Learning disability market position statements: are they fit for purpose?

Introduction

In the UK throughout the 1980s and early 1990s extensive reforms took place in the role of the state in relation to social care. In particular, there was a drive to redesign post-war statutory services towards a system organised along market principles and orientated towards consumer choice (Le Grand and Bartlett, 1993; Walsh, 1995).

Between 1997 and 2010 the New Labour government put in place mechanisms to enable greater choice and control over care and support, including through individual budgets. *Putting People First* (2007) officially introduced the idea of a personalised adult social care system.

The Care Act (2014) introduced new duties for English local authorities. It emphasized that the core purpose of adult care and support was to help people achieve the outcomes that mattered to them in life. It placed a duty on local authorities to promote the wellbeing of individuals and carers. The Act also required that local authorities ensure a functioning market that promotes a range of services to meet individual needs, including enabling and promoting access to universal community amenities. This market was required to provide diverse provision of high quality that could respond to current and emerging local needs, as well as different interests and life choices. Councils were also to ensure the market was developed sustainably.

This market shaping task can broadly be summarised under two headings:

- Market intelligence – activities that seek to understand the market, including collection and analysis of data on provider stability to enable oversight and risk management in relation to the 'health' of the market.
- Market influencing –activities that influence the current and future range of care and support available. This refers not only to local care and support provision, but also the local authority's own commissioning and social work practices including brokerage, funding mechanisms and communication between the local authority and partner agencies, individuals, carers and the wider market.

The Care and Support Statutory Guidance (Department of Health, 2014) emphasised the local authority role in leading and communicating a shared understanding of supply (the market) and demand (needs and aspirations) as a key part of the move towards market shaping. One tool for fulfilling this market shaping duty is a market position statement (MPS) that is co-produced with local care and support providers, people who use services and other partners. An MPS should inform a wide range of providers about the supply and demand in a local authority area or sub-region, and signal business opportunities within the market in that area. The MPS should be the basis for strategic commissioning and be published, reviewed and updated regularly. It is intended to be used by providers to plan for the future, thereby informing business decisions including investment in capital or personnel and encouraging innovative responses to emerging need.

The substantive characteristics of an MPS are that it:

- contains a picture of current demand and supply, anticipates future demand and clarifies how commissioners plan to support and intervene in their local market.
- provides an evidence base for analysis by bringing together material from a range of sources including Joint Strategic Needs Assessments, surveys, contract monitoring, market reviews and relevant national and local data sources.
- presents the data that the market will find useful to inform their business plans.
- covers all actual and potential users of services in the local area, including carers, not only individuals receiving local authority funding.
- is the start, not the end point, of a process of market shaping.
- is provided in a straightforward and easy to use format, in a brief document that is analytical, not just descriptive.

While there is a range of good practice guidance on commissioning and market shaping, there remains limited peer-reviewed research on these topics. The research that has been carried out has tended to focus on the failures of commissioners to implement policy and good practice (e.g., Kerrigan and Hopper, 2017). The research reported below was completed after undertaking a number of consultancy projects on market shaping, funded by the Department of Health.

The purpose of the current paper is to review the quality of published learning disability market position statements (MPS), discuss the issues underlying their apparent poor quality and explore the implications this carries for people with learning disabilities and their families.

Method

The Institute of Public Care (IPC) has developed a database of all known, published market position statements. This database was used to find all published MPS that focussed only on Learning Disabilities, of which there were fifteen on 11th August 2016. There were also 66 MPS covering the whole of adult social care in a local authority area and including a section on Learning Disability. These tended to provide a brief summary of demographics and occasionally the type of services Local Authorities wanted to encourage providers to develop. These MPS were discounted for the purposes of this study due to the brief nature of the Learning Disability sections.

IPC had previously facilitated the development of a Market Position Statement Good Practice Checklist (IPC, 2016). The checklist was developed as part of consultancy work funded by the Department of Health. The checklist was co-produced with a variety of stakeholders including commissioners and providers with the aim of clarifying what a good market position statement should contain and the questions it should answer. The authors subsequently made minor amendments to the checklist to make it relevant to Learning Disability MPS. The questions making up the checklist are shown in Table 2.

Once the MPS were collated, both authors reviewed them using the good practice checklist independently. For each MPS both authors scored each of 18 questions on the checklist on a scale of 0-5 (0= no information, 1= poor, 5= excellent), and provided comments that explained the rationale for the score. To ensure a consistent approach the checklists were compared between authors and where there were occasional differences a shared consensus was reached and a score agreed. This resulted in the use of in between ratings e.g. 3.5. MPS scores were compared and analysed using an Excel spreadsheet. The comments were thematically analysed using Nvivo (Hilal and Alabri, 2013).to identify the recurring issues underlying checklist scores.

Results

Geographical origins and total checklist scores for the fifteen MPS assessed are shown in Table 1.

Table 1: Learning Disability MPS included in study and Good Practice Checklist total scores and ranks

Region of England	**Type of Local Authority**	**Year Published**	**Total Checklist Score (Maximum = 90)**	**Rank (from 1 = highest to 15 = lowest)**
North East	LA 1 (Unitary)	2015	10.5	15
	LA 2 (Unitary)	2015	26	12
	LA 3 (Shire)	2014	28	10
North West	LA 4 (Unitary)	2012	55	1
Yorkshire and Humber	LA 5 (Unitary)	2013	35.5	5=
	LA 6 (Shire)	2014	50	2
West Midlands	LA 7 (Unitary)	2015	16.5	14
East Midlands	LA 8 (Shire)	2015	33.5	7=
	LA 9 (Unitary)	2013	27	11
Eastern	LA 10 (Shire)	2015	41	3
South East	None available			
South West	LA 11 (Shire)	2014	35.5	5=
	LA 12 (Unitary)	2014	20	13
	LA 13 (Shire)	2014	32.5	9

London	LA 14	2013	33.5	7=
	LA 15	2014	38.5	4

The maximum score possible for each MPS using the checklist was 90. Scores ranged from 10.5 to 55 with the median score being 33.5. In summary, the overall quality of MPSs was poor and there were no exemplars. Eleven of the MPS were written after the publication of the Care Act (2014) and four were written before. There was no evidence that those written later were better than those written earlier – indeed, the highest scoring was written first.

Aggregate scores for individual questions are shown in Table 2. The maximum aggregate score possible for each question on the checklist was 75 (obtainable if all fifteen MPS scored 5 for the question). Aggregate scores for individual questions ranged from 4.5 for question 9 (How well does the MPS analyse the local care and support workforce?) to 48.5 for question 18 (To what extent is the MPS concise, readable and clear?) with the median score being 29.

Table 2: MPS aggregate scores and ranks on each question of Good Practice Checklist

Area	**Question**	**Median (range) of individual MPS scores**	**Aggregate Score (adding across all 15 MPS) (Max = 75)**	**Rank (from 1 = highest to 18 = lowest)**
Demand	1. How well does the MPS analyse and provide insight into the current population and current unmet demand?	3 (0-4)	43	3
	2. How well does the MPS analyse and provide insight into the future population and projections of future demand for services?	2.5 (0-4)	36	5
	3. How well does the MPS show the number of people currently being supported by the local authority and spend by the local authority (or with partner commissioning agencies)?	3.5 (0-4.5)	44.5	2
	4. How well has understanding of demand been informed by current and potential service users, their families and carers?	2 (0-5)	29	10
Cu	5. How well does the MPS show what services are available	2 (0-4)	30	9

	locally, where they are and who provides them?			
	6. How well does the MPS set out the state of the local care market, identifying whether it is growing, contracting or stable? Does it identify the risks and outline risk management strategies?	0 (0-3)	8.5	17
	7. How well does the MPS set out where there may be a shortfall of supply currently and in the future?	2.5 (0-4)	35	6
	8. How well does the MPS provide intelligence about what is purchased using direct payments and / or individual service funds?	0 (0-5)	16	12=
	9. How well does the MPS analyse the local care and support workforce?	0 (0-1.5)	4.5	18
	10. To what extent does the MPS offer intelligence about the quality of the local market, i.e. performance as shown through complaints, monitoring, CQC inspections, consumer research, etc?	0 (0-4)	13	15=
What is the Local Authority doing?	11. To what extent does the MPS describe what services or models of care commissioners would like to see in their local area in the future?	2.5 (1-4.5)	41.5	4
	12. How much information is provided about the resources that are likely to be available in the future for care and support? Does this cover a range of traditional and innovative resource generation?	1 (0-3)	13	15=
	13. To what extent does the MPS set out the support that the local authority offers to providers e.g. future contract opportunities, land availability, help with planning consent, training and development, etc?	1 (0-4)	16	12=
	14. How much information does	1.5 (0-4)	25.5	11

	the MPS offer about the business opportunities there are likely to be in the immediate future?			
	15. How much information does the MPS offer about the types of providers the local authority would like to work with in partnership in the long term?	2 (0.5-4)	31	8
Overview	16. To what extent does the MPS take a whole population, joint, whole systems, lifespan approach (where appropriate)?	0 (0-4)	13.5	14
	17. To what extent is achieving well-being outcomes a core theme throughout the MPS?	2.5 (0.5-4)	34.5	7
	18. To what extent is the MPS concise, readable and clear?	3 (1-5)	48.5	1

Overall, it is clear from Table 2 that MPS received low ratings on most areas of the checklist. Analysis of the comments made by raters highlighted five areas where the MPS were particularly poor across the majority of those reviewed.

Co-production with people with learning disabilities and their families
Very few of the MPS gave the impression that they had been co-produced. Some were completely devoid of the voice of people with learning disabilities or their families. Only two provided comprehensive insight by summarising the findings from independently facilitated events with people with learning disabilities and their families. In many cases there was no clear link between what people were saying and the implications in terms of current or future demand and commissioning intentions.

Application of a whole population, whole system, lifespan approach
Only one MPS attempted to take a lifespan approach where children, young people, adults and older adults were mentioned consistently throughout the MPS. Five MPS did refer to health but only in vague terms. The other nine focused solely on adults and social care. There was limited evidence that providers of learning disability services from any part of the system had been engaged in the development of the MPS. There was no evidence that the wider community including mainstream services or community groups had been involved. This is surprising given that the wellbeing duty outlined in the Care Act is a council wide duty, not only a social services duty and the definition of wellbeing is holistic. *Building the Right Support* (NHS England, 2015) emphasised the need to take a whole systems, integrated approach to developing services in the community; the accompanying *Service Model for Commissioners of Health and Social Care Services* (NHS England, 2015) highlighted the need for people with learning disabilities to receive good care and

support from mainstream health services, to be included in the strategic planning of housing and to be supported to access, participate in and contribute to their local communities. Such agendas were generally not apparent in the MPS reviewed here.

Presentation of an understanding of the current quality and shape of the market

Only one MPS provided no information about what services were available. Most only provided information on the services they commissioned with only a couple giving any information about which organisations provided the services. Few recognised that commissioned provision did not present a full picture of what services were actually available in the community. No MPS made any reference to whether the market was growing, contracting or stable. Risk management strategies were absent from all. Only one MPS provided anything approaching comprehensive information on the quality of the care and support market. None sufficiently addressed how their market intelligence was driving a culture of continuous improvement.

Analysis of current and future care and support workforce requirements

Workforce was the area that scored lowest of all of 18 topics on the checklist. Eleven MPS did not provide any intelligence at all on the local care and support workforce. The four that did provided only brief reference to the need for more personal assistants and a skilled workforce. No MPS provided any information on the skills people with learning disabilities and their families wanted for their future workforce.

Provision of clear information about the support that the local authority can offer providers, both within and outside of commissioning

Only limited information was provided on future resources with the majority of MPS simply making broad statements about reducing budgets. None provided information on innovative resource generation or potential new forms of income. Only one MPS offered comprehensive information on available support for providers which included information on their e-market place, accreditation service, assistance with training and recruitment, support with business planning including social enterprise support services. Generally, reference to other key elements from the local authority or wider care system, such as health or housing, was totally absent. Only three MPS offered reasonably comprehensive information about future business opportunities including providing links to the procurement plan and tender portal.

Discussion

Inevitably, the current study is limited in a number of ways, in part because of the lack of funding for more extensive research. The study only reviewed learning disability MPS on the IPC database at the time of writing, thus excluding MPS that cover all adult social care client groups. The limited resources also meant that it was not possible to undertake interviews with commissioners or other stakeholders. Neither was there capacity to review associated council documents. MPS only cover what is communicated in a public document about market shaping activity and may not cover the whole scope of activity being undertaken. Nonetheless, the central role accorded to MPS in the Care and Support Statutory Guidance (Department of Health, 2014) suggests that their analysis has some value.

Overall, the Learning Disability MPS reviewed in this study were very limited. As noted above, there were particular deficits in respect of co-production, the use of whole population, whole system, lifespan approach, information about the current market, analysis of workforce requirements, and provision of information about local authority support for providers.

These deficits have significant implications for people with learning disabilities and their families. Local authorities that do not put the voice of people with learning disabilities and their families at the heart of strategic planning risk shaping a market to provide services and support that will not meet people's needs, leaving people and their families with little choice and control. The lack of whole system, life span approaches to market shaping suggests that strategic planning is still being undertaken in silos. The implication for people with learning disabilities and their families is that they will continue to be unable to achieve the holistic, wellbeing outcomes that matter to them because services and support continue to be designed in ways that do not meet real needs. Without taking into account the needs of children and young people, service planning for young adults will continue to be reactive rather than proactive. Without considering the needs of the ageing population, services and wider amenities will not be able to respond to, or sufficiently cater for, older people who have a learning disability.

The lack of information provided on the quality of services is also concerning. Given the amount of data collected by local authorities and the Care Quality Commission on quality it is hard to believe that this information was not available. Perhaps local authorities did not want to publish the information or perhaps they did not think it was relevant to include in a MPS. Whatever the reason, the lack of information coupled with the lack of co-production and a whole systems approach suggests there is unlikely to be a shared and common view of where the risks lie or what needs to be done to minimise them. It is a similar story when we look at the shape of the market and the lack of information on whether the market is stable or where the financial risks may lie. The very real implication of failing to address, understand and share information about the market is that people with learning disabilities and their families will continue to access, or even be directed towards, poor quality services that do not meet their needs and may even abuse their rights. It also leaves individuals vulnerable to using services that could cease to operate with little warning, leaving them without a service. At this point the local authority would intervene, but in a crisis-response mode that is unlikely to result in the quality of service provision that could be facilitated through effective advance planning.

The failure to include analysis of workforce requirements flies in the face of research on how the quality of a service is determined by the quality of the interactions between staff providing care or support and the person in receipt of care or support (e.g., Beadle-Brown *et al*., 2016; Bigby *et al*., 2015). Nationally, providers struggle to recruit and retain staff across health and social care (Skills for Care, 2016). Without enough staff with the right skills people with learning disabilities will not receive the support they need to achieve the outcomes that matter to them. Furthermore, if strategic workforce planners do not ask people with learning disabilities and their families what skills and attributes they value in care and support workers, and if this information is not placed at the heart of decision making, then the workforce is unlikely to be fit for purpose.

It has been clear for some time that people with learning disabilities and their families want choice and control over the way in which they receive support. Initiatives such as Shared Lives , Community Catalysts , Integrated Personal Commissioning and

Think Local, Act Personal provide many case study examples of support being delivered in innovative and creative ways. Moving away from traditional service models to more creative, person-centred, asset-based, community approaches requires a change in processes, skills and attitudes. Local authorities have a key role in arranging support for providers and community groups to make these changes and without such support the local market will continue to stagnate. Outdated service models that do not meet people's needs will continue to be the norm and people with learning disabilities and their families will continue to experience inequalities (Emerson and Baines, 2010; Emerson and Hatton, 2014).

Concluding Comments

The analysis of the MPS reviewed provides little evidence that local authorities are engaging in their market shaping duties. Many MPS mirrored a 'Commissioning Strategy' style document that might be used internally within the council or with its partners, rather than an outward, market-facing document to be used by providers to inform their business planning. The focus on adult social care suggests that market shaping is sat firmly in the lap of adult social care commissioners rather than being seen as a council-wide responsibility, despite the requirements of the Care and Support Statutory Guidance (Department of Health, 2014). Yet many of the activities that shape the market are not held within a 'social services' department. Local authority housing, for example, shares the duty under the Care Act to promote the efficient and effective operation of the market so that it meets the needs of all people.

Further evidence to suggest that local authorities are not fulfilling their market shaping duties is the absence of any information related to market stability. Analysis of the MPS highlighted that they did not contain any clear statements about how risk will be shared between different stakeholders; or about gaps in knowledge, or where there are uncertainties in the market. This is a key gap given several high profile market failures within the care system in recent years. Ensuring the market stays vibrant and sustainable means working collaboratively to understand the impact of decisions taken in one organisation on the ability of others to meet need; and also to develop care models that extend beyond organisational and service boundaries. The MPS is intended to be the stimulus for ongoing dialogue in these areas and the dearth of information in the MPS suggests that no such conversations are taking place. If they are, they are not being communicated in these documents.

Finally, the scarcity of information about the practical support available for providers seeking to engage, the extent to which innovation will be supported, future business opportunities, potential land and buildings availability, help with planning consent, training and development, other sources of funds and how these can be accessed, signals time and again that local authorities are not fully engaging in market shaping.

The reality is that the Care Act (2014) does not (so far) seem to have resulted in local authorities effectively shaping the market for people with learning disabilities. Nowhere can this be seen more clearly than in the ongoing battle to move people with learning disabilities out of hospital and the persistent lack of appropriate options within the community to support them effectively (Bubb, 2016).

Further research is required to explore the barriers to market shaping, to identify the factors that contribute to shaping the market successfully, and how to measure that a market (without clear boundaries and in a constant state of flux) has been shaped successfully. These insights are urgent, and are required to ensure the market is able to provide diverse, sustainable and quality care and support, including opening up access to mainstream services, for local populations of people with learning disabilities and their carers.

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