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

Overview

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

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

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

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

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

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

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