needs and wants being expressed locally and there is a need to develop mechanisms for involving a diverse group of people who represent a wide range of constituents. Approaches by which citizens are
empowered to contribute their own resources (time, expertise and effort) to have greater control over public resources to achieve a valued outcome has come to be referred to as co-production (Cabinet Office 2007). Co-production clearly fits with the current government’s concept of the Big Society. The importance of user led organisations in developing a more truly collaborative approach to local developments cannot be underestimated. There are tools relating to co-production on both the Putting People First and SCIE websites. One easy approach to making use of person-centred information was outlined in Working Together for Change (Putting People First 2009).

12.4 Personal Assistants
In order to achieve greater control and community inclusion, the majority of people holding personal budgets will seek to employ one or more people to support them. Some research suggests that recruiting people can be difficult and local authorities should consider how to ease these difficulties and promote peer support. The debate about whether personal assistants should be registered looks set to continue for some time but research suggests that the majority of this group of workers would welcome it. Registers of personal assistants are one way forward and also reduce recruitment costs.

12.5 Carers
Whilst the bulk of the work on outcomes suggests that for most people a personal budget provides improvements in most domains of their lives, the research on family carers provides less certain findings because many fewer of them have been consulted. Organising elements of a relative’s package may become a source of stress and it is important that carers’ own rights to assessment and services should are not sidelined.

12.6 Costs
Research on the cost effectiveness of self directed support is not plentiful and in order for good quality research to be conducted, local data systems will need to be developed so that data can be collated and lessons learned for commissioning. It is important that there is consistency across areas so that direct comparisons can be made in terms of numbers, costs and outcomes (Audit Commission 2010).

12.7 Outcomes
Ways to monitor outcomes from personal budget are documented in the recent Putting People First document Personal budgets – checking the results (Putting People First 2010). The Personal Outcomes Evaluation Tool (POET) developed by In Control and Lancaster University is available on line at https://www.in-control.org.uk/researchandevaluationtools.

Dr Carol Robinson
Freelance consultant in social care
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