take your choice
a commissioning framework for community care
The Audit Commission promotes the best use of public money by ensuring the proper stewardship of public finances and by helping those responsible for public services to achieve economy, efficiency and effectiveness.

The Commission was established in 1983 to appoint and regulate the external auditors of local authorities in England and Wales. In 1990 its role was extended to include the NHS. Today its remit covers more than 13,000 bodies which between them spend nearly £100 billion of public money annually. The Commission operates independently and derives most of its income from the fees charged to audited bodies.

Auditors are appointed from District Audit and private accountancy firms to monitor public expenditure. Auditors were first appointed in the 1840s to inspect the accounts of authorities administering the Poor Law. Audits ensured that safeguards were in place against fraud and corruption and that local rates were being used for the purposes intended. These founding principles remain as relevant today as they were 150 years ago.

Public funds need to be used wisely as well as in accordance with the law, so today's auditors have to assess expenditure not just for probity and regularity, but also for value for money. The Commission's value-for-money studies examine public services objectively, often from the users' perspective. Its findings and recommendations are communicated through a wide range of publications and events.

For more information on the work of the Commission, please contact:
Andrew Foster, Controller, The Audit Commission, 1 Vincent Square, London SW1P 2PN, Tel: 0171 828 1212
Website: www.audit-commission.gov.uk
1. Reviewing the Market and Developing a Strategy
   A planned approach is needed, making use of information about supply, demand and resources.

2. Making Commissioning User-led
   Users should be supported throughout the process to help meet their needs more effectively.

3. Enabling Care Managers to Play a More Effective Commissioning Role
   Organisational barriers and workload pressures restrict care managers' ability to tailor care to meet assessed needs.

4. Getting a Better Service From Providers
   More mature relationships with providers are needed to improve service delivery.

5. Supporting the Process Centrally
   Social services departments need to develop skills and information systems to be able to manage the market more effectively.

6. Bringing It All Together (Action Plan)
   Authorities need a plan of action to make it all happen.
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Preface

The Audit Commission oversees the external audit of local authorities and the National Health Service (NHS) agencies in England and Wales. As part of this function the Commission is required to undertake studies to enable it to make recommendations for improving the economy, efficiency and effectiveness of services provided by these bodies and to comment on the effects of statutory provisions or guidance by central government on the economy, efficiency and effectiveness of these agencies.

The Audit Commission has recently published a report entitled *The Coming of Age: Improving Care Services for Older People*. This drew upon research on the following two topics:

- continuing care – a review of the arrangements for people leaving hospital who require ongoing or ‘continuing’ care; and
- commissioning of community care – a review of how local authorities commission services for people who are assessed as needing services.

This handbook is intended to provide social services departments with a more detailed analysis of the issues highlighted in *The Coming of Age* relating to their commissioning role. In particular it aims to help authorities – through the key questions and case study examples – to develop their framework for commissioning. The research base has focused on the commissioning of services for the older people client group. While some of the characteristics of commissioning services for older people are unique, many of the principles outlined in the handbook apply equally to other client groups. As such it is hoped authorities will use the handbook in looking at their commissioning arrangements for care services more broadly. The handbook does not cover the area of joint commissioning. Authorities wishing to review their approach to this area should refer to the Department of Health publication *Practical guidance on joint commissioning for project leaders*, produced in 1995.

The handbook has been produced in close liaison with the Joint Reviews of Local Authorities’ Social Services. It does not form any part of the review process but instead offers a way by which authorities can themselves review and improve their arrangements. The ability to shape services to meet local needs through good commissioning and contracting is a fundamental part of the Joint Reviews judgement of an authority’s performance. The handbook identifies good practice which authorities can learn from and build upon.

At the time of publication (December 1997) work is in progress to develop the Best Value framework for all local authority services. Authorities should note that the principles outlined in this handbook will be reviewed as part of the development of that framework for social services.
The research on which this handbook is based was carried out by Laura Hawksworth and Chris Baker of the Health and Social Services Studies directorate under the direction of David Browning and Jonathan Boyce. Core fieldwork for the handbook took place in 12 local authorities in England and Wales, although many visits were made to follow up on specific good practice initiatives. Extensive consultation with independent providers was also conducted, through fieldwork, meeting with associations and representation on the advisory group.
Introduction

1. Commissioning is a term which is often used in the management jargon of the modern public sector. However, the question 'what is commissioning' in social services is likely to produce a variety of responses among staff, politicians, academics, auditors and inspectors!

2. For the purposes of this handbook commissioning is taken as the process of specifying, securing and monitoring services to meet individuals' needs both in the short and long term. As such it covers what might be viewed as the purchasing process as well as a more strategic approach to shaping the market for care to meet future needs.

3. The definition is deliberately broad: if commissioning is going to be successful in improving authorities' effectiveness in meeting needs, social services must be able to learn from practice on the ground, use this information to help develop their strategies and in turn amend their purchasing processes. However, it excludes the setting of eligibility criteria which some include in the broadest definitions.

4. Commissioning is now a key activity of social services departments (SSDs). The estimated net expenditure on services for adults, excluding management and support services costs, was approximately £5.5 billion in 1996/97 [TABLE 1]. Managing this money to ensure it is spent effectively and efficiently requires constant review by authorities.

5. As well as meeting the needs of current service users, social services departments should have a framework in place that allows them to have a clear idea of:
   • the type of services they will need in the future;
   • the volume of services they will require;
   • what quality and price services should be; and
   • how current supply can be changed, innovation encouraged, and redundant or inefficient services decommissioned.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>£ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net expenditure on services 1996/97</td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>3,515</td>
</tr>
<tr>
<td>People with physical or sensory disabilities</td>
<td>592</td>
</tr>
<tr>
<td>People with learning disabilities</td>
<td>999</td>
</tr>
<tr>
<td>People with mental health needs</td>
<td>418</td>
</tr>
<tr>
<td>Total</td>
<td>5,524</td>
</tr>
</tbody>
</table>

Source: Chartered Institute of Public Finance and Accountancy (CIPFA) Personal Social Services statistics (1996/97 estimates)
6. Authorities’ current commissioning arrangements are setting the future shape of the care markets they will face. Applying short-term solutions to purchasing problems may simply be storing up difficulties for the future through blocking the development of better approaches and constraining innovation. If authorities are to meet future as well as current needs, they must be thinking strategically about the framework in which commissioning takes place and considering what action is required to help this process work more effectively. Many authorities have found this difficult, especially at a time when most social services departments are under strong resource pressures. The aim of this handbook is to help departments develop their commissioning approaches, by setting out a framework which they can use to look at their arrangements, and providing self-diagnostic questions and case studies.

7. The handbook is intended primarily for the lead officer for community care and officers responsible for contracting and commissioning. The structure of the handbook uses a framework for commissioning based on the role of the four key participants [EXHIBIT 1]:

- users and carers;
- care managers;
- service providers; and
- the social services department ‘centre’ (incorporating strategic planning, contracting, finance and administrative functions).

EXHIBIT 1
The commissioning framework for community care

The commissioning process involves four key groups.

Source: Audit Commission
For an authority to develop its commissioning processes it must have solid foundations in place.

8. Users and carers should be at the heart of the commissioning process (Section 2). If services are to meet the needs of users effectively, the whole process of commissioning must be as user-responsive and user-led as possible. To make this happen the other groups must play their part:
   - care management should be in place to support users and carers, championing the role of users throughout the time they are receiving care;
   - service providers must be able to deliver services that are responsive to users' needs; and
   - the centre must help users to make informed choices, enable them to complain and get action when things go wrong and take on board their views in commissioning services for the future.

9. Not only are the links with users and carers significant. Equally important are the relationships that exist between care managers, providers and the centre:
   - Care managers must be empowered and supported by the centre to maximise their ability to arrange user-responsive services, while in turn providing essential feedback to the centre on service delivery and unmet needs (Section 3).
   - Relationships with providers should be characterised by accountability to care managers and the centre but also trust, openness and commitment on the part of both commissioners and providers (Section 4).

10. For an authority to develop its commissioning processes it must also have solid foundations in place. This requires the right skills and information base. An authority has to know what information it requires, how to obtain it and how to use it to develop a commissioning strategy. Members must also play their part by setting clear priorities (Section 1). Similarly an authority must have the right skills available to develop contracting processes, financial systems and market management mechanisms (Section 5).

11. The final challenge is to bring all these elements together, setting an agenda for managing a continuous improvement in commissioning arrangements (Section 6).

12. Other groups are also important to this framework – the NHS and housing in particular. *The Coming of Age* covered the role of the NHS in relation to continuing care. A report on the housing aspects of community care is due to be published by the Audit Commission in spring 1998. However, social services departments can do much to develop their own commissioning arrangements while helping other agencies to work with them to secure a more 'seamless service' for users.
Getting started

13. The attached self-diagnostic questionnaire allows authorities to examine their current commissioning arrangements. It is not a pass/fail checklist – its intention is to provoke thought about how current commissioning arrangements are functioning and to help identify the areas where further work would be most beneficial.

14. If authorities have confidence in their current arrangements it is hoped the handbook will still be of interest. At the very least the case studies and examples can be reviewed to help authorities learn from the experiences of others.

Self-diagnostic commissioning questionnaire

15. This questionnaire is intended to provide authorities with a simple diagnostic of their current arrangements for commissioning. The questions are intended only as prompts for the authority, and to get the most from the handbook and focus further work effectively they need to be answered as frankly as possible.

16. The questionnaire covers a wide area of activity and includes reasonably detailed questions on care management, contracts, planning and finance which are likely to be beyond the scope of the responsibilities of any single officer. It is therefore suggested that individual sections are circulated to relevant staff and results compared with those of the lead officer with responsibility for community care or commissioning. One approach could be to answer the questions as part of a team exercise to stimulate debate.

17. While undertaking the fieldwork for the handbook it was clear that some of the questions on making commissioning user-led and the role of care managers provoked quite different sets of responses from senior officers and care managers. Authorities may also find it useful to check whether the perception of commissioning by front-line staff is different by asking care managers to complete these sections of the questionnaire and comparing the results.

Interpreting the results

18. If authorities find they are answering ‘no’ to most of the questions in any of the five parts of the questionnaire, they should review the relevant section(s) of the handbook in detail.

19. If there is more of a balance between ‘yes’ and ‘no’ answers, a less detailed check is recommended, although authorities should examine whether ‘no’ answers are grouped in any of the separate sub-sections of the questionnaire and review these appropriately.

20. For those authorities which answer ‘yes’ to most of the questions, a review of the case studies is still likely to provide valuable insight into other authorities’ ideas and examples of good practice. A review of the Action Plan in Section 6 may also provide a quick way of checking whether the issues raised in the handbook have been addressed by the authority.
Section 1: Reviewing the Market and Developing a Strategy

1.1 Mapping the market to understand both demand and supply

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the Authority know how many people are currently supported in all types of services?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2. Does the Authority have a profile of these users by age, gender and ethnic group?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>3. Does the Authority analyse the source of its referrals to get a clear picture of where demand is coming from?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>4. Are the views of users, carers, care managers and providers collected systematically to identify gaps in services?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>5. Does the Authority have length-of-stay data on users in different service types?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>6. Does the Authority have information on its suppliers, in terms of their:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• numbers and location?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• quality?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>7. Does the Authority know what proportion of the local market it represents (in relation to other funding sources such as private payers, preserved rights and other authorities) in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• residential and nursing home care?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• home care?</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>

1.2 Understanding current resource allocation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the Authority have a clear idea of how it compares with other similar authorities in terms of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• expenditure on different service types?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• expenditure on different sectors (in-house, private and voluntary)?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• proportion of resources on assessment and care management against spend on provision of services?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2. Does the Authority know what proportion of its expenditure is accounted for by its largest five providers in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• independent sector home care?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• independent sector residential and nursing care?</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>
### 1.3 Developing an informed strategy

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the Authority have a written commissioning strategy?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2.</td>
<td>If so, has it</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• been agreed with health and housing agencies?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td></td>
<td>• been based on the needs of users rather than organisational constraints?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td></td>
<td>• incorporated a thorough understanding of the market and been discussed with providers?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td></td>
<td>• taken a long term view of where the authority wants to be?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td></td>
<td>• set targets and established ways of monitoring whether these have been achieved?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td></td>
<td>• set out purchasing intentions for independent sector providers in the form of extra services it needs and those it plans to reduce?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>3.</td>
<td>Does the strategy include financial modelling to assess likely spending implications and match these to estimated resource projections?</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>

### 1.4 Planning for decommissioning

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Have the areas of current activity which need to be decommissioned to meet the Authority’s objectives been identified?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2.</td>
<td>Have members formally agreed these?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>3.</td>
<td>Have they been discussed with providers?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>4.</td>
<td>Has the Authority planned how it can minimise the impact on current service users?</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>
Section 2: Making Commissioning User-led

### 2.1 Helping users influence and control their care

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the Authority provide information to users about how the care management process works?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>2. Do all users and carers get a copy of their:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• assessment?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>• care plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• details of their financial assessment and calculation of their contribution?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>3. Does the Authority have an advocacy scheme which is available to users, and information on how many users it serves?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>4. If so, are users encouraged to use advocacy at the key points in the care process, for example during discharge from hospital or at the first review?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>5. Has the Authority developed a Direct Payments scheme?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>6. Does the Authority undertake regular reviews of the accessibility and responsiveness of its complaints procedures?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>7. Is complaints information used in a systematic way to inform commissioning?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
</tbody>
</table>

### 2.2 Supporting user choice

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the format of the directory of care homes reflect the key factors influencing user choice such as geographic location of homes?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>2. Does the directory provide any objective information on service quality?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>3. Are inspection reports easily accessible to service users and are they in a user-friendly format?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>4. Does the Authority record the range of service provider offered to users and the choice made?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>5. Does the Authority promote choice through its contract agreements, for example by allowing users/carers to arrange their own respite care?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
</tbody>
</table>

### 2.3 Making services more user-focused

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the Authority have a user/carer forum for individual client groups?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>2. Has the Authority conducted a survey of users to determine their views about services and the care management process in the last 12 months?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>3. Have significant changes to services resulted from user consultation?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
<tr>
<td>4. Is information from individual care plans collated and used to plan services?</td>
<td>a.a</td>
<td>a.a</td>
</tr>
</tbody>
</table>
Section 3: Enabling Care Managers to Play a More Effective Commissioning Role

### 3.1 Removing organisational barriers to commissioning

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do the Authority's main home care providers offer a service in the evenings and at the weekends?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are care managers able to choose which provider they feel will meet a user's needs best and not restricted by having to try one provider first?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are the costs of all service providers included when determining the gross cost of packages for financial limit purposes?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3.2 Improving the effectiveness of care management

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the Authority have information on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the time spent by care managers on different activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• care managers' workloads?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does the Authority have information on the proportion of users who received a formal review of their care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If so, are reviews of all users with home care packages undertaken at least once every 12 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3.3 Aligning managerial and financial responsibility for commissioning

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the Authority devolved significant financial resources to team or care managers to purchase care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are care managers/team managers directly responsible for ensuring purchasing budgets are not overspent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are care managers applying eligibility criteria consistently?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do care managers/team managers have the flexibility to purchase:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• innovative packages of care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• intensive short-term packages to assist the rehabilitation of users?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 4: Getting a Better Service From Providers

4.1 Developing more mature relationships

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is the Authority taking action to promote long-term relationships with selected independent sector providers?</td>
<td>a</td>
</tr>
<tr>
<td>2.</td>
<td>Is quality rather than price ever the key factor in negotiations with providers?</td>
<td>a</td>
</tr>
<tr>
<td>3.</td>
<td>Does the Authority recognise the concerns of independent sector suppliers and take them into account in a way that benefits both parties when undertaking contract negotiations?</td>
<td>a</td>
</tr>
</tbody>
</table>

4.2 Developing a clear role for in-house services

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the Authority set targets for the number of contact hours the in-house home care service will provide annually and monitor this?</td>
<td>a</td>
</tr>
<tr>
<td>2.</td>
<td>Does the Authority set quality standards for the in-house home care service (for example targets for reliability and consistency) and monitor these?</td>
<td>a</td>
</tr>
<tr>
<td>3.</td>
<td>Does the Authority have a clear picture of the activities being undertaken by the in-house service and the proportion of time and resources spent on each?</td>
<td>a</td>
</tr>
<tr>
<td>4.</td>
<td>Does the Authority incorporate the above information into a formal Service Level Agreement (SLA) for the in-house home care service?</td>
<td>a</td>
</tr>
</tbody>
</table>

4.3 Fair and open contracting

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the Authority have an effective system to give assurance that providers will deliver services to a minimum standard acceptable to the Authority?</td>
<td>a</td>
</tr>
<tr>
<td>2.</td>
<td>Does this take account of providers’ needs in terms of ensuring information requirements are not too onerous or unnecessarily costly to compile?</td>
<td>a</td>
</tr>
<tr>
<td>3.</td>
<td>Does the system adequately reflect the difference in the size of providers?</td>
<td>a</td>
</tr>
<tr>
<td>4.</td>
<td>Are all providers given adequate support to help them get through the system?</td>
<td>a</td>
</tr>
</tbody>
</table>
### 4.4 Developing better contracts

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In purchasing services from the independent sector does the Authority make use of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• cost and volume contracts?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• block contracts?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2. Does the Authority's current contracting approach give enough security to providers to allow them to invest to improve services?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>3. Does the Authority's approach also minimise the financial transaction costs of purchasing services?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>4. Has the Authority used tendering to improve its approach to purchasing services?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>5. Does the Authority have a clear idea about what represents quality and how this can be specified in contracts for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• residential and nursing home care?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• home care?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>6. Does the Authority feel confident that the standards it uses in contracts help ensure quality in service delivery?</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>

### 4.5 Contract monitoring and compliance

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the Authority have a contract monitoring approach that co-ordinates the roles of contracts officers, care managers, inspectors, users and providers?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2. Are surveys used to get user feedback on provider performance?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>3. Are all major providers monitored using the same criteria and measures to enable comparisons of performance?</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>

### 4.6 Communicating with providers

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the Authority encourage providers to discuss with it how commissioning arrangements can be improved?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2. Does the Authority monitor areas that are of concern to providers, for example:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the complexity of contract documentation?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• the number of days notice given to providers before services are to start?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>• the length of time before payment?</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>3. If so, are the results of this monitoring communicated to providers?</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>
Section 5: Supporting the Process Centrally

5.1 Developing commissioning skills

1. Has the Authority reviewed the skills it needs for commissioning:
   • to support the process centrally?
   • to facilitate commissioning by team/care managers?

2. Is the Authority confident that it has the right balance between spending on central support and direct services to maximise value for money in the use of its resources?

5.2 Financial support systems

1. Is budget monitoring information as timely and accurate as it needs to be to manage resources effectively?

2. Does budget monitoring include detailed information on activity levels to improve financial planning?

3. Do budget holders have easy access to financial advice?

5.3 Information strategy and systems

1. Does the Authority have an overall strategy for developing the information required for commissioning decisions at different levels of the organisation?

5.4 Managing the market

1. Does the Authority use its market management and pricing strategy to influence the market to:
   • improve quality?
   • encourage innovation?
Many social services departments (SSDs) are struggling to develop a planned approach to commissioning. Departments need to learn more about the needs they are facing, what supply exists, how resources are allocated and what effects current purchasing arrangements are having. This information should be used to inform commissioning priorities, in turn helping to develop a strategy for meeting needs better in the future.
21. When the NHS and Community Care Act reforms were implemented in April 1993, social services departments (SSDs) inherited a set of established providers. In many authorities this included a large number of independent sector providers, especially in residential and nursing home care, as well as existing in-house services and users.

22. Indications of the likely short-term demand for these services were unclear and most authorities initially adopted a cautious approach to commissioning. However, in the longer term authorities need to improve their arrangements through developing a detailed understanding of what service providers are available, their location, market share, cost and quality, and how this matches with the anticipated demand for services [EXHIBIT 2]. This information is essential not only to help build up a clearer picture of how supply is currently meeting care needs, but also to determine how authorities might better meet needs in the future. Having now had a few years of experience authorities should be:

- developing a good knowledge of supply and demand in their area;
- reviewing the current pattern of resource distribution; and
- using this information to plan for the future.
23. Many appear to be struggling, not only to obtain information on the local care market to help inform their commissioning, but to determine what information they need and how this might be put to best use to develop a commissioning strategy. Financial pressures and uncertainty over future resource levels do not help. However, in many respects they increase the need for good planning. If authorities are to limit the impact of cuts in services on the care of users they must determine which services are meeting needs least efficiently and least effectively and focus cuts on those.

24. This section outlines the issues that authorities need to consider to develop a commissioning strategy.

Mapping the market to understand both demand and supply

- mapping the pattern of needs of the local population, now and in the future;
- developing a good understanding of the type, volume, cost and quality of existing supply; and
- gathering information on the relative market power of the authority as a purchaser in the local care market.

Understanding current resource allocation

- examining the SSD's financial structure and the allocation of resources by client group, provider type, service type and contract type.

Developing an informed strategy

- discussing options, agreeing priorities and establishing ways to monitor achievement.

Planning for decommissioning

- identifying areas for decommissioning, discussing options with providers and getting the approval of members.

Note: Some of the activities described below have implications for staff training, and information systems (see Section 5).

25. Mapping the market is not an end in itself. It merely provides a starting point to work towards developing an informed commissioning strategy. Authorities need to undertake market mapping to help address the following issues:

- What are the needs of our population and how will these change in the future?
- What supply is currently available, how good is it and how much does it cost?
- What market power do we have as a purchaser?

26. To answer these questions, authorities must have good information on the factors that influence demand, supply and market power; for example, the source of referrals, the length of stay of users in services and the location and number of suppliers [EXHIBIT 3]. It is important to
note that demand is not the same as need. Some groups with needs, such as ethnic minorities, may make few demands on services. Tracking demand provides a start and comparisons between areas can show gaps which might begin to give some insight into unmet needs.

**Mapping the pattern of needs**

27. This has traditionally been more difficult and received less attention than supply mapping. It is not an exact science and demands for services have been very difficult to predict in many authorities. Yet it should be the aim of all departments to understand their population and how it is changing before looking at the supply needs – this is a key part of moving from a supply-led to a needs-led approach. Questions authorities need to address include:

- How many people are we currently supporting?
- What is the profile in terms of age/sex/ethnic status/client group/type of need?
- With what type and level of service are people being supported?

**EXHIBIT 3**

*General issues for market mapping*

Authorities need good information on the factors influencing demand and the supply of services.

*Source: Audit Commission*
• How many new people do we take on? How many are leaving services?
• How long do users stay with services?
• What do users, carers and care managers think of current services? Are there services they would like to see which do not exist?
• Where do our referrals come from? Should we be trying to understand the causes of referrals better?
• More broadly, are there sectors of the community we might have expected to see more referrals from?
• How might needs change in the future?

28. Many authorities have developed detailed statistics from population data and deprivation indices and some have used these to directly inform their commissioning [EXHIBIT 4]. It is also important to monitor the types of need and how these are changing [EXHIBIT 5, overleaf]. Such analyses require an imaginative combination of qualitative and quantitative research. Not all should necessarily be undertaken every year – some demands change less quickly than others.

29. Both needs and supply mapping should always take account of the views of those at the 'front line' of service delivery, such as users, carers, care managers and providers. Central staff are typically remote from the daily feedback these groups experience. Therefore part of needs mapping should include imaginative ways of canvassing these views. This might include enlisting the help of market research agencies to test the views of consumers [CASE STUDY 1].

30. The above approach will help authorities understand the numbers coming forward and the type of services they might require. A further aspect of demand is the length of stay of those who are admitted to care services. The ‘turnover’ of those in the system is key to understanding the number of people who can be accommodated.

CASE STUDY 1

Market mapping

Kensington and Chelsea Social Services Department has conducted a borough-wide service mapping exercise of needs and services for older people. It adopted a ‘rapid-appraisal’ market research technique to survey current service users and older people in the community at large. It also mapped all of their provision by geographic area. Recent analysis of the research has enabled the SSD to identify how well services meet the needs of the community, and it has identified undersupply in areas such as daycare and carer support. The research has also raised issues over the quality of home care provision.
EXHIBIT 4

Using population data
Buckinghamshire Social Services Department has combined data on its population and the location of current residential and nursing provision to help identify potential gaps in services.

Source: Buckinghamshire SSD
Research by the North West Business Management Working Group (NWBMWG) (Ref. 1) showed that in 1996 individuals cared for in residential and nursing homes in the region had on average been resident for three and two and a half years respectively. However, it noted a growth in the proportion of people resident for less than a year as well as those staying longer than three years [EXHIBIT 6]. As more dependent cases are prioritised, the turnover rate may increase – the Personal Social Services Research Unit (PSSRU) (Ref. 2) found current lengths of stay as low as one and a half years on average for those now being admitted.

Authorities need to track length of stay at a local level, compiling data on home care and other non-institutional care as well as residential and nursing home placements. Many authorities which have got into severe financial difficulties have done so because they have underestimated length of stay and the impact this has on committed expenditure. Until authorities are able to get estimates of this information, financial projections based on anticipated demand for services will remain weak. A better understanding of length of stay and new admissions allows authorities to calculate the ‘equilibrium’ number of places they need to maintain and fund for a given pattern of new placements [CASE STUDY 2].
EXHIBIT 6
North West Business Management Working Group – changing profile of residents’ length of stay
The proportion of people in the North West resident for less than a year has risen, as has the proportion staying for longer than three years.

Source: NWBMWG data

CASE STUDY 2
Monitoring length of stay data – Kent County Council
Kent Social Services Department has been tracking placements and discharges of residents since 1993/94. From this analysis it has been able to build up data to predict the likely length of stay of future residents based on current placement patterns. Using this information to formulate the number of client weeks that will be demanded and applying a unit cost, it is possible to calculate anticipated expenditure. For the second six months of 1996/97 the accuracy of the model in predicting client weeks was:

Variance from actual value (%)
Older people client weeks -1
Learning disability client weeks -1
Physical disability client weeks -3
Mental health client weeks 2
Developing a good understanding of supply

33. Most authorities have conducted reviews of supply in their area. However, few are thorough enough to answer pertinent questions with confidence, such as:

- Do we know about all potential home care providers in the authority?
- What is the comparative quality of home care provision?
- Do we know the cost structure of the independent providers we use or their motivations for being in the market?

34. An astute commissioner needs to understand the abilities and constraints of providers. Supply mapping is not simply a head-count of providers. Authorities should have a clear idea about how providers see the market developing and their capabilities to innovate and change. Other external factors also need to be considered, such as the state of the local labour market and the likely available supply of care workers [Exhibit 7].

EXHIBIT 7
Mapping the market supply indicators
Mapping supply requires more than just a head-count of providers.

Source: Audit Commission
Authorities should have an idea of who else is purchasing in each of their markets...

35. Talking to every provider may be too onerous a task given the numbers involved. However, authorities should take a reasonable approach to canvass views and obtain data, possibly using other methods such as market research to supplement face-to-face meetings. Much information is already likely to exist through contracts data, for example on financial checks undertaken as part of approved list processes or from inspection and registration sections. Supply mapping also needs to reflect the different factors and influences in individual markets, taking each separately – home care, residential care, nursing home care, day care – and should be an ongoing process [CASE STUDY 3].

36. A good knowledge of the local market is essential information but to get the most from it, authorities need to share the data among themselves to develop benchmarks to compare performance and provide a wider picture of changes in supply. Arrangements for comparing data on anything more than an ad hoc basis are scarce. However, where such arrangements do exist they have provided the authorities involved with valuable commissioning information [CASE STUDY 4, overleaf].

Gathering information on market power

37. One consequence of the new responsibilities and finances that authorities were given as a result of the NHS and Community Care Act 1990 is that councils now wield significant purchasing power. In residential, nursing home and domiciliary care the local authority will be the largest single buyer in most parts of the country and many providers are dependent on it for demand.

38. Authorities should have an idea of who else is purchasing in each of their markets, at what price and quality, so as to understand better how they can influence supply. Few authorities visited during the fieldwork for the handbook had a good understanding of this. A range of

CASE STUDY 3

Mapping the market in Westminster

Westminster Social Services Department conducts market reviews on an ongoing basis, starting with user consultation and specifying services. Its central contracts unit then meets with key provider organisations from time to time to gain an understanding of the capabilities of providers to undertake the plans of the authority. Over time the unit has observed changes in the maturity of the market and is more confident now in using the independent sector for services such as provision for people with learning disabilities.
Mapping the market across authorities – North West Business Management Working Group

North West Business Management Working Group – residential care for older people

In 1991 the 17 authorities in the northwest of England (through their local Association of Directors of Social Services (ADSS), NHS Executive and Social Services Inspectorate (SSI) regional groups) decided to conduct a market mapping exercise to find out more about the market for providing residential and nursing care. The project was so successful that they have repeated it each year and now have trend data from before the implementation of the NHS and Community Care Act.

How the market is mapped

All providers (in-house and external) are surveyed for the following data:

- number of beds;
- vacancies;
- clients’ funding source;
- turnover rates; and
- length of stay of residents.

A consultant then draws together the results for feedback to each individual authority and writes a regional report, the last of which was published in November 1996.

Cost of project

Each authority has contributed around £500 per year towards the cost of the collation, analysis, interpretation and dissemination of the work. In addition each authority sends out questionnaires to all its providers, chases up responses and draws up its own summary sheet. The consultant estimated this took one or two clerical staff about two weeks.

Providers must complete the questionnaire, and to date there has been a 60 to 70 per cent response rate. In particular, large nursing homes have found it difficult to complete some of the questions for an entire year, due to the rapid turnover of clients.

What they have learned

The information has enabled staff to test hypotheses about the development of the market after the Community Care Act, in order to inform their commissioning strategies. For example, DSS-funded residents still account for almost half of the residents in homes, especially in the nursing sector. This challenges the assumption that there would be few of these residents by the end of 1996, and augurs ill for occupancy rates in that sector in the future.

Lessons for other such initiatives

Such an initiative requires commitment from senior management. Participating authorities need to see a benefit to obtaining and supplying information yet also must recognise that it takes time to learn to use the data. Many authorities are now beginning to ask more detailed questions, and seminars have been held for senior managers to discuss and interpret the findings. Finally, commitment from providers is critical to the success of the project and so authorities need to give useful feedback to them to justify their time.

Potential sources of data exist which authorities could use to start this process [BOX A].

Some surveys of providers in particular regions have been conducted by research bodies, such as the Nuffield Institute (Ref. 3). Other authorities have conducted their own research [EXHIBIT 8] or joined together at a regional level [EXHIBIT 9, overleaf].
BOX A

Sources of data on market power

<table>
<thead>
<tr>
<th>Residential and nursing care</th>
<th>Public sources</th>
<th>Other sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>• percentage funded by Health, DSS, private and other authorities</td>
<td>Department of Health surveys, Department of SocialSecurity statistics</td>
<td>Market reports, surveys of providers</td>
</tr>
<tr>
<td>• percentage of new residents from each source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• prices paid by each purchaser</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home care/daycare/other</th>
<th>Public sources</th>
<th>Other sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>• percentage of private payers, other sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• prices paid by other purchasers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• intensity of service, client group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EXHIBIT 8

Reviewing market share

Buckinghamshire Social Services Department has undertaken a simple analysis of the local residential and nursing home market to provide a clearer indication of its market share.

Source: Buckinghamshire County Council
EXHIBIT 9

Funding sources of residents

The North West Business Management Working Group has tracked a major shift in purchasing power over the last three years.

Source: NWBMWG

40. Where an authority is a major or majority purchaser it must acknowledge its collective influence on supply. In such cases what the market supplies will be set by what the authority specifies and the price it is prepared to pay. Its quality thresholds will become the norm, and other purchasers will depend on it to maintain standards.

41. The opposite to this situation occurs where the purchaser faces a monopoly provider. This may well happen in more specialised markets, such as some types of care for people with physical disabilities and people with learning difficulties. Here the provider often has greater market power and ability to influence the prices and quality offered. Even in such situations authorities can improve their bargaining position if they can agree a common approach with other purchasers and establish purchasing consortia.

KEY QUESTIONS

Have we enough information on demand to know what we are dealing with at the moment and can expect in the future?

Are our current providers able to meet these needs effectively?

How is our market power influencing each care market?

1.2 Understanding current resource allocation

42. As well as having a good knowledge of the supply of services and demand for care, authorities need to be able to assess what impact their current arrangements are having on shaping local care markets. This requires good information on how resources are currently distributed and what purchasing arrangements are in place. Tracking this information over time also helps authorities review whether objectives
are being met. Monitoring changes in the proportion of resources spent on community, as opposed to institutional-based care can be used as one indicator of whether the objective of supporting people in their own home wherever practicable is being achieved.

43. Authorities should be asking questions about their current arrangements to help generate this information [EXHIBIT 10].

44. A similar approach can be adopted for reviewing purchasing arrangements. The following information might serve as a starting point:

- Expenditure/volume of hours purchased from each independent sector provider
- Expenditure on independent sector services by contract type (see Section 4 for contract definitions) for:
  - home care;
  - residential care;
  - nursing home care; and
  - other services.
- Proportion of expenditure on voluntary sector organisations provided through grants/purchased under contracts.

---

EXHIBIT 10

Reviewing resource allocation

Authorities should be asking questions about the current distribution of resources.

Source: Audit Commission
45. SSDs can use this information to start to raise questions about their commissioning approach; for example, fieldwork for the handbook showed a large variation in the fragmentation of supply in home care and residential care [EXHIBIT 11]. Authorities faced by a highly fragmented purchasing pattern, for example in home care, might need to adopt a commissioning approach which seeks to establish closer partnerships with a smaller number of preferred providers.

46. Some authorities have started to undertake quite detailed analyses to inform their commissioning; for example, Buckinghamshire Social Services Department has reviewed the concentration of supply in residential care to identify the providers it is doing the most business with [EXHIBIT 12]. As with market mapping this information really becomes valuable when authorities compare their position against others, for example to examine the changes in the use of different contract types (see Exhibit 21 in Section 4).

**KEY QUESTIONS**

Do we use the information we have about how current resources are being spent to inform commissioning?

Do we use the information we have on current purchasing practice?

Can we compare ourselves against other authorities?

---

EXHIBIT 11

**Concentration of supply – independent sector expenditure**

SSDs can use information on purchasing arrangements to start to raise questions about their commissioning approach.

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*Source: Audit Commission fieldwork*
1.3 Developing an informed strategy

47. The information produced by carrying out the market mapping and resource allocation exercises outlined in the previous two sections provides the raw data on which to start to develop a strategy for commissioning. This needs to be used to inform the process of setting the authority’s priorities, acting as a basis for discussions and consultation with key participants in the system: users and carers, members, managers, providers and other agencies. Members in particular must be involved and signed up to the aims and objectives of the strategy. A checklist for the questions that might be included is presented overleaf [BOX B].

48. In developing commissioning objectives, it is equally important that they are informed by what is happening directly at the frontline: to the users and carers receiving care, to care managers in undertaking their role, to service providers and centrally in supporting the purchasing process. Sections 2 to 5 look at what action needs to happen to enable changes in these areas to occur. Section 6 brings the whole process together in an Action Plan.
**BOX B**

**Brainstorming questions**

- Are we achieving the objectives we have set ourselves in previous plans? If not, why not?
- What should commissioning be trying to achieve?
- Is there a monopoly provider which dominates the market and makes it unattractive for other providers, or is the size of providers fairly even?
- Are there gaps in service provision (for example in certain places, client groups)? If so, are these of higher priority than some existing services?
- Do we have confidence in the quality of services on the ground?
- Is the market competitive? If so, is competition benefiting users and carers, or is it at the expense of quality?
- Are providers rewarded for innovating or improving standards? Are we as purchasers sending the right signals to encourage this?
- If providers’ prices or costs are particularly high, can they openly justify these through higher standards or by providing a more intensive service to more dependent clients?
- Do our in-house services represent value for money in the long term?
- Is our purchasing approach creating a boom/bust instability for providers?
- Do our contracts and specifications seem reasonable to providers? Are they restraining innovation or improvements in quality?
- Are there opportunities to look for partnerships with providers from which we purchase large proportions of our services?
- Are other neighbouring authorities gaining more favourable terms by their commissioning strategy?

49. Several examples were found of strategic approaches being taken to address specific concerns within authorities [CASE STUDY 5]. However, there were few integrated long-term commissioning plans which met good practice criteria [BOX C, overleaf].
Case Study 5

Developing a strategy for home care and daycare provision for older people from racial minorities

In 1994 Borough-wide needs mapping in Wandsworth Social Services Department identified that older people from racial minorities were under-represented within the users of social services. This under-representation was due both to a low level of awareness in these communities of the services available and a lack of ethnically sensitive services. The health and social services authorities commissioned research which confirmed that existing services were not adequately meeting needs, but showed that a range of voluntary organisations had experience and expertise in providing services for this group. However, these organisations would be unlikely to meet approved list standards as yet.

The Department therefore funded a three-year project to develop this sector to work with the Authority’s care managers. The specific aims were:
- to develop elderly racial minority providers with a view to ultimately reaching the approved list;
- to increase the number of racial minority elderly people coming forward for community care assessments; and
- to encourage the development of ethnically sensitive assessment practices in care management.

Four voluntary organisations were selected and consultants appointed to work with them to provide training and to help them become more business-like. In the first year a six-month block contract was agreed to give the providers some security of income, although in practice this financial support was needed for only four months as their incomes soon exceeded this level. Training sessions included:
- the community care legislation and its local implementation;
- contracting for community care;
- setting yourself up as a community business;
- financial management;
- home care awareness;
- managing multiple priorities;
- training of care workers;
- building quality into your work; and
- disability awareness training.

Meetings were also organised with care management staff to establish a working relationship and seminars were held to publicise the work of the groups to the community at large.

Care managers value the new providers: they are purchasing the services of these organisations despite their hourly rates being generally higher than those of other providers. The outcome of the project has been a steady rise in the proportion of referrals from ethnic groups: 9 per cent in the third quarter of 1994, rising to 13 per cent in the last quarter of 1995.
Commissioning strategy – good practice

Commissioning strategies should:

- be agreed with health, housing, education and pressure groups – a complementary/joint approach;
- take account of current and future projections of the financial resources available;
- be based primarily around the service user rather than the department's organisational constraints;
- be based on a thorough understanding of the market (both demands from users and carers and providers' capabilities) and the organisation's capabilities;
- set out where the authority is now, where it wants to be in a few years and how it will get there (take the long-term view);
- set targets and monitors performance against these each year;
- be communicated to providers and care managers (or the changes will not take place); and
- clearly signal commissioning opportunities for providers and also those areas where authorities are seeking to reduce services.

**KEY QUESTIONS**

Are we clear what our commissioning objectives are?

Are our staff, providers and other agencies also clear about what we are trying to do?

How will we know what progress we are making?

1.4 Planning for decommissioning

50. So far, Section 1 has outlined the processes authorities need to go through to develop a commissioning strategy. However, for many authorities, the imperative has been not to commission more services but to respond to reductions in base budgets. Commissioning strategies need to reflect the continuing pressure on social services. In reality identifying the services that are no longer the most efficient or effective use of resources to meet needs, and developing exit strategies for them, will be as important a task as commissioning new services to fill gaps.

**Identifying services**

51. Determining what services need to be decommissioned should flow from developing a commissioning strategy. With a cash limited budget, deciding what services require increased funding must involve identifying those service areas that are less of a priority. Privately most officers could identify the services they felt their departments could no
There are never any easy choices when cutting services. However, few authorities have made explicit statements in planning documents identifying where services need to be reduced or changed. Officers felt that to expect authorities to make such statements formally was unrealistic given:

- the difficulty in obtaining member support for decommissioning priorities;
- the uncertainty they would create among providers; and ultimately
- the unsettling effect on current service users.

52. There are never any easy choices when cutting services. Political pressures make any options that involve reducing existing services to users extremely difficult, even where they release resources for reinvestment in new, more efficient and effective services. However, SSDs need to be able to make these hard choices in a planned way rather than in an ad hoc way in response to pressure generated by the annual budget cycle.

53. While recognising that such planning processes are difficult and that authorities need to develop and improve their approaches over time, there is much they can do now. The precise level of resources that departments have in any one year is difficult to determine in advance, but most can make a good estimate. SSDs should be modelling different assumptions about resource projections in the next two or three years and matching them to the available data on anticipated commitments using placement patterns and length of stay data. These can then be used to engage members and providers in discussions about the future. The shift towards longer-term community care plans provides a framework.

54. The problem with not being clear about services that need to be decommissioned is that authorities can instead be forced into making incremental cuts to services which they may want to develop in the longer term, simply to balance the books. Such a short-term approach tends to preserve the existing pattern of services and inevitably focuses debate on current prices and fees. Price is always going to be an area of contention, but officers and providers noted that in the absence of a clear plan, discussions often tended to be dominated by price to the exclusion of quality and other issues.

55. While it is clear that resource pressures will continue, few authorities appeared to be able to take a longer-term view and discuss and plan alternative approaches, such as looking at the potential for shifting the emphasis of residential and nursing home care towards shorter-stay rehabilitation and away from more costly permanent placements. Squeezing providers to cut costs may be an option in the short term but it will have implications for developing the relationships authorities need with providers to improve service delivery in the longer term (see Section 4).
56. Being explicit about commissioning and decommissioning priorities takes a high level of confidence in the SSD’s market mapping data. Departments must see these processes as fundamental and necessary to the process of managing budget cuts rather than as a separate exercise.

57. A lack of planning is also likely to limit the ability of SSDs to minimise the impact of cuts on existing service users. Making cuts quickly can limit choice; for example, residents may have little time to find another residential home when their home closes. Planning cuts allows staff time to consult properly, think through the implications for those involved – users, carers and staff – and find the most acceptable solution to a difficult situation.

KEY QUESTIONS

Have we identified what services need to be decommissioned?
Have they been set out in the commissioning strategy?
Have we discussed these with members, providers and users?
### Reviewing the Market and Developing a Strategy

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Take Your Choice

Making Commissioning User-led

Most users and carers are unlikely to have ever had any contact with social services. Supporting users and carers throughout the commissioning process – from assessment and individual care planning to designing services for the future – is essential if needs are to be met effectively. Authorities can do more to help users and carers influence their care, make informed choices and improve the user-responsiveness of services.
58. Users and carers must be at the heart of the commissioning process if it is to be effective [EXHIBIT 13]. If local authorities are to purchase services that meet users’ needs, users and their carers or advocates must be supported throughout the process. This section looks at how this can be done within the restrictions faced by social services departments (SSDs).

**Helping users influence and control their care**
- helping users understand the process;
- supporting users in controlling their care; and
- being responsive when things go wrong.

**Supporting user choice**
- providing the information users need on services;
- promoting choice of provider through administrative arrangements; and
- promoting choice of provider through contract arrangements.

**Making services more user-focused**
- making the views of users really count.

59. Users and carers must be assisted to control their care if the services they receive are to continue to meet their needs. Most users are unlikely to have ever had any previous contact with SSDs and will be unaware of how the assessment and care management process works, their rights within it, and who to contact with queries about care – particularly when things go wrong.
Providing information is essential to help users and carers understand the process...

Helping users understand the process

60. Users and carers need to be aware of why they are getting services, what services they are to receive, when they should be expected and what they are aiming to do. Providing this information, preferably both in a verbal and written form through copies of assessments, care plans and service records, is essential to help users and carers understand the process, challenge it if they feel it is wrong and ensure services are delivered as planned. This process should be led by care managers to ensure it applies to all users regardless of which provider delivers their services.

61. Evidence from the first ten joint reviews showed that 38 per cent of users had not received anything in writing about the help or services that SSDs were going to arrange. However, some authorities are thinking about how they can do more to help users understand what is going on, improving administrative efficiency at the same time [CASE STUDY 6].

CASE STUDY 6

Developing user-centred records – Cheshire County Council

Officers in Cheshire Social Services Department were concerned that some users were receiving services with little understanding of what these services were supposed to do. With care packages becoming more complex, with more visits and different staff entering individuals’ homes, the Authority recognised that better co-ordination was essential to ensure the effectiveness of these services.

It was evident that other services such as District Nursing successfully adopted user-held records. The Authority recognised that much of the information it recorded on client details was also held by other agencies. In response the Authority has been integrating its client documentation. This has culminated in the development of a ‘Care Folder’ which contains:

- the client assessment form;
- a record of dependency in terms of the ability and help required to perform certain daily living activities;
- the care plan;
- a care programme to record details of tasks undertaken;
- a record of significant events, for example illness, GP visits;
- a client preference sheet;
- a list of user’s property for those entering a residential home;
- a record of client finances; and
- a provider feedback form for completion by the provider to highlight for care managers the outcomes of reviews and whether quality standard targets have been met.

Care Folders stay with service users throughout the period of their care, and should accompany them on a stay in residential care or in hospital. The key aims of the Folder are to:

- improve the accountability of the process and services to users and carers;
- help provide information to hospital and residential care staff on admission by providing a care history and assist in the formulation of better care plans;
- ensure care staff are clear as to what tasks they should be undertaking;
- co-ordinate the activities of different care services better;
- help monitor service delivery; and
- provide a baseline for monitoring users’ needs.
Supporting users in controlling their care

62. Some individuals will always be too vulnerable to manage their own care effectively and many users and carers are likely to find the administration and bureaucracy of the system a daunting challenge. Authorities should have effective processes in place to help enable users to control their care. Care managers have the primary responsibility for this role. However, it is evident that as a result of the pressures to complete assessments, few manage to fulfil it effectively.

63. Many authorities have advocacy services available through the voluntary sector and yet few use them in a focused way to help users control their care [CASE STUDY 7].

CASE STUDY 7: Developing a focused advocacy service

In 1995 the Citizen's Advice Bureau in Tameside approached the Social Services Department with a proposal to develop an advocacy scheme for older or disabled people receiving residential or nursing home care funded by the Council. The idea was to link the advocacy to the review of residents’ care undertaken by care managers. The Department funded a pilot scheme at a cost of approximately £50,000 per year. The objectives of the scheme were:

- to review independently the needs of users as set out in their care plans and to assess whether they continue to be met by the service;
- to judge whether the service is continuing to meet needs; and
- to help the person gain access to any further or different services if necessary.

The scheme was implemented after consultation with individual homeowners and their associations. Initial difficulties occurred with providers in ensuring there was a clear distinction between advocacy and contract monitoring, and in the precise role and level of authorisation and access of advocates. These problems have diminished as the scheme has become more established.

An independent evaluation showed that between January and September 1996 the project made contact with 733 clients in residential and nursing homes, arranged 196 pre-review meetings with clients and attended 157 reviews. In 77 per cent of the reviews, issues were raised on behalf of the service user by the advocate. These resulted in such diverse outcomes as:

- investigating and assuring a homeowner that a relative was not defrauding a resident of his or her money;
- ensuring a resident had access to incontinence pads which he or she had been too embarrassed to ask for, although they were in the care plan;
- arranging for a resident to have a single room when he or she had not complained for fear of upsetting staff at the home; and
- the relocation of a nursing home resident who had made some recovery and wanted to move to a residential home (both improving the resident’s satisfaction and saving money).

Recent developments have extended the scheme to provide advocacy during the initial placement and at the first review after six weeks. This is acting as an important check to:

- ensure the issue of user choice is addressed properly;
- examine whether care plan objectives are still applicable given the probable change in circumstances;
- provide an independent perspective as to whether the placement is appropriate; and
- provide help in dealing with financial issues.
 Authorities should track the effectiveness of complaints procedures to inform their commissioning...

64. Although some service users will require this kind of support many may be in a position to take the main role in controlling their care directly. The intention of the Community Care (Direct Payments) Act 1996, which became operative on 1 April 1997, is to allow service users greater control and choice by giving them the resources to arrange, pay for and manage their own care. But the power is discretionary and is currently restricted to people with disabilities under the age of 65.

65. Evidence from reviews of the various independent living schemes (Ref. 4) is that this kind of arrangement can be advantageous both to users and authorities. Given the right support direct payments should represent the most cost-effective method of meeting users’ needs. Accounting and financial management guidelines for direct payments schemes are due to be published by CIPFA in late 1997, and authorities should seek to ensure these are fully incorporated into any scheme they are operating or considering implementing.

Being responsive when things go wrong

66. Where problems do arise, authorities need to be responsive to users. For older service users this is particularly important. Many may be concerned that complaints will lead to services being cut or withdrawn, or they may have such low expectations of the services they receive that even poor services are viewed positively. Authorities need to be conscious that a very low number of complaints may be a concern in itself, possibly indicating an inaccessible complaints process rather than quality services.

67. As well as helping users to control their care, complaints and compliments can also contribute to monitoring and quality assurance processes. Strong links should be evident with authorities’ contracts sections. As well as reviewing their own procedures, authorities should evaluate providers’ complaints processes. It should be clear which complaints should be notified to the authority and which should be dealt with by the provider.

68. Authorities should track the effectiveness of complaints procedures to inform their commissioning by:
   • monitoring the number and source of complaints;
   • analysing the different types and service areas that complaints are about;
   • recording the action taken and whether complaints were resolved to the satisfaction of the complainant; and
   • reviewing users’ perceptions of complaints procedures through user surveys or other consultation mechanisms.
69. Evidence from the first ten joint reviews showed that:

- 57 per cent of service users claimed that they had not been told how to make a complaint; and
- 50 per cent of those who complained felt that the complaint was not dealt with to their satisfaction.

KEY QUESTIONS

Do we do enough to help users and carers understand what is going on?
Are we helping users and carers to control the care they receive?
Are we using the information we have about complaints to inform commissioning?

2.2 Supporting user choice

70. The ability of users and carers to make an informed choice over what, where and by whom care is to be provided is of huge importance, particularly for those entering a residential or nursing home. For most older people this is likely to be a choice about where they will spend the rest of their lives.

71. Authorities should seek:

- to help users make an informed choice;
- to ensure artificial barriers to choice are not established by contracting arrangements; and
- to help ensure choice is offered by recording and monitoring the choices offered and made.

Providing information

72. In practice there is a wide variation in the amount and type of information given to users and carers to make a choice. Many authorities provide little useful information to compare providers. Good information may not only help users and carers make more informed choices but could save care managers time by answering basic questions about homes.

73. All the authorities visited in the fieldwork for the handbook produced a directory of care homes. Typically this is just a list of names, addresses and telephone numbers of homes and providers’ advertisements. Some of the better directories include detailed advice on what to consider when choosing a home, maps showing the location of homes and listings by geographical area, as well as the number of places and client groups cared for [CASE STUDY 8, overleaf]. Information on different home care and daycare providers was rarely available, although some authorities are now starting to address this [EXHIBIT 14, overleaf].
CASE STUDY 8

Developing information for users

Hampshire Social Services Department has been developing its Guide to Residential Care to improve the information users and carers have available to choose residential and nursing homes. The Guide contains:

- details of 750 homes by geographical area;
- basic information on services provided;
- contact names and telephone numbers of other organisations providing independent financial advice and help in finding residential care;
- complaints procedures;
- organisations providing advice for different client groups; and
- a detailed pull-out checklist of points to consider in choosing homes.

The longer-term aim is to produce, with the support of providers, a 'star ratings' system for homes. To help ensure providers have confidence that the Guide is circulated, the Authority guarantees a print run of 25,000 and has produced a poster to advertise it. Officers are currently developing other mechanisms to check on the effectiveness of the Guide.

The Authority has now produced a Guide to Care at Home 1997/98. As well as introductory information on the community care process it gives details on the 250 domiciliary and daycare providers in Hampshire. This information includes the geographical areas covered by providers, whether they are on the Authority's approved list, and the type of tasks undertaken. As with the residential care guide, information is also provided on useful contact points including both local and national organisations.

The guides are produced in-house and are self-funding through advertising revenue. The Authority is currently trying to attract a wider take-up of advertising space for the Guide to Care at Home from manufacturers of home care related products.

74. Few authorities give users any information on quality of providers. The Direction on Choice places a statutory duty on local authorities to arrange places for users in the residential or nursing home of their choice, subject to certain conditions. As a result, many authorities were concerned about the implications of producing anything which appeared to favour particular homes. While this may militate against providing a subjective assessment of the quality of care, more basic objective information could easily be compiled. Examples might include:

- whether rooms had en-suite facilities;
- whether telephone and/or television points were available in rooms; and
- whether residents could keep pets.

75. Where information is poor authorities should review how this can be improved.
76. **Inspection reports** could provide a very useful source of information on residential homes. The primary function of these reports is not to provide users with a view of what a home is like, but to address registration issues and make recommendations to their managers. However, this does not mean that they could not be made more user-friendly.

77. Many authorities suggest users read reports. However, they are often not easily accessible. In practice they are rarely seen by users or even by most care managers. As part of the fieldwork for the handbook a review of a random selection of inspection reports was undertaken to assess how useful they could be to users. This showed that there was much in the reports which could of been of interest to potential
residents, but that the reports were not produced in a format which made them easy to read. Some authorities are taking steps to ensure inspection reports are more clearly written [CASE STUDY 9].

**Promoting choice through administrative arrangements**

78. As well as providing information, authorities should ensure that users are aware that they can choose between care providers. Few authorities have the administrative processes in place to give any assurance that they are complying with the Direction on Choice. Documenting the choices offered and made can provide an important control in helping to ensure that this process takes place [EXHIBIT 15]. A similar situation exists with emergency placements. Users who enter homes in a crisis should subsequently be offered a choice when they are sufficiently able to make it. As with non-emergency placements choices should be documented as part of the care management process.

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**CASE STUDY 9**

**Making inspection reports more user-friendly**

Sheffield City Council provides guidance to inspectors on the content of reports. This stresses the importance of producing reports that are:

- **jargon free** (Officers) will avoid words and phrases, wherever possible bearing in mind the wording of the legislation and official documents, which would not easily be understood by the public.

- **objective** Reports will be unbiased and state actual facts, not feelings. (Officers) will not use subjective or interpretable words, for example 'warm atmosphere'. A subjective view expressed by someone interviewed could be stated.

- **factual** (Officers) will describe what is known to have occurred or be true. If an opinion is expressed or a view stated this will be prefixed by 'in the Inspection Officer’s opinion/view...'.

- **descriptive** (Officers) will state the actual characteristics of what is being described in detail. They will state how many residents/staff mentioned a specific issue or point of view out of the number asked. The report will describe particularly whether or not standards are met.

- **concise** The report will be short and sharp and will not ‘think out a situation on paper’. Situations will be thought out first and the outcome will be recorded as concisely as possible.
EXHIBIT 15
Dorset County Council's choice of residential provider form

Documenting the choices offered and made can provide an important control in helping to ensure that this process takes place.

Source: Dorset County Council
If services are to be as user-focused as possible, managers and staff need to have an informed view of what it is users want from them.

79. Recording information on the choices offered and the reasons why a particular home was chosen can provide a key source of data to help develop commissioning plans (see Section 1) by:
• clarifying the key factors that are influencing choices;
• giving further evidence as to the comparative popularity of providers among potential users; and
• identifying preferred service options as a way of supporting analyses of unmet needs.

Promoting choice through contract arrangements

80. A number of studies have shown that users who have received respite care in a home tend to choose the same home when they subsequently need long-term care (Ref. 5). While recognising that some providers are ill-equipped to provide respite care, artificially restricting the choice of respite providers can have an important influence on the ability of users and carers to make informed choices. Authorities can help promote choice directly through their contracting arrangements [CASE STUDY 10].

KEY QUESTIONS
Are we helping users maximise the choice they have available and giving them the information they need?
Do we record user choices and use this information to help our commissioning?
Are we using information on user choice to improve commissioning?

2.3 Making services more user-focused

81. As well as helping users and carers to maximise the available choice and control they have over their care, authorities need to address how they can make services more user-responsive. This requires authorities to have effective methods of consulting with users and carers, and also mechanisms to ensure changes to services result.

Making users’ views really count

82. If services are to be as user-focused as possible and improve the effectiveness of service delivery, managers and staff need to have an informed view of what it is users want from them. From fieldwork sites the most common ways of obtaining user views were through:
• user and carer forums; and/or
• user surveys.

However, of the fieldwork sites visited only half had conducted user surveys.
CASE STUDY 10

Promoting choice in respite care

Users and carers in Bradford wanted to be able to arrange respite care without having to go through the local authority each time. In response the Council established a voucher scheme for users to give them more flexibility, choice and control over when and where they use respite care.

Users are assessed to see if residential or nursing home care is required and a financial assessment is also completed. If clients have £16,000 or less in liquid assets they are able to obtain up to 56 vouchers per year – each voucher being equivalent to one night’s care. The vouchers are printed with the client’s individual details and contain a unique reference number to satisfy audit requirements. Users and carers can then choose from more than 200 residential or nursing homes which offer respite care in the Bradford area. Vouchers can be used whenever the user or carer wishes.

A voucher is given to the homeowner for each night’s care. The user and homeowner sign it and forward it to the Social Services Administration Section for payment. The charge for users/carers is based on the minimum income support entitlement less twice the personal allowance figure (in recognition that users have continuing living costs at their own home). This works out at around £15.80 per night. The Authority also established that Residential Allowance was claimable for single-night stays in independent sector homes, reducing the charge to users to approximately £7.80 per night. Homeowners receive the equivalent of the standard weekly charge for the assessed category for that user.

One factor contributing to the success of the scheme is the oversupply of residential places in the Authority, which has been evident since April 1993. However, there are only a few dedicated respite beds and the primary concern of homes is to attract permanent residents. This can make it difficult for carers to book places well in advance, although there has been a recognition by some homeowners that today’s respite users are likely to be tomorrow’s permanent residents. Similarly, clarity was needed over the varying dependency levels of different users and the value of the voucher used. This led to a range of 11 different voucher categories being introduced.

In the first six months of 1997/98, approximately 8,000 vouchers have been used by people in the private and voluntary sector. The scheme complements Bradford’s own respite care provision which it operates within its own Part III homes. Last year it was able to offer the equivalent of 66,000 bed nights for people who chose to use a respite care bed in a local authority home. The voucher scheme is enthusiastically supported by carers, users and the proprietors of the residential and nursing homes. If you would like further information on Bradford’s voucher scheme please contact Philip Lewer, Assistant Director for Services to the Elderly, on (01274) 752903.

83. As was noted in the previous section there are particular difficulties associated with obtaining the views of older people. It is important to ensure that these users are not given a lower priority than the typically more vocal and articulate users and carers of other client groups. Establishing specific user and carer forums for older people may be one way authorities could approach this problem.

84. Among users and carers there was a concern that, while authorities may have established ways of consulting with users, there was little evidence that their views made much impact on service delivery. Clearly
Much can be done to involve users directly...

it can be difficult to isolate the reasons why particular changes are made to services. However, authorities need to be clear about the purpose of consulting with users and carers and be able to point towards at least some service changes that have resulted. Users need to be involved at an early stage in the planning process so that the most effective use can be made of their views and knowledge. Some authorities have invested considerable resources in helping promote user organisations to try to make services more user-focused [CASE STUDY 11].

85. Much can be done to involve users directly: for example getting users to specify what the outcomes of the services they receive should be as part of the contracting process, thus helping to evaluate service effectiveness. Users and carers can also play a key role in designing service specifications to help ensure user considerations are paramount in clarifying what and how services are provided.

KEY QUESTIONS
Are we paying enough attention to what our users want when we commission services?
Service users as agents of change – user involvement in Wiltshire

Wiltshire Social Services has moved towards developing a user-led commissioning and service delivery approach through the influence of an independent user-controlled organisation. Wiltshire & Swindon Users’ Network was formed in 1991 to help organise service users to respond to the new opportunities offered by the forthcoming NHS and Community Care Act. The initiative has had strong support from the Director of Social Services and other senior managers but has been entirely led by service users.

Service users with experience and knowledge of Social Services and the voluntary sector, support other service users, helping them speak out and gain in confidence. In addition to meeting regularly to discuss issues of concern, the Network is proactive in lobbying for involvement in all aspects of Community Care, for example participating in staff training and the formulation of policy evaluating services.

In April 1993 the Network negotiated funding from Social Services of £55,000 in a rolling service agreement. This money helped provide support to service users and to facilitate direct links between the Department and users. The Network developed an infrastructure to support users in their involvement and manage the links with Social Services and the Health Authority, which now also funds the Network for user involvement. The Network now has a membership of over 600 service users, many of whom are older people, and is managed by a Board of Directors who are service users.

The Network has also negotiated funding and developed a number of projects employing staff in the fields of independence living, information and advocacy. The Independence Living Support Service supports over 100 people purchasing their own care. There are two projects supporting mental health service users to speak out, and a project specifically enabling older service users to give their views to inform the development of an older people’s strategy. The Network now has an annual turnover of £500,000 and employs 27 members of staff.

The Network’s philosophy is to ‘riddle the system’ with as many users’ views as possible to enable Social Services personnel at all levels to learn from user expertise. Early involvement of users is found to be more effective than consultation in the final stages. In relation to the commissioning process, some of the pieces of work users have been involved in are:

- designing specific policies to address certain commissioning issues;
- participating in reviews of services;
- commenting on service specifications;
- assisting in selecting service providers;
- training care management staff;
- designing the care management process;
- carrying out research to evaluate a service;
- designing a questionnaire to evaluate the home care service; and
- training home care staff on user-led monitoring procedures.

Further information about the Network and seminars about their work can be obtained from The Director, Wiltshire & Swindon Users’ Network, 7 Prince Maurice Court, Hambleton Avenue, Devizes SN10 2RT.
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<th>Aspect of performance</th>
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<tr>
<td>Helping users understand the process</td>
<td>• administrative procedures that ensure users receive (as a minimum) copies of their assessments, care plans and financial assessment calculations</td>
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<td>Supporting users in controlling their care</td>
<td>• establish a direct payments scheme for eligible users</td>
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<td>Being responsive when things go wrong</td>
<td>• review the responsiveness of complaints procedures at least annually</td>
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<td>Providing information on services</td>
<td>• systematically record complaints information for use in contract monitoring</td>
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<td>Helping ensure users receive a choice</td>
<td>• improve the information provided to users in the care homes directory</td>
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<td>Promoting choice through contracting</td>
<td>• ensure users have access to inspection reports and that they are in a user-friendly format</td>
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<td>Making users’ views really count</td>
<td>• record the choices made by users and the reasons for choice</td>
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<td>• ensure choice is offered to users after the crisis period following an emergency placement</td>
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<td>• minimise the organisational and procedural boundaries to choice through contracting arrangements</td>
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<td>• undertake regular user surveys and establish user forums for each client group</td>
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<td>• be able to demonstrate changes to service delivery resulting from user consultation</td>
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Enabling Care Managers to Play a More Effective Commissioning Role

Care managers are faced by organisational, resource and workload constraints which makes it difficult for them to play an effective commissioning role. Authorities can do much to remove these barriers: giving care managers more flexibility to put together appropriate packages of care; aligning financial and managerial responsibility to get the most out of existing resources; and giving sufficient priority to reviewing needs.
86. The aim of the shift towards the care management model produced by the implementation of the NHS and Community Care Act was that social workers would take a more active role in helping to manage individuals’ care and tailoring services to meet their needs. The role of the care manager is therefore key to ensuring the services users receive meet their needs effectively [EXHIBIT 16].

87. In reality this care management function is balanced with the role of ‘gatekeeper’ to services. At a time of strong resource constraints these roles are potentially in conflict. Certainly the pressure on care managers to complete assessments can be a major factor restricting their ability to maintain a wider ‘care management’ role. However, if commissioning is to work effectively sufficient emphasis needs to be given to ‘user championing’ in the process – ensuring services are appropriate, of a good quality and tailored to the needs of the individual. If insufficient priority is given to this role, or barriers are placed in the way of flexible care management, it is unlikely that those individuals who do meet eligibility criteria will receive either the type of service that meets their needs, or that effective use is made of the services they do receive.
It is important to note that this handbook does not cover the assessment process itself. Getting assessments right is obviously vital in making sure needs are met appropriately, but it is a subject that is beyond the scope of the research for this handbook. The Social Services Inspectorate (SSI) has recently undertaken work on the care planning process covering assessment (Ref. 6).

Authorities can take action in a number of areas to enable care managers to operate more effectively within the commissioning framework.

Removing organisational barriers to commissioning

- developing flexible services; and
- establishing a single purchasing framework for all services.

Improving the effectiveness of care management

- understanding care managers’ workload and activity; and
- giving enough priority to reviewing existing needs.

Aligning managerial and financial responsibility for commissioning

- devolving budgets for services to those making the purchasing decisions.

From the fieldwork sites visited to compile data for the handbook, care managers identified a number of barriers to commissioning services to meet users’ needs. The most often cited barriers were:

- constraints of having to use an in-house provider, at least as the first port of call;
- lack of a framework to purchase innovative care options; and
- resource constraints and inflexible financial limits.

The Social Services Inspectorate (SSI) has recently undertaken work on the care planning process covering assessment (Ref. 6).

One of the great challenges of the community care reforms for local authorities was to move away from having a predominantly service-provider culture to one where decisions are taken on an individual needs-led basis. This has clear implications for the management of in-house services. If care managers are to have the ability to meet needs effectively, they need flexibility in choosing between care options and providers. In turn this means that a different type of management approach is needed for in-house services, focusing more clearly on what purchasers want.

Similarly, meeting another objective of the Act – supporting people in their own homes wherever feasible – requires that in-house home care services are flexible enough to meet the needs of more dependent users. This requires a move away from operating to traditional work practices and from providing traditional domestic care services. Providing flexibility is a difficult task requiring renegotiation or changes to staff contracts and a refocusing of services on personal care. However, a number of authorities have managed this process successfully [TABLE 2, overleaf].
Establishing a single purchasing framework

93. One of the key drivers behind ensuring this change in culture happens is to make providers financially accountable to purchasers and to operate a single purchasing framework for in-house and independent sector providers. Authorities should ensure all services are properly costed and that care managers take account of both in-house and independent sector costs in putting together packages. Without proper cost information or local purchasing budgets, in-house services tend to be regarded as a ‘free good’ by care managers in contrast to the strict limits applied to care provided by the independent sector. This can lead to inequality for users [EXHIBIT 17].

94. Some authorities have taken this process further by setting up internal trading mechanisms for in-house services [CASE STUDY 12, overleaf]. This has helped to make unit costs more ‘real’, allowing care managers greater flexibility in purchasing care. It also gives the provider a strong incentive to manage costs and develop its management information systems.
EXHIBIT 17
Inequalities created by the lack of a single purchasing framework
Even though Mrs Smith and Mr Jones have similar needs the sizes of their care packages may be very different.

Source: Audit Commission

95. Managing the change to internal trading is a difficult process. Clearly authorities need to ensure that money is not wasted by having spare capacity which has already been paid for. However, by not allowing care managers flexibility to choose when and when not to use the in-house service, their ability to purchase care packages that best meet individuals' needs will inevitably be restricted. A sensible approach would be a phased introduction – undertaken in line with the devolution of purchasing budgets (see Box E, page 64) – allowing authorities greater scope to monitor and manage any change in the pattern of services.

KEY QUESTIONS
Are our services flexible enough to meet the objectives of community care?
Are we purchasing services from different providers on a comparable basis to help ensure equity for users?

3.2 Improving the effectiveness of care management

96. Being able to manage individuals' care throughout the period users are receiving services is an essential part of effective commissioning. However, few authorities have information on how well care managers are doing this by recording how they spend their time between assessment and care management functions, or how many reviews they are undertaking. Unless care is reviewed periodically a detailed initial assessment is undermined if packages are not adjusted subsequently as needs changed.
CASE STUDY 12

Setting up an internal trading system

At the start of the implementation of the community care reforms, Kensington and Chelsea Social Services Department (SSD) recognised that if it was to be able to commission efficiently and effectively to meet needs, then the costs of in-house as well as externally purchased services needed to be clear and accountable to purchasers. In order to achieve this the Authority decided to establish an internal trading mechanism for the in-house home care service.

Detailed analysis was undertaken to determine appropriate allocations of management and support service costs, both from within the SSD and other Council services. After pilot work during 1993/94 the trading account became operational in 1994/95. The system initially had teething problems. Contact hours data was calculated from a sample analysis of productive time (that is, excluding training, travel and other non-contact time). This analysis proved problematic, requiring a mid-year price adjustment in 1994/95 to balance the trading account. To improve the accuracy of the data, productive time is now estimated more realistically and in more detail. Contact hours are based on data compiled directly from timesheets and are input into the home care IT system.

The internal trading arrangement has developed into a type of cost and volume contract. The provider is guaranteed approximately 80 per cent of its capacity with 20 per cent being available for purchase by care management teams on a spot basis. Pressure is building to allow a greater proportion of hours to be purchased on a spot-contract basis.

Despite the difficulties, officers remain positive about the benefits of operating an internal trading process. Key advantages have focused on:

- the pressure exerted through the system to improve productivity, principally by reducing non-contact time;
- the drive to develop more robust management information with which to manage the service; and
- the visibility given to management and support costs.

Improved management information has, in turn, helped to provide data on which to make more informed judgements about wider commissioning issues such as what services should be contracted from the independent sector and what the best future use of the in-house home care service should be.

Although operating such a system has costs in terms of staff time, officers noted that these had diminished as the system had developed, and estimated that they now accounted for less than one full-time officer post.

The internal trading system is now supported by a service level agreement with the purchaser section. This has helped clarify what services are to be delivered and service standards expected, giving care management a greater say in shaping the service to meet their needs.

Understanding care managers' workload and activity

97. A common concern among fieldwork authorities was that they were having to respond to a significant increase in the number of referrals and assessments as well as undertaking a care management role. This view is supported by national statistics from the Local Government Management Board (Ref. 7). Few authorities had looked at the impact this has had on the workload and activity of their care managers. Subsequently they had little data to assess how they could best manage
these pressures [CASE STUDY 13]. If commissioning is going to work authorities need to have a good idea of what care managers are and are not doing, and also what they want them to do. If reviews are not taking place managers need to be aware of this and either strengthen contract monitoring and compliance processes or reappraise the priority, training and resources given to care management.

CASE STUDY 13

Monitoring care managers’ activity

Buckinghamshire Social Services Department conducted an audit of care managers’ workload over a period of three weeks to:

• ensure the distribution of resources to care management teams was based on need; and
• identify core/non-core tasks for care managers.

The audit comprised two main components:

• the completion of forms by care managers listing the activities undertaken and the time spent per activity (this lasted for one week); and
• follow-up interviews with a sample of care managers and other staff to identify core/non-core tasks and skills and training requirements.

The activities recorded included:

• pre-assessment work (taking a referral, duty visit, etc);
• assessment work (by type of assessment);
• care planning, monitoring and reviewing; and
• miscellaneous and non-client related work.

In addition information was collected on case loads and the status of those cases.

Interviews focused on care managers’ views of what their job content currently was and what they thought it should be, as well as the skills requirements of the job and any training they had received or felt they needed.

Key conclusions of the audit included:

• the time spent by care managers on setting up care packages was more than that spent on assessments; and
• a blurring of roles existed between qualified and unqualified staff.

In drawing lessons for other similar exercises, the Authority noted that careful planning was essential to ensure staff were clear about the purpose of the exercise and that adequate time was allowed for piloting. A recognition was also made that such exercises had implications for other groups of staff – such as those in support services – and that the results should not therefore be considered in isolation.
Some authorities have undertaken specific exercises to review existing care packages...

Giving enough priority to reviewing needs

98. Individuals’ needs at the time they are assessed are unlikely to remain unchanged during their care. It is more likely that they will change significantly, often making the care package they receive inappropriate. This leads to an inefficient use of resources, poor targeting, or worse, inadequate support or an increase in dependency.

99. Reviewing care packages remains a care management function in most authorities. In reality the pressure on care managers to complete assessments and arrange initial care packages has taken priority. As a result, only in a few authorities were care managers undertaking any review of non-complex packages after the initial one-month period following the start of services. A number of authorities relied on their in-house home care staff to signal to care managers when packages were becoming inappropriate, but were less willing to trust independent sector providers to do this.

100. Authorities need to ensure that sufficient priority is given to reviewing existing packages. There would seem to be little point arranging care services that were only likely to meet needs in the very short term. A number of authorities have recognised that care managers are failing to undertake reviews and some have introduced a designated reviewing officer role as part of their care management teams to check the needs of existing service users.

101. Some authorities have undertaken specific exercises to review existing care packages, often prompted by changes to eligibility criteria [CASE STUDY 14]. One important lesson from such reviews is that authorities should not make the assumption that packages provided by the in-house service will necessarily be responsive to changing needs. Reviews should not therefore be limited to packages provided by the independent sector. A second lesson is that not providing time for reviews is a false economy; people often need less help as the crisis that generated the initial assessment recedes. A regular programme of reviews not only ensures that users are getting the services they need, but can also release resources for re-use.

CASE STUDY 14

Ensuring care packages are meeting needs cost effectively

In 1995, following the introduction of eligibility criteria, Buckinghamshire County Council instigated a review of home care packages provided both by the local authority provider and external providers.

To date it has assessed 3,474 clients. Reassessments of needs enabled it to identify packages that were not meeting users’ needs: 14 per cent were no longer deemed a priority and so their packages ceased; 42 per cent of users had their packages reduced, but this was compensated by 44 per cent where more care was needed. In effect, the exercise has enabled the Council to target resources more effectively.
KE Y Q U E S T I O N S
Are we sure that care packages are responsive to changing needs?

3.3 Aligning managerial and financial responsibility for commissioning

102. Throughout government and the private sector there has been a drive to devolve financial responsibility down management structures. The basis of this shift has been that the promotion of greater efficiency and good financial control requires an alignment of financial and managerial responsibility. In effect, the people who take the decisions to commit resources need to be responsible for their financial implications. This message is not new and has been often repeated by the Audit Commission in its publications on financial management (Ref. 8).

103. For SSDs the need to create a closer link between financial and managerial responsibility in commissioning care is particularly important given the size and number of purchases being made. Without such alignment there will always be an incentive for care managers to overstate needs to secure resources. Many authorities have struggled to devolve budgets down the management structure even for services purchased from the independent sector. Given the tight resource restrictions which SSDs have faced it is tempting to keep a tight central control on spending. A lack of progress with devolving budgets is therefore not surprising. However, more needs to be done if commissioning is going to work effectively. Financial limits, resource panels and waiting lists may provide stop-gap methods for enforcing financial control but will not improve purchasing practice in the longer term.

104. Authorities which still have a strongly centralised system of financial control need to take action now to establish a framework in which purchasing budgets can be devolved. If financial accountability continues to remain remote from purchasing decisions taken on the ground, it is unlikely that:

• eligibility criteria will be operated rigorously and hence that users will be treated equitably;
• systems will be flexible enough to enable innovative packages of care to be purchased; and
• sufficient purchasing pressure can be exerted on providers to deliver care that is more tailored to individuals' needs.

Organising budget holders

105. Finding the right level at which to devolve financial accountability will depend on local circumstances. Budgets should not be devolved to care managers just for the sake of it. In deciding the most appropriate budget structure, authorities should consider some of the principles outlined in the Audit Commission publications on financial management.
**BOX D**

**Principles for budget devolution**

**Budget responsibility should be delegated when:**

- **a lot of short-term decisions are involved...**

  Purchasing care involves a mix of short-term and long-term decisions. Packages of respite care or fluctuating home care packages involve a series of short-term decisions. Placements into residential and nursing home care are clearly longer term. As a result many authorities require authorisation for high-cost packages and or placements into residential and nursing homes to be made by a resource panel of senior officers, and use weekly ceilings to restrict expenditure. There may be good reasons for reviewing assessments to improve care management practice. However, this process can become highly bureaucratic and inefficient if used simply to limit spending. Perversely it also encourages care managers to think in terms of short-term limits and boundaries rather than long-term costs, which acts as a disincentive to try intensive rehabilitative packages rather than simply to look at residential options.

- **the need for expenditure is unpredictable and the costs might be significant enough to affect the delegated total...**

  Devolving resources to individual care managers without a good indication of their likely workload or case-mix would devalue the process. However, it should not be simply assumed that demand is unpredictable and hence devolvement unsuitable. As was noted in the previous section, authorities need to build up a clearer idea of care managers’ activity. Where case-mix appears unpredictable or subject to wide variations, authorities would be wise to hold budgets at a team or area level.

- **incentives would be perverse or undesirable...**

  The perverse financial incentives that encourage authorities to commission residential care rather than intensive home care packages have been well documented (Ref 9). Should budgets be devolved these may exert an even stronger influence on financially hard-pressed managers. In any devolvement, authorities would need to think carefully about how appropriate adjustments can be made to ensure this perverse incentive is restrained, possibly by explicitly subsidising the cost of community-based packages for budget purposes.

- **the service aims to respond to clients’ needs...**

  This is the key underlying principle of the community care reforms.

- **costs are particularly dependent on individual’s actions...**

**Don’t delegate when:**

- **the need for expenditure is unpredictable and the costs might be significant enough to affect the delegated total...**

  The decisions made by care managers are usually the determining factor in deciding whether an individual is both eligible for care and what and how much he or she should receive.

- **organise a mix of budgets between those that might respond to incentives but cannot be directly controlled and those that can be cash limited...**

  The nature of a needs-led approach means that cash-limiting any individual element within a care budget is undesirable. Devolving budgets should, however, ensure that managers have a strong incentive to ensure equitable treatment of users with reference to the authority’s eligibility criteria, and consequently an appropriate share of available resources.

- **arrange budgets so that the same manager bears the cost whichever alternative is chosen, for example in-house or outside provision...**

  The principles behind moving to a single purchasing framework for in-house and independent sector providers and across service types has already been set out (see page 56).

*Source: Audit Commission, ‘Better Financial Management’*
106. The practical difficulties involved in devolving budgets are not to be underestimated. Indeed, devolution should only be attempted where authorities have confidence that the financial systems, skills and controls to support them are in place. Ways of improving these areas are examined in Section 5.

107. Budget devolution is not therefore a process that should be attempted overnight. Careful planning is required if the process is going to be successful. Even with good support authorities will need to pilot and review extensively before embarking on a process of devolution (EXHIBIT 18 and BOX E).
Identify resources to be devolved
Budgets for devolving could be phased in by service or devolved in part, although authorities need to guard against creating perverse incentives.

Clarify roles and responsibilities
A single named budget holder should be responsible for each budget. The budget should contain only those items that the budget holder has control over and exclude those which he or she does not. Lines of responsibility to senior managers should be clear, and appropriate supervision arrangements agreed with budget holders. Formal guidelines or handbooks should be issued to budget holders setting out their duties, rights and responsibilities.

Ensure budget holders have skills and support
Budget holders will need training in financial management skills if they are to be expected to manage their responsibilities. Even with this training they are likely to need extra support from finance professionals, and arrangements for providing this need to be in place. Budget monitoring systems and information need to be user-friendly. The ability to input commitment data and process invoices locally could improve accuracy and timeliness. Further details on these areas is provided in Section 5.

Define an indicator of demand
In the first instance this is likely to be based on historic spend and the number of existing users. However, increasingly use should be made of a range of potential indicators such as the number of over-85 year olds, deprivation indicators and measures of dependency to ensure budgets reflect care needs rather than service use.

Allocate budgets
The organisation of care management teams varies across authorities. Some use hospital-based assessment teams whose responsibilities to care manage individuals are transferred to a local area team following the first six-week or one-month review. Both should have budget holding responsibilities and appropriate apportionments to reflect this arrangement. Some contingency resources should be held back to minimise the impact of the risk of overspending.

Review
Proper piloting is essential to reduce the risks associated with the change in financial control responsibilities. Teething problems are almost inevitable and regular reviews will need to identify and deal with difficulties such as overspending by some budget holders, inequalities in resource allocation, and a range of procedural problems that are likely to occur.

KEY QUESTIONS
Are care managers applying eligibility criteria equitably or is there an incentive for them to overstate needs to secure resources?
Are care managers able to commission intensive packages of care to rehabilitate individuals and avoid long-term commitments?
Do care managers have the necessary purchasing influence to commission services tailored to individual needs or are they bound by what providers can deliver?
## Enabling Care Managers to Play a More Effective Commissioning Role

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<th>Good practice features</th>
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<td>• staff contracts enable providers to deliver intensive packages of care</td>
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<tr>
<td>Establish a single purchasing framework</td>
<td>• the costs of all services are used to determine whether care packages are within the financial limit</td>
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<td>Effective organisation</td>
<td>• management information on the workload and activity of care managers is available</td>
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<td>Giving enough priority to reviewing needs</td>
<td>• reviews of home care packages are undertaken to ensure they are still appropriate to the needs of users and carers</td>
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<tr>
<td>Organising budget holders</td>
<td>• budget structures reflect a clear alignment of financial and managerial responsibility</td>
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Getting a Better Service From Providers

All relationships between purchasers and providers have certain features which are needed if they are going to be successful in the longer term—accountability, openness, sustainability and trust. Social services departments (SSDs) typically have adversarial relationships with the independent sector but a lack of accountability in arrangements with in-house providers. A broader range of funding and contracting arrangements are needed incorporating clearer specifications of quality as well as the development of more effective monitoring processes.
108. The relationships that exist between purchasers and providers play a crucial part in determining the success with which authorities can meet the needs of users and carers effectively and manage resources efficiently [EXHIBIT 19]. This applies as much to in-house services as to the independent sector.

109. Many authorities have experienced difficulties in developing good relationships between purchasers and providers. Frequent concerns include:

- poor quality service delivery;
- 'in-house first' policies which restrict the use of the independent sector;
- 'cherry picking' of more attractive cases by the independent sector;
- overly legalistic and bureaucratic contracting processes;
- high transaction costs;
- the lack of a clear specification for in-house services;
- preoccupation with short-term considerations; and, more generally
- the adversarial nature of many purchaser/provider relationships.

110. This section looks at how authorities can improve commissioning to get the most from providers, securing long-term improvements in the efficiency and effectiveness of service delivery.
Developing more mature relationships

• learning from other markets to develop less adversarial approaches to contracting with external providers.

Developing a clear role for in-house services

• developing a specification and service level agreement (SLA) for in-house services.

Fair and open contracting

• establishing a framework which safeguards the authority's and users' interests but is responsive to providers' needs.

Developing better contracts

• establishing a contracting framework which makes use of a broader range of contract types;
• improving contracting processes to tender for services; and
• specifying quality and how it can be measured.

Contract monitoring and compliance

• co-ordinating the roles of the groups involved; and
• monitoring the performance of all providers on a comparable basis.

Communicating with providers

• getting a better impression of providers' views through the use of techniques such as surveys and provider forums for different service types.

4.1 Developing more mature relationships

111. There are several principles which need to be present in all successful purchaser/provider relationships [EXHIBIT 20]. Without these it is unlikely the relationship will develop to enable purchasers to get a more efficient service or users to benefit from higher quality in the longer term.

Learning from other markets

112. If authorities are to get the most from their providers they need to base relationships more on a partnership approach rather than traditional adversarial arrangements. Further support for this can be found from other industries.

113. In the construction industry the Latham Committee Report (Ref. 10) outlined the features of a modern contract. These included:
• a specific duty for all parties to deal fairly with each other... in an atmosphere of mutual co-operation;
• firm duties of teamwork, with shared financial motivation to pursue those objectives. These should involve a general presumption to achieve 'win-win' solutions to problems which may arise during the course of the project;
EXHIBIT 20
The features of successful relationships

As with any relationship there are certain features which must be present for it to be successful.

• easily comprehensible language with guidance notes attached;
• while taking all possible steps to avoid conflict on site, providing for speedy dispute resolution if any conflict arises, by a predetermined impartial adjudicator/referee/expert; and
• providing for incentives for exceptional performance.

114. The DTI-CBI Partnership Sourcing Initiative (Ref. 11) has been another response to the concerns raised over the effects of adversarial contracting arrangements. It argues that organisations need to move away from 'the master-servant syndrome where the supplier is merely told what to supply and the customer is told the price' and 'heavy legalised contracts'. However, it also notes that 'it isn't philanthropy: the aim is to secure the best possible commercial advantage'. Relationships should be based more on partnership with respect for one another's objectives and 'open book costing'. Many leading companies now subscribe to the initiative, including British Airways, GlaxoWellcome, IBM, Nissan, Rank Xerox and Tesco.

115. As part of the initiative a specimen 'contract' has been produced which more closely resembles a service level agreement (SLA) than a contract [BOX F, overleaf].
BOX F

Extracts from the Guidelines for Agreement, adapted for this handbook

1. **A Statement of Principle** – for example, ‘Partners A & B agree to work together in an open and trusting style in partnership deliberately to create a business relationship which is ethical and progressive, delivering tangible, measurable benefits to both partners over a long period’

2. **Scope** – The partnership covers the following services (list)

3. **Cost** – Each partner will work year-on-year to ensure the total acquisition cost of services will go down

4. **Service** – The supplier will work to ensure achievement of customer performance and service levels of not less than x % timeliness of delivery, y% quantity of delivery, z% quality of delivery

5. **Forecasts** – The customer will ensure that it will provide accurate forecasts regularly. Such forecasts will provide x months firm orders and y months forecasted business volume

6. **Process improvement** – Each partner will work to improve the process of service delivery and regularly review specifications to ensure the effectiveness of service delivery. Process improvement projects will be defined, agreed and implemented

7. **Continuous improvement** – Both partners will start a continuous improvement programme in their own organisation, apply it to the services supplied and meet regularly (at least quarterly) to assess improvements

8. **Objectives** – Each partner will agree and set specific agreed annual objectives and obligations of task performance and will review these at quarterly meetings

9. **Hardship** – In the event that either partner gets into difficulty under the terms of this partnership agreement they will have the right to approach the other partner requesting relief from hardship. At this point, both partners will meet to openly discuss the issues involved and the pro-active positive solutions to them

10. **Cost structure** – For each of the items or services supplied an agreed open book cost structure will be created (consisting of a formula containing labour, materials, overheads, profit, plus other categories, for example return on investment). These will be agreed at the initiation of the partnership and reviewed regularly in the light of the continuous improvement programme, cost reduction objectives and process improvement objectives of the Partnership Agreement

11. **Materials** – The customer will work with the supplier to minimise the cost of the supplier’s material purchases, for example offering joint agreements for similar materials used in its business, and offer to hold joint negotiations with material suppliers to minimise costs

12. **Capital investment** – Where expenditure on capital is required to be undertaken by the supplier to manufacture items on the behalf of the customer, these will be identified at the beginning of the partnership. The criteria for investment and payback and return from that investment will be clearly agreed and defined between the partners before any investment is made

13. **Confidentiality** – The nature of the partnership will involve the passage of sensitive information between both partners. It is an absolute obligation of this agreement that any information is not passed to any other third party of any kind

14. **Exclusivity** – Where investment is made in specialist services, developed between the two parties, supply may not occur under any circumstances to any third party unless specific explicit agreement is made in writing between the partners

15. **Termination** – In the event that all other avenues are exhausted, and both partners come to a conclusion that the partnership must be dissolved, a notice period of x must be given prior to termination

16. **Management, Education and Publicity** – Each party will undertake to brief its management and staff regularly: initially on the nature of the agreement and subsequently on the status of development of the relationship between the two partners

17. **Key contacts** – The key contacts in this partnership, who initially have the responsibility of managing the critical relationships between the organisations, are x and y

Source: Partnership Sourcing Limited
116. Adversarial approaches to contracting are clearly evident in social services arrangements. The current financial pressures under which authorities are operating tempt them to use their market power to drive prices down and squeeze as much as possible from providers in the short term. In the longer term this approach will prevent the development of the higher quality services authorities want, and will remain expensive in terms of the high transaction and monitoring costs. To move forward, authorities need to understand their providers better, recognising and accepting their motivations and reflecting this in their approach to contracting.

**KEY QUESTIONS**

Do we seek ‘win-win’ solutions when negotiating with providers?

4.2 Developing a clear role for in-house services – accountability

117. If providers are to plan and manage services efficiently they need to have a clear idea of what it is specifically they are expected to provide. While many authorities have gone to considerable lengths to specify the services they want from independent sector providers few have clarified precisely what is expected from in-house services and documented this. A number of authorities were unable to even identify how many contact hours their own in-house services provided or how many users they had.

118. Cost comparisons with independent sector providers will keep the spotlight on in-house services. As such, ensuring it is clear what the added value of in-house services is and how this can be assessed should remain a key management objective.

119. Specifications are needed to ensure:

- realistic expectations are established about the capabilities of in-house services; and
- benchmarks are available to assess the relative efficiency of the services provided.

120. The specification should be agreed between purchaser and provider and should clarify the services to be provided, their cost, volume and quality [CASE STUDY 15, overleaf].

**KEY QUESTIONS**

Do we have realistic expectations of our in-house services and have we got a benchmark to assess their performance?
CASE STUDY 15

Developing a service specification for in-house services

Kensington and Chelsea Social Services Department developed an internal trading arrangement for its in-house home care service [Case Study 12]. To support and complement this process the Authority has recently been developing a service level agreement (SLA) for the home care service.

The 1997/98 SLA clarifies the aims of the service, service types, availability, unit costs and purchasing arrangements. Unit cost data is supported by detailed analyses of the components of costs and details of sickness and productivity data.

Targets for response times have been established to cover:
- requests for services by social workers;
- notification of changes in circumstances, such as admission to hospital – both from home care to social workers and vice-versa;
- management information provided to finance support officers or team managers from home care; and
- requests by care co-ordinators for contributions to reviews of users’ needs.

Service delivery commitments are also specified in terms of arrangements for ensuring:
- continuity of care worker;
- reliability; and
- timeliness.

Monitoring arrangements for these key indicators and for the service agreement more generally are also outlined.

4.3 Fair and open contracting – openness and trust

121. If they are to develop the trust and security on which to build relationships, authorities must have confidence that the providers they are buying from will deliver services to at least a minimum standard and safeguard authorities’ financial and legal responsibilities. For social care this is even more important given the vulnerability of those receiving services, often within the closed environment of their own homes. However, authorities need to balance this with ensuring potential providers are not discouraged by having to face a bureaucratic and expensive contracting process with no guarantee that it will lead to any business.
Safeguarding the authorities’ and users’ interests

122. The most common method by which authorities aim to check providers’ competence to deliver services is through the use of accredited or approved lists. There is a degree of confusion over these terms. Authorities have different perceptions of what is meant by an ‘approved list’ and apply them differently to residential and home care providers. ‘Approved list’ and ‘accreditation’ are often used interchangeably. To provide some clarity the handbook uses the following definitions:

- **An approved list** relates to residential providers and requires achievement of a set of criteria above those relating to registration standards. These will be variable. Many approved lists simply represent a way of checking the financial viability of homes and the adequacy of insurance arrangements. Others require homes to meet a set of care standards or a specification to be an approved provider. This is then linked to a pre-placement contract agreement. The Direction on Choice states that an authority must place an individual in the home of his or her choice so long as certain conditions are met. These conditions include the cost, but also whether the home meets the authority’s usual terms and conditions. A number of authorities have chosen not to operate approved lists due to concerns that the Direction on Choice will limit their ability to enforce higher quality standards than those required for registration.

- **Accreditation** is used to apply a similar process to home care providers. Typically, accreditation schemes are more common given the absence of statutory registration and inspection of home care providers. As a result authorities use accreditation to clarify what they expect from providers in terms of service quality and to evaluate providers’ management and administrative processes to assess whether these service standards will be met. Accreditation schemes can be voluntary, or made a contract requirement. Similarly, authorities are under no obligation to contract purely with accredited providers.

123. Well-operated accreditation and approved lists can be a valuable way of helping to ensure effective service delivery and may also provide other benefits. Linked to good user information, a credible approved list system can provide an attractive marketing opportunity for providers in much the same way as membership of respected trade associations does for other services – consequently helping to shift the pattern of demand towards higher-quality providers.

124. Approved lists and accreditation schemes can also generate useful market information that would not otherwise be obtained, for example on the longer-term financial stability of providers.
Being responsive to providers' needs

125. While authorities need to be confident that their interests and those of their users are adequately safeguarded, they need to be responsive to providers and be able to demonstrate fair-handedness in the way they deal with all providers. Without this, approved lists or accreditation schemes are likely to be both inefficient and ineffective. Common failings that authorities need to address include:

- **onerous detail** – little recognition is made by authorities of the costs of compiling and providing information

- **in-house services exempted** – standards are applied that could not be met by the in-house provider

- **lack of credibility** – no continued monitoring is undertaken once approved/accredited status achieved

- **blanket approaches** – too much emphasis is placed on external quality assurance 'badges' and not enough examination of local management on the ground

- **lack of recognition of the circumstances of small providers** – no simplified processes exist for low volume providers

- **lack of support to providers** – no assistance is given to help with filling in forms or clear guidance produced on the process

- **lack of co-ordination with other authorities or with tendering processes** – providers face different requirements from different authorities and duplication of information requests when tendering for services

- **failure to link to market position** – no recognition is made of the need for incentives for providers to go through the process (especially important where undersupply exists)

- **a lack of front-line feedback** – the views of care managers, users and carers on the performance of providers are not sought and hence there is a lack of knowledge about service delivery

126. Getting provider and care manager feedback can help the authority determine the extent to which its current arrangements suffer from these problems.

**KEY QUESTIONS**

Are our quality assurance processes really identifying the providers we do and do not want to contract with?
4.4 Developing better contracts – sustainability

127. Although it is now several years since the community care reforms were implemented, the types of contract arrangements authorities are using remain dominated by the direct funding of in-house services and the spot purchasing of services from the independent sector. In line with the development of more mature relationships with providers, authorities need a better approach to contracting, incorporating a broader range of contract types, greater use of tendering to help secure efficiency savings, and a clearer view about what quality means and how it might be specified and measured.

Using a range of contract types

128. Much debate has focused around the type of contracts authorities are using to purchase services. For social care, the contract types used can be categorised into three groups.

129. Spot contracts – Services are purchased on a case-by-case basis. This can be done by using a unique contract for each individual. Typically this is used for one-off residential placements outside the authority. Many authorities also use pre-placement or pre-service agreements. This involves the provider meeting a standard service specification and set of contract conditions usually linked to an approved list or accreditation process. This agreement establishes an option to purchase with the provider, usually at an agreed price. When the purchaser then makes a placement or arranges a care package with the provider an individual service contract is produced outlining user details, care requirements and the rights and responsibilities of each party – user, purchaser and provider.

130. Block contracts – A fixed level of service is purchased at a fixed price over a set time period to an agreed, written specification.

131. Cost and volume contracts – These combine some of the features of block and spot contracts. A certain number of units of service are guaranteed to be purchased in a block arrangement. Above this additional units of service can be purchased on a spot basis.

132. Spot purchasing remains the main type of contract used to purchase services from the independent sector. Only four out of ten fieldwork authorities used block or cost and volume contracts to purchase residential or home care services, and this was often only for small-scale projects or with former in-house providers [EXHIBIT 21, overleaf].
EXHIBIT 21
Contract types for independent sector (expenditure on care for older people 1996/97)
Spot purchasing is still almost universally adopted for the independent sector.

EXHIBIT 22
Current local authority funding arrangements for provision
Funding arrangements are still characterised by central direct-funding of in-house services and local spot purchasing from the independent sector.

133. Authorities should be broadening the range of contract types they use [EXHIBIT 22]. There will always be a place for spot contracts in purchasing because of the flexibility they provide. However, the continued use of direct funding and spot contracting on such a wide scale has serious draw backs [TABLE 3]. Block and cost and volume arrangements help share the risks of contracting between purchaser and provider. This is not to argue that authorities should contract whole services on block contracts as this clearly risks reducing the flexibility and choice available to service users. However, some authorities are starting to use block contracts in ways which promote service development and improve efficiency [CASE STUDY 16, overleaf].
### TABLE 3

Advantages and disadvantages of current contract arrangements

<table>
<thead>
<tr>
<th></th>
<th>Advantages</th>
<th>Disadvantages</th>
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| **Central direct payment** | • No transaction costs  
  • Security of supply  
  • Easier financial control | • Inflexible services that are less responsive to users' needs  
  • Little pressure to innovate  
  • Less incentive to improve productivity or develop management information  
  • Less accountable to purchasers |
| **Local commissioning through spot contracts** | • Users’ needs can be accommodated flexibly  
  • No cost for unused services  
  • Competition among providers potentially reduces prices | • High financial transaction costs  
  • No security for providers – little incentive/opportunity to invest in staff training, develop new services or management infrastructure  
  • Providers reliant on high turnover, low wage, low-skilled staff leading to poor quality services  
  • Financial control more difficult  
  • Requires purchasing skills among care managers  
  • Difficult to develop more mature relationships |
| **Cost and volume contracts** | • Lower financial transaction costs than spot purchasing  
  • Retains competitive element to improve productivity and management information  
  • Gives some security to invest  
  • Tendering process acts to specify services and rigorously examine management processes  
  • Allows for development of more mature, longer-term relationships concentrating on non-price issues | • Requires specialist market knowledge to get the right balance between block and spot elements  
  • Contracting costs of tendering processes  
  • Potentially reduces the number of suppliers and choice |
| **Block funding** | • Low financial transaction costs  
  • Security to provider to innovate and develop services  
  • Tendering process acts to specify services and rigorously examine management processes  
  • Allows for development of more mature, longer-term relationships concentrating on non-price issues | • Requires specialist market knowledge to avoid excessive unused capacity  
  • Contracting costs of tendering processes  
  • Opens potential for accusation of ‘sweetheart’ deals  
  • Potentially reduces the number of suppliers and choice |

*Source: Audit Commission*
CASE STUDY 16

Making room for partnerships in the home care market

Hertfordshire County Council spends close to £12 million a year on independent sector home care. It recognised that its current spot contracting arrangements were inappropriate for such a large volume of service. In response it has been progressively expanding the proportion of expenditure under block contracts to cover over £2.5 million in total. The block contracts aim to:

- reduce the administrative and transaction costs of dealing with a large number of providers;
- facilitate the improved evaluation and monitoring of standards; and
- reduce service costs if business done with more expensive providers is transferred to block contracts.

The Authority estimated that block contracting could save £300,000 (7.5 per cent of expenditure) based on the business it had with its 19 most expensive providers, and reduce the risks to service users of service interruption resulting from business failure of small providers.

The Authority's approach has been to develop 18 block contracts ranging from 5,000 hours per year to one county wide contract for over 130,000 hours. The intention of the smaller blocks is to help encourage smaller providers to develop by giving them some security of income. These providers can of course also provide further hours on a spot purchase basis, according to the pattern of demand and their capacity.

The county wide contract is viewed as more of a partnership, allowing the Authority:

- a benchmark with which to compare local authority services;
- to reduce 'transaction' costs both financial and administrative; and
- to take advantage of lower unit prices in the independent sector.

Improving contracting processes to tender for services

134. Authorities have wide experience of tendering for services. The impact of compulsory competitive tendering (CCT) has meant that councils are accustomed to the discipline of specifying large and complex services within a tight regulatory framework. In contracting for social care, authorities should aim to make use of the freedom they have in voluntarily tendering for services with the wider purchasing skills they have developed. However, many providers will have had little experience of the process. To be successful in improving the efficiency and effectiveness of service delivery, tendering must not only consider the authority's requirements as a purchaser but also be sensitive to and support providers' needs [B0X G].
Developing tendering processes for social care

The tendering process should reflect the volume and complexity of the service involved. The process described below outlines the steps that an authority should consider in tendering for a medium-sized home care contract (for example 30,000 contact hours).

The tendering process is divided into seven stages:

1. review options and arrangements for project management;
2. test the availability of supply;
3. invite expressions of interest;
4. build up a short list;
5. refine a specification;
6. evaluate tenders and select the preferred provider; and
7. award the contract.

Review options and arrangements for project management

Deciding what is going to be tendered should be driven by SSDs’ commissioning strategies (see Section 1), but this still leaves scope for authorities to review different options. Of key importance in this process will be what is affordable. This may be less of an issue for home care where tendering is likely to represent a change in contract type – spot contracts being replaced by a block or cost and volume arrangement – than for new services. A fully costed model of the most likely contract can help to serve as a reference point with which to review tenders at a later stage in the process.

Tendering involves making a series of complex evaluations and decisions, and committing a large amount of resources over several years. Good project management is essential. Departments will need to review the skills they have available, making use of expertise from outside. Tendering processes must comply with the corporate framework set out in financial regulations and standing orders. An outline should be made of the key tasks to be completed and responsibilities assigned. Timetables should reflect what is realistic and allow adequate time for discussions and negotiations.

Test the availability of supply

In a relatively new market such as home care an early test of providers’ interest in tendering is important. Ongoing consultation with providers should give a feel for the size and type of service they would be interested in supplying. Even so, some providers may feel uncomfortable about the constraints of even a small block contract. Informal discussions can help give a better impression about what providers are able to supply and whether they are ready to undergo a tendering process. There is nothing to prevent authorities giving support to providers to help them...
develop the skills needed to undertake tendering. However, the criteria for qualifying for this support should be clear; it should be open to all providers and based on the ability of the provider to deliver services rather than the sector – private or voluntary – it belongs to.

**Invite expressions of interest**

The first formal stage in the tender process is to invite expressions of interest. Information should be made available to all providers covering:

- the background and scope of the project;
- the criteria for selecting the providers invited to tender;
- a draft specification;
- a clear statement of the information prospective providers should submit; and
- the proposed basis for selecting the successful tender.

A common criticism from providers has been the length, detail and legalistic language used in contract documentation. Overly detailed service specifications can be particularly off-putting for providers, requiring them to invest a large quantity of resources at an early stage of the tendering process with only a limited expectation that they will be successful.

At this stage it is important to outline only the core requirements of the specification, for example what the authority really wants in terms of service outputs, and avoid outlining how it expects it to be provided.

**Build up a short list**

A framework is needed to reduce the number of expressions of interest the authority receives to a short-list of providers who will be invited to negotiate. Producing a full tender can be expensive and can ultimately be reflected in higher tender prices in future contracts, and so the short-list needs to be kept to the minimum number of providers to ensure genuine competition. The key criteria for this should include an assessment of the technical competence and financial stability of the provider.

Authorities with accreditation schemes for home care providers should already have most of this information, and where it is sufficiently up-to-date they should use it to avoid duplication.

**Refine a specification**

Having selected a short-list, authorities need to develop more of the detail of the specification. This can be done in consultation with potential providers as long as general rules about the equitable treatment of tenderers are followed. In practical terms this may be difficult to ensure. However, the specification should still provide for some degree of flexibility on the part of providers. CIPFA (Ref. 12) notes that although it may be technically possible to make specifications watertight they may...
still be open to criticisms:

- by tenderers, for thwarting innovation, and for stopping them using what they say are modern and efficient methods;
- by staff, for de-skilling their work – prescriptive specifications transfer to the specifier, or clients’ agents, a discretion previously exercised by middle managers;
- by clients, for fossilising the service;
- by service users, for making it easy to stone-wall their complaints;
- by budget holders, for stopping them making economies when these are demanded by eventualities such as capping; and
- by elected members, for obstructing the democratic choice of the electors, especially when majority control changes early in the life of long-term contracts.

Specifications need to strike a balance between providing detailed information on which to help evaluate tenders and being too onerous for providers. The use of method statements may allow this flexibility to be retained. They are written statements produced by a provider to describe how it will meet certain criteria specified by the purchaser. These should then be incorporated into the final contract documents. Such statements may be particularly useful in an area such as home care where the flexibility required in service delivery to meet individual needs makes a highly technical specification inappropriate. They can also be helpful in tender evaluation to assess quality, allowing comparisons between the different standards each tenderer would provide in terms of processes, skills, experience and qualifications of staff.

Consideration also needs to be given to how the specification will be monitored. This should review the arrangements for checking user and carer satisfaction, the information required from providers and the role of inspection and registration, care managers and contract officers (see page 83).

### Evaluate tenders and select the preferred provider

Once final tenders have been submitted these can be evaluated using a number of methods. Quality checks can be made through inspections or references. Interviews and presentations enable the authority to scrutinise the capabilities of the staff involved and allow further clarification and detail of the points made in tenders. Written records should be kept of these processes and unsuccessful tenderers informed as soon as possible.

### Award the contract

The contract can be awarded and where appropriate a contract award notice placed in Official Journal of the European Community (OJEC).
Specifying quality in contracts

135. Much debate has focused on achieving the right balance between inputs, outputs, processes and outcomes in measuring the quality of care services. Good practice would suggest that specification and monitoring should concentrate on the outcomes for users that result from services rather than the tasks undertaken or how services are organised. However, defining outcomes for social care services that can be monitored objectively is not a simple task. Much of what represents quality in a caring relationship will depend on the subjective views of individual users. As such, authorities need to use proxy measures for quality, based as much as possible on the key factors that users define as important in providing care.

136. The Nuffield Institute and the United Kingdom Home Care Association (UKHCA) are currently working on developing and evaluating user-centred outcomes for domiciliary care services (Ref. 13). From the user interviews and focus groups they have undertaken, the recurring characteristics of a quality home care service include:

- reliability;
- continuity;
- kindness and understanding shown by home carers;
- cheerfulness;
- competence;
- flexibility; and
- knowledge of the needs and wishes of the user.

The most commonly mentioned features of a poor service included:

- problems with the attitude and training of care staff;
- lack of continuity;
- inflexibility; and
- general lack of time available.

137. A few authorities have started to incorporate some of these indicators into their contract specifications. Kensington and Chelsea included clauses on the reliability, consistency and training needs of staff in the specification it designed for its own in-house service (see Case Study 15). Inventive ways have also been found to monitor these indicators; for example, a number of authorities have undertaken trials of systems which use code numbers, punched in via the user's telephone, to record data on the reliability and timeliness of home care workers.

138. Recent work by the Personal Social Services Research Unit (PSSRU) (Ref. 14) has focused on the elements that constitute quality in residential care. This research used a large set of measures – around 100 mainly medical indicators – to attempt to evaluate quality in a sample of residential homes. These included factors such as:

- the level of depression;
- medication usage;
• provision of care to meet physical needs such as immobility;
• provision of opportunities for daily social activities; and
• staffing ratios.

Interestingly, the research showed that 'homes which perform better on ...[the PSRRU] indicators did not have significantly higher overall costs than those that performed less well'. Clearly, specifying such a large number of indicators in contracts would be impractical. However, authorities need to think about how they can shift the emphasis of monitoring towards more objective measures to get a better impression of the quality of their providers. Birmingham City Council has used such an approach in developing its pricing strategy for residential and nursing home care (Section 5, Case Study 18)

KEY QUESTIONS
Are our contract types appropriate for getting what we want from providers?
Are we making enough use of tendering in our approach to secure better efficiency and effectiveness?
Are our specifications good enough at defining quality in a way we can actually measure?

4.5 Contract monitoring and compliance – accountability and trust

If authorities are going to ensure that services are being delivered to the agreed specification and quality standards, they must be able to undertake effective monitoring. To be efficient, monitoring has to be a co-ordinated task with contracts officers, care managers, users, carers and providers all playing a part.

It should also be a two-way process. To develop effective commissioning, monitoring information needs to be fed-back to care managers and users to allow them to make more informed choices, and to providers to act as an incentive to improve services. Monitoring should not be confined to services purchased from the independent sector. If authorities are to determine the relative value for money of both in-house and independent sector services, they must be monitored using the same criteria and through the same processes.

Co-ordinating roles in monitoring

Information on the performance of providers exists in several areas [EXHIBIT 23, overleaf]. Those receiving services are ideally the best source. However, few authorities surveyed users for contract monitoring purposes or recorded complaints users make about providers in any kind of systematic way.
Developing a co-ordinated approach to monitoring

Information on the performance of providers exists in several areas and co-ordination of roles and responsibilities in contract monitoring is needed.

143. Another key source is authorities’ own care managers who are clearly well placed to provide feedback for monitoring purposes. Care managers noted that they were rarely asked to record their views and experiences of providers, or had any monitoring data fed back to them except where particularly poor performance had been identified. Without any other sources care managers form opinions about providers solely on the often limited and subjective information available to them. Ineffective monitoring and communication of information then results in subsequent purchasing decisions that are poorly informed.

144. In practice much of the detailed information on service delivery will only be available from service providers. Few authorities asked providers for any data on monitoring except for services purchased through block contracts. Much of the information that is provided is
necessarily taken at face value. However, it is clear that some authorities make little attempt to review any of it in detail, or worse, ignore it entirely. Some authorities have established stronger relationships with providers, enabling them to have more confidence in the ability of providers to deliver services and their willingness to share problems.

145. Even where relationships with providers are good, authorities will need to retain an independent contract monitoring role to ensure providers do not become complacent in meeting specifications and delivering services. Many authorities have designated 'client-side' monitoring officers, although often they can be responsible for monitoring hundreds of contracts. Authorities need to ensure that the effort and resources they put into specifying services and developing their contract types is not undermined by an inability to monitor effectively. Few authorities have attempted to co-ordinate the various sources of monitoring data and the roles and responsibilities of those involved. There is a clear need for authorities to establish a monitoring approach which takes account of the various sources of data and uses these effectively.

**Monitoring providers on a comparable basis**

146. Many authorities use entirely separate systems for monitoring services purchased from the independent sector and those provided in-house. A number of authorities argue that in-house services need less monitoring because of the line management links that exist, and that further monitoring would be inefficient, involving unnecessary duplication.

147. However, being directly managed is no guarantee of adequate service performance. Authorities need to be able to assess the value for money of different service providers by comparing both cost, quality and case-mix on a like-for-like basis. This should not be regarded as an additional monitoring cost. Recording what, how much and to what quality services are delivered is key management information and is essential if services are to be delivered efficiently and effectively.

**KEY QUESTIONS**

Is it clear who should be monitoring what and are we making the most of the information we have on individual providers?

Are we monitoring all providers in the same way so we can compare their performance?

148. Once services are in place providers have the closest day-to-day link with users and carers, so their views can make a valuable contribution to improving the effectiveness and efficiency of care services. Authorities also need a clear picture of the problems facing providers and the effect this is having on users, if they are to respond positively. Similarly, unless authorities can signal commissioning information and opportunities effectively to providers, they will be unable to develop the services they want for the future.
Authorities could do more to demonstrate their commitment to improving relationships

Providers’ views on the relationship

149. Over the course of the research for this handbook, a number of internal and external providers and provider associations were consulted to obtain their views on how commissioning could become more effective [TABLE 4]. These covered providers in all major service areas: home care, residential care and daycare. Interviews identified frustration in some authorities with a perceived reluctance to use the private sector and a lack of recognition of providers’ needs. Common concerns centred on:

- the lack of openness in contracting processes;
- the favouring of in-house services; and
- poor communication of commissioning opportunities.

150. One of the themes of this handbook has been that social services departments need to have constructive relationships with all their providers to ensure the best care for service users. Such relationships ought to be in the interests of all involved in the process.

151. From the suggestions made by providers in Table 4, commissioners could improve their relationship with providers by being more accountable and open. Most authorities have established provider forums to talk to the independent sector. However, these often include providers of all service types. Some home care and smaller providers felt their views were not taken onboard. Authorities could do more to demonstrate their commitment to improving relationships by developing and measuring key indicators of how well they are enabling providers to serve users. Indicators could include:

- the length and complexity of contract documents;
- the amount of expenditure in block contracts;
- the number of days notice given to providers before a service is expected to start;
- information on the number of users expressing a choice of provider;
- the number of referrals made to each provider; and
- the average length of time taken to pay invoices.

152. Surveys may also be a useful way of keeping in touch with providers and helping to generate useful management information for social services, perhaps allowing them to express their views confidentially.

KEY QUESTIONS

Are we paying enough attention to our providers to understand the constraints they are operating under and their opportunities for innovation?
### Table 4
Independent sector provider concerns and suggestions

<table>
<thead>
<tr>
<th>Concerns</th>
<th>Suggestions</th>
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<tbody>
<tr>
<td><strong>Information/access</strong></td>
<td></td>
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<tr>
<td>• Need to share problems with providers, not to impose changes or cuts without consultation</td>
<td>• Need to share information on changes in strategy which will affect providers</td>
</tr>
<tr>
<td>• Often insufficient contact with key purchasing staff; often difficult to address issues due to size and infrequency of forums and absence of relevant staff</td>
<td>• More regular forums of a reasonable size, possibly area-based, and more informal contacts at different levels of the organisation</td>
</tr>
<tr>
<td><strong>Culture/attitude</strong></td>
<td></td>
</tr>
<tr>
<td>• Belief that users are not always given a choice of provider</td>
<td>• Need for authorities to enable informed choice and demonstrate that users are making choices</td>
</tr>
<tr>
<td>• Feeling that in-house or not-for-profit providers are favoured over private sector</td>
<td>• Open and measurable criteria about how authorities choose providers, and application of these criteria to providers in all sectors</td>
</tr>
<tr>
<td>• Need to trust the independent sector to build a relationship</td>
<td>• Greater pursuit of innovative schemes with contracts which offer more security for providers and better services for local authorities</td>
</tr>
<tr>
<td><strong>Strategic planning</strong></td>
<td></td>
</tr>
<tr>
<td>• Need for more forward planning – longer-term purchasing plans, not summaries of decisions already taken</td>
<td>• Longer-term community care plans</td>
</tr>
<tr>
<td>• Not enough risk-sharing – authorities are not entering into block contracts</td>
<td>• Need to explore benefits to both purchasers and providers of block contracting</td>
</tr>
<tr>
<td>• Need for more clarity around the boundaries of purchaser/provider (and other) monitoring roles</td>
<td>• Monitoring strategies which reflect the fact that providers are front-line, and can naturally do some monitoring more effectively</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td></td>
</tr>
<tr>
<td>• Lack of prompt payment in some authorities</td>
<td>• Some authorities have direct debit; others have gone for standard invoicing</td>
</tr>
<tr>
<td>• Paperwork is unwieldy, for example specifications are too legalistic and input-focused</td>
<td>• More outcome-focused specifications, greater reliance on partnership, less focus on the contract</td>
</tr>
<tr>
<td>• Some tendering applications are bureaucratic, ask for unnecessary information and do not state selection criteria</td>
<td>• More open and standard tendering procedures in keeping with best practice authorities</td>
</tr>
</tbody>
</table>
## Getting a Better Service From Providers

<table>
<thead>
<tr>
<th>Aspect of performance</th>
<th>Good practice features</th>
<th>Current practice</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>A clear role for in-house services</td>
<td>• service level agreements (SLAs) are in place that specify the type, volume, cost and quality of each in-house service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair and open contracting</td>
<td>• contract processes are adequate to safeguard the authority’s and users’ interests&lt;br&gt;• information requests to providers are not onerous (requiring a large quantity of resources with little indication as to likely future work) or are not duplicating information already held&lt;br&gt;• purchasing procedures are as consistent as possible with other authorities&lt;br&gt;• extensive use is made of front-line feedback&lt;br&gt;• sufficient incentive is offered to providers to engage in the contracting process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing better contracts</td>
<td>• a broad range of contract types are used including some block and cost and volume arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specifying quality in contracts</td>
<td>• measurable indicators used to help provide some objective information on quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract monitoring and compliance</td>
<td>• a contract monitoring approach is in place that clarifies the roles and responsibilities of contracts officers, care managers, users and carers, providers and the inspection and registration section&lt;br&gt;• common standards used for all providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicating with providers</td>
<td>• regular canvassing of providers’ views through forums and surveys</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Supporting the Process Centrally

Maximising the resources available for service delivery may be attractive politically at a time of financial pressures, but authorities need to be certain that such resources are being used efficiently and effectively. To do this requires appropriate commissioning skills and information. Social services departments (SSDs) need to develop these areas, gaining confidence to take a more proactive role in managing care markets to deliver commissioning objectives.
153. The implementation of the community care reforms brought with it a huge expansion in the scale of the commissioning role of social services departments (SSDs). To manage this role effectively, authorities must have enough staff with the skills to support the process both centrally and locally, and the systems in place to provide both the day-to-day and longer-term management information required [EXHIBIT 24].

154. This expanded commissioning role has come at a time of severe financial pressure on local authorities. In such a climate the temptation is to maximise the resources spent directly on services at the front-line by cutting central support. However, this process can go too far, resulting in authorities having little idea whether money is being spent either efficiently or effectively. This section looks at the role of the social services department in supporting the process.

**Developing commissioning skills**

- reviewing what skills are needed and checking these against what is currently available; and
- reviewing whether the number of staff available is sufficient to fulfil the authority’s commissioning role and to ensure efficient and effective use of resources overall.

**Financial support systems**

- improving financial information and accountability;
• supporting budget holders by developing more accurate and timely budget and activity data; and
• improving payment processes to reduce transaction costs.

**Information strategy and systems**
• determining what management information is needed, what is currently produced, areas of duplication, and alternative sources, and bringing it all together.

**Managing the market**
• taking a more proactive approach through pricing or other mechanisms to encourage the market to deliver the authority's commissioning objectives.

### 5.1 Developing commissioning skills

In most social services departments commissioning takes place at both the local and the central or area level [EXHIBIT 25].

**EXHIBIT 25**

**Commissioning framework – breakdown of tasks**

Some commissioning tasks are undertaken centrally, and some locally.

Source: Audit Commission
156. There is no single organisational model for commissioning, but however the authority organises itself, it must ensure that it is able to function flexibly and effectively. This requires:

- staff with appropriate skills and expertise;
- support for budget holders; and
- sufficient staff to fulfil roles.

**Reviewing what skills are needed**

157. Commissioning requires a number of skills. Some of these skills are necessary for all staff, and others are specialist skills. A key role for commissioners is to understand the provider's point of view. This will mean authorities are likely to need to review their experience and skills mix, and maybe recruit more broadly to bring in some of these skills and interests [TABLE 5].

<table>
<thead>
<tr>
<th>Skills/tasks</th>
<th>Central staff</th>
<th>Local staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall demand mapping</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Networking to gauge ideas</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Market research</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mapping of providers</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Negotiation and appreciation of how suppliers are motivated</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Communication skills</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Individual needs assessment</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>Budget management</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Understanding budgets</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Understanding of costs and outcomes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Contracting and legal expertise</td>
<td>✓</td>
<td>X</td>
</tr>
</tbody>
</table>

*Source: Audit Commission*
158. Research for this handbook found many staff in a central commissioning role had social work backgrounds – essential if staff are to understand the nature of the service they are commissioning – but an absence of relevant skills in purchasing. Counter-examples were rare: in one authority the occupational therapy service manager had an MBA, in another a contracts manager also had this qualification. Similarly, a few officers had an Institute of Purchasing qualification. Such qualifications are not the only solution, but they demonstrate an interest in and exposure to current management thinking.

**Reviewing staff numbers**

159. Attention also needs to be given to the resources (in terms of staff numbers) required to complete commissioning tasks properly. Fieldwork identified that central resources for undertaking market mapping, contracting, monitoring, and liaising with providers, were typically confined to a contracts or commissioning unit and appeared thin on the ground [TABLE 6].

This could be a particular problem in large authorities, where the ability of these staff to fulfil contract compliance roles might be questioned. In fact it was common to find just one officer in the contracts unit who had to interface with hundreds of providers. Although there is no rule as to how many staff an authority should have, all authorities must ensure that central support is adequately resourced in order to ensure commissioning delivers value for money.

**TABLE 6**

<table>
<thead>
<tr>
<th>Authority</th>
<th>Contracts staff</th>
<th>1997/98 Social services net expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>18</td>
<td>£223m</td>
</tr>
<tr>
<td>B</td>
<td>3</td>
<td>£132m</td>
</tr>
<tr>
<td>C</td>
<td>1</td>
<td>£96m</td>
</tr>
<tr>
<td>D</td>
<td>10</td>
<td>£74m</td>
</tr>
<tr>
<td>E</td>
<td>10</td>
<td>£73m</td>
</tr>
<tr>
<td>F</td>
<td>1</td>
<td>£61m</td>
</tr>
<tr>
<td>G</td>
<td>7</td>
<td>£58m</td>
</tr>
<tr>
<td>H</td>
<td>10</td>
<td>£54m</td>
</tr>
<tr>
<td>I</td>
<td>3</td>
<td>£50m</td>
</tr>
<tr>
<td>J</td>
<td>3</td>
<td>£49m</td>
</tr>
<tr>
<td>K</td>
<td>6</td>
<td>£37m</td>
</tr>
<tr>
<td>L</td>
<td>1</td>
<td>£27m</td>
</tr>
</tbody>
</table>

Source: Audit Commission questionnaire; CIPFA estimates
KEY QUESTIONS
Are we giving enough priority to getting the right number of staff with the skills needed to commission efficiently and effectively?

5.2 Financial support systems

160. Sound financial management must underpin the commissioning process. Authorities need to support this at the centre with appropriate systems design and infrastructure, information and support for budget-holders. The Audit Commission has identified the following principles of good financial management (Ref. 8):

- financial responsibility is aligned with managerial responsibility;
- responsibilities should be clarified, with managers operating within clear rules;
- financial information systems should be in place; and
- good financial support and advice is needed for managers.

161. Section 3 deals with the first of these issues; the devolvement of budgets. This section looks in more detail at the framework within which that takes place.

162. In most authorities the budgets for in-house and independent sector services are still separated, with only the latter (often only in part) being given to care managers or care management teams [EXHIBIT 26].

Improving financial information and accountability

163. Since the NHS and Community Care Act, the proportion of spend in the independent sector has grown steadily – from 40 per cent in 1994/95 to 52 per cent in 1995/96 (Ref. 15). Moving to a common structure and a single commissioning budget would enable authorities to:

- achieve greater clarity over the activity and costs of in-house services; and thereby
- provide accountability for resource decisions made for half of their expenditure.

164. A number of steps need to be taken to achieve an improvement in financial accountability:

- calculation of unit costs;
- development of a SLA for in-house services;
- costing of services into care packages;
- internal trading of services; and
- exposure of services to competition.

165. Most fieldwork authorities had not moved beyond costing all services in care packages [EXHIBIT 27].
Some authorities have used voluntary competitive tendering to market test services such as home care. Such an approach has advantages in terms of reducing the management costs of the exercise and realising revenue benefits sooner, although care is needed to ensure specifications and costings are robust and that block contracts do not suffer from the problems described in Section 4. More incremental approaches are possible, such as that taken by Kensington and Chelsea for their home care service (see Case Study 12).

Improving the financial accountability of in-house services requires a detailed and accurate knowledge of the costs of services. All authorities with Part III residential homes should have undertaken some calculation of unit costs to determine their standard charge for other local authorities’ and residents’ contributions. However, the robustness of the methodology for calculating these charges, and unit costs more generally, is variable.

Budget reporting structures tend to make direct cost information readily accessible. However, some authorities are still having difficulties in calculating appropriate capital charges and in applying CIPFA classifications (Ref. 16) to help determine appropriate allocations of management and support services costs.
Budget devolvement brings with it new responsibilities for staff

169. Unit costs should be based on the full costs of providing services and therefore include the full value of capital charges and management and support services costs. The sophistication of apportionment frameworks to determine costs is a matter for local discretion. Clearly, the more relevant the apportionment bases used and the more accurate the information, the greater the likelihood that budget holders will be able to scrutinise and manage overhead costs effectively. If these data are missing authorities should not use them as an excuse not to calculate unit costs. Evidence from the data on residential care costs collected by District Audit showed that management and support services only accounted for approximately 6 per cent of total costs, and capital charges 9 per cent (see Appendix). Initial calculations using available data and based on reasonable assumptions are unlikely to materially affect final unit costs.

170. Unit costs should be calculated for all in-house services. From an accounting perspective difficulties can be created by the organisation of services: for example the trend towards ‘resource centres’ where several services are based at one site. In developing reasonable unit costs none of these problems should be insurmountable. Assumptions about care workers time and the use of accommodation can be made at a local level to provide valid unit costing data.

Support for budget holders

171. Budget devolvement brings with it new responsibilities for staff. Adequate support is needed from finance professionals, especially in the initial stages, to ensure that the transition works smoothly. Good information systems, training and advice are essential.

172. Having a system which can forecast the full year implications of making a commitment to fund an individual’s care is an essential tool in managing social care resources. Many authorities are still using the systems they established in April 1993 with little further development in sophistication. Typically these are stand-alone spreadsheet systems, maintained centrally and run in parallel to an authority’s main accounting system, often relying on invoices to register commitments.

173. Such systems have considerable drawbacks:

- information is often out of date by the time it is reported, and prone to inaccuracies;
- they tend to be cumbersome, and often reliant on manual checks at a team level to check the validity of information;
- their problems encourage budget holders to develop local budget monitoring systems which are themselves a wasteful duplication and increase the potential for invalidating the accuracy of central systems; and
- they are poor at providing anything other than a broad impression of whether the department as a whole is overspending or not.
174. Authorities should now be improving their commitments systems, starting to integrate them with client databases, and where practical devolving them to local teams rather than maintaining input of data centrally.

175. Some authorities have used models to improve their budget profiling; for example Kent has used its analysis of length-of-stay data to start to build up an idea of turnover rates (Section 1, Case Study 2) and can use these data to build up a more detailed analysis of future financial commitments. Other budget monitoring analyses can be built around the '78' model, which profiles the budget into 78 periods – 66 full months and 12 half months [EXHIBIT 28]. In its basic form this model is simplistic assuming an even take-up of services with no turnover. The addition of informed assumptions about length of stay and seasonal fluctuations in placement patterns are needed to make it more realistic.

176. Good budget management requires more than just data on financial spend. Activity data are essential in helping budget holders really understand and take control of their budgets. At the very least budget monitoring data needs to be supported by information on changes in the number of service users, analysed by service type, provider and cost of package.

EXHIBIT 28
The '78' model
Authority A has a £7.2 million budget for nursing care beds. By using the '78' model the budget profile can be determined.
There is much authorities can do to make financial administration meet the needs of providers

177. Even with well-developed budget monitoring systems budget holders will need support. Help will be required to collate information, deal with queries, respond to ad-hoc requests and supervise and help with further development of systems and processes at a local level. Some authorities have developed budget support officer roles to meet this need. In one fieldwork authority this was done as a short-term step to help budget holders adjust to the new system. In another authority financial staff were actually based with the care management team. It was noticeable that where authorities had made local support available, budget holders felt more confident in managing their financial management role.

Improving payment processes

178. Providers rely heavily on purchasers to process invoices and arrange payment as efficiently and quickly as possible (see Section 4). Inefficiencies are eventually passed on to users in the form of poorer quality services, as providers are unable to pay staff or the business closes, or in the form of higher prices to purchasers to cover the costs of increases in providers’ short-term borrowing. Joint research by the Audit Commission and the Association of Financial Assessment Officers (AFAO) indicated that many authorities were still operating bureaucratic procedures; for example:

- only 19 per cent of the authorities who responded had proforma invoices which providers could use;
- 48 per cent of authorities paid all providers by cheque; and
- the number of payments made to home care providers varies widely but averaged 250 per provider (or 15,000 per authority in one year).

179. There is clear potential for more efficient processing; for example one authority had worked with a major home care provider to streamline invoices through standardising. It now processes a single invoice, where previously it processed 100. Transaction processing time in the finance section has dropped from three days to three hours.

180. Another authority had reached agreement with its providers to pay all pro forma home care invoices within 28 days. Other invoices which did not have the necessary data recorded were taking up to 48 days to process at the time of the fieldwork visit.

181. A likely driver of potential high transaction costs are inefficient purchasing arrangements. The heavy reliance on spot contracts, with invoices paid to providers on a weekly basis is likely to cause an administrative burden. There is much authorities can do to make financial administration meet the needs of providers [BOXH].
5.3 Information strategy and systems

Information is the life-blood of the commissioning process. Without timely and accurate information managers will risk taking uninformed decisions and the authority will risk overspending and achieving poor value for money. Much of the management information an authority needs it may well already have. However, this information is likely to be located in a number of different systems and areas, for example:

- in-house provider time recording systems (home care contact hours);
- commitments monitoring systems (expenditure data);
- financial assessment and home care charging systems (number of service users);
- client database (assessment and care plan details); and
- planning and contracts (provider information).

KEY QUESTIONS

Is our financial accounting structure shifting to meet the needs of commissioning?

Are our budget monitoring systems providing information that is accurate and timely enough?

Can we make our financial administration procedures responsive to the needs of providers and improve their efficiency?

BOX H

Improving financial administration processes to meet the needs of commissioning

- Ensure providers have accurate and up-to-date information on financial administration procedures and processes and know who to contact with queries.
- Ensure providers are clear about the minimum data set required to process invoices and use pro forma invoices to help reduce processing time.
- Reduce the number of cheque payments required by paying established providers by standing order (or direct debit if feasible).
- Devolve processing of payments to local teams or areas.
- Ensure authorisation procedures are streamlined, for example the appropriate budget holders are easily identifiable, and authorised signatories lists are discrete and complete.
- Give incentives to providers to improve and adjust their invoicing procedures, for example by guaranteeing payment times.
183. Authorities need to think about how they can best use these data. An information strategy is needed to address:

- how to make the most of the data currently available;
- what gaps exist;
- how these might be addressed;
- how duplication and errors in the data can be avoided; and
- ways of ensuring core data can be reconciled in each system.

184. Some authorities have reviewed the information they need to support commissioning in the way they have developed their information strategy and systems [CASE STUDY 17].

**CASE STUDY 17**

Cheshire’s information strategy

Cheshire Social Services Department has developed its management information systems to produce centrally, information for commissioners and providers which brings together key dimensions of:

- units of service activity;
- cost; and
- dependency levels (case-mix).

Providers complete a core document called a service return which provides all the basic information, such as cost and activity data. Costs are allocated for in-house providers based on central calculations. Dependency levels are attributed to clients from 1 to 5, with an ‘unknown’ category for lower levels. Levels 4 and 5 require nursing home care. The information outputs are mapped as follows:
Reports are generated on either a routine basis for provider forums, the senior management team and the Social Services Committee – or as one-off queries.

Each local purchaser team is given a monthly management information report by service type (for example a sheet for home care and residential care, and a sheet for ‘packages’ of services), which shows them monthly trends over the last year of activity and cost and sector of provider. It also shows in detail the last month’s performance in terms of activity, cost and dependency levels.

A central support team responds to other requests on a one-off basis. Such one-off reports have included:

- a report for senior management on the number of packages costing more than £500 – which localities they were in, which client groups and which providers; and
- a report on home care requests based on one month’s tracking of specific activities, including source of referral, size of package, period of notice given to providers and variations between localities.

Another feature of the strategy is the production of reports for provider forums, for example tracking hours purchased and the total value purchased from the independent sector by area and dependency level over time. The Social Services Committee is also provided with information on length of stay in residential settings.

Recent developments
As the number of records on the system has increased, so the confidence in some of the trends has increased (such as the data on length of stay). Also the availability of Department of Health data on disk has enabled the Authority to make greater use of comparative information to monitor its position in relation to other authorities.

At the start of this process Cheshire found that staff had mixed attitudes on the usefulness of the information provided. The performance management team has worked with staff to try alternative formats of presentation to overcome this. It has also held workshops for staff to discuss use of the data.

Cheshire is now looking to focus more on the qualitative side, on how users progress through their care ‘career’ and the outcomes of different care options on different clients.

KEY QUESTIONS
Are we confident that we know about all the information we have available from within the Authority to help our commissioning?
5.4 Managing the market

185. While Section 3 stressed the importance of the role of care managers in commissioning services that are tailored to individuals' needs, there will always be a role for the department centrally in managing the market at an authority wide level.

186. Some authorities have taken a hands-off approach to this role, not intervening actively in the market much beyond operating an accreditation scheme for home care providers or setting prices according to former Department of Social Security rates. Such an approach misses an opportunity to use the commissioning role of social services departments to improve the efficiency and effectiveness of service delivery and ultimately the quality of services for its users.

Taking a more proactive approach

187. A number of authorities are now taking a proactive approach to commissioning and trying to 'manage the market' for care services. Birmingham is using a pricing strategy for residential care which makes a stronger link between price and quality in the residential care market [CASE STUDY 18]. Southwark, on the other hand, has used innovative contracting approaches to try to develop voluntary sector home care providers [CASE STUDY 19, overleaf]. These examples may not suit the local circumstances of other authorities. However, after four years of the community care reforms all authorities should now be starting to use commissioning to improve the value for money they get, and developing services that are tailored to the needs of users and carers.

CASE STUDY 18
Using pricing to improve quality in the residential care market

Birmingham Social Services Department has contracts with 249 homes for older people within the city and a further 429 outside the city. It conducted a full competitive tendering exercise in 1993. After the first year of contracting the council noted that the prices charged by homes varied by over £40 per resident per week. This prompted the question 'what are we getting for our money in the higher priced homes?' and committed it to developing a system that related the price paid to the standard of service delivered. This approach also avoids the risks of using price as the only determinant of a tender. Following extensive negotiations with the independent sector the council agreed an approach that linked price to the standards of care delivered.

Higher and standard band homes, defined by the percentage of care staff with NVQ level 2 training qualifications and the number of care hours on duty per resident per week, were introduced in 1994. The Department also defined threshold values, and homes that could meet the higher standards could justify charging a higher tender price. Evidence of admission and occupancy rates showed that service users preferred higher band homes.
In 1996 the Department faced budget reductions, which forced it to cut the price paid for residential and nursing care. In a desire to maintain quality, it developed a ‘star rating’ system and added a third standard:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Nursing homes</th>
<th>Residential homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care hours star</td>
<td>&gt; 29 hours on duty per resident per week</td>
<td>&gt; 19 hours</td>
</tr>
<tr>
<td>2. NVQ level 2 star</td>
<td>&gt; 50 per cent care staff trained or in training</td>
<td>&gt; 35 per cent care staff trained or in training</td>
</tr>
<tr>
<td>3. Quality assurance star</td>
<td>Meets Department’s detailed spec, independently verified</td>
<td>As for residential care</td>
</tr>
</tbody>
</table>

All three stars are optional, and for each a higher tender price can be accepted. However, competition means that some three-star homes charge a lower price than some one-star homes. To stimulate the competition, homes are published in all lists in rank order, first by the number of stars, then by price, then by the amount of extra ‘top-up’ fees charged to the resident. This produces a ‘best value’ ranking that encourages homes to try to get to the top by offering higher quality at lower prices. The Department’s own homes are included in the star rating exercise, but not the tender. A designated compliance officer manages the system through quarterly returns that are signed by individual staff. Failure to comply leads to price reductions and loss of the star rating. A contract with an accrediting organisation ensures independent verification that the quality assurance (QA) system meets the Department’s specification.

The project evolved over two years, but the star rating-system was developed in one year by the contracts officer with IT experience. One full-time post manages the compliance issues, with the external contract for QA verification costing £30,000 a year. The impact on NVQ take-up has been dramatic, seeing a 400 per cent increase. Care hours on duty have increased from 13 to 16 hours per resident. Service users continue to show a preference for higher star rated homes, with three-star rating homes nearly twice as popular as zero-star homes. Combined with the tendering exercise, the Department has actually saved £0.6 million in the first year.
CASE STUDY 19

Developing home care providers – encouraging voluntary sector providers

Southwark Social Services Department was keen to attract new home care providers to meet its priorities in developing community and domiciliary support. One potential source was the voluntary sector organisations that existed in the Borough. However, the Authority recognised that the voluntary sector faced a number of difficulties in developing home care services:

- although the voluntary sector had specialist knowledge of different client groups it had little experience of providing home care;
- it had limited ability to borrow money in order to develop services;
- the lack of certainty over the likely level of income and the cashflow problems associated with the authority's payments processes made home care an unattractive option; and
- the small size of most organisations meant that few had the necessary skills to compete for large volumes of work by themselves.

To deal with these problems Southwark in partnership with Southwark Community Care Forum (a local voluntary sector umbrella group) established an organisation called the Federation of Voluntary Sector Providers Limited. The start-up costs amounted to just over £100,000, divided between the Federation and support to the organisations themselves. Any voluntary sector organisation can apply to join. Only organisations which meet the standards in the Department’s service specification for domiciliary care can provide services. The Authority contracts with the Federation which in turn contracts with the voluntary organisations. In 1995/96 the Federation had six full members. These were block contracted to provide 73,500 hours in 1995/96. This increased to 85,000 in 1996/97 with further increases planned in 1997/98.

The Federation provides:

- central training, quality assurance and monitoring processes to members;
- a 7-days-a-week referral agency and 24-hour emergency contact point for care staff; and
- an access point for new small voluntary organisations to enter the home care market.
CASE STUDY 19 (continued)

The Authority has gained a number benefits:

- The quality of provision has improved by being able to provide a high level of management input into supervision and training, combined with the specialist skills for each client group.
- The Federation acts as a single information point for care managers on the services available from member organisations.
- Choice has improved by enabling service users to choose between providers once a referral to the Federation has been made.
- The Federation provides another option for clients to make complaints. This can be especially important if a person is concerned that a complaint to the provider organisation or the Social Services Department will lead to the service being withdrawn.
- The Authority is able to provide services to people with more complex needs and higher levels of dependency due to the investment made in training and the specialist services offered.
- Transactions costs of contracting have been cut through the reduced finance and monitoring costs of having a single contract.

The investment made in the Federation and voluntary sector providers has resulted in the unit costs of the service being higher than the prices paid for private sector home care. However, this is less than the unit cost of the Authority’s in-house service.

KEY QUESTIONS

Are we managing the market to meet our objectives or is the market managing us?
Supporting the Process Centrally

<table>
<thead>
<tr>
<th>Aspect of performance</th>
<th>Good practice features</th>
<th>Current practice</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing commissioning skills</td>
<td>• a skills audit is undertaken to assess the skills required and available</td>
<td></td>
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<tr>
<td></td>
<td>• monitoring is undertaken of the number of staff involved in commissioning and comparisons made with other similar authorities</td>
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<tr>
<td>Financial support systems</td>
<td>• accurate up-to-date unit cost data available and disseminated to front-line staff</td>
<td></td>
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<td></td>
<td>• accurate and timely monitoring data are available to budget holders</td>
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<tr>
<td></td>
<td>• key activity as well as financial data are provided to budget holders</td>
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<tr>
<td></td>
<td>• payments processes reviewed to assess the extent to which they meet providers' needs</td>
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<tr>
<td>Information strategy and systems</td>
<td>• an information strategy has been developed which outlines information needs, current sources, gaps and developments</td>
<td></td>
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</tr>
<tr>
<td>Market regulation and management</td>
<td>• a proactive approach is taken through pricing and contracting processes to manage the market to deliver commissioning objectives</td>
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</tbody>
</table>
Bringing it All Together (Action Plan)

The final challenge is to bring it all together, using an Action Plan to establish targets and facilitate the monitoring of the progress made in implementing changes.
188. Sections 1 to 5 of this handbook have set out a framework for authorities to improve their commissioning arrangements. The final challenge is to bring this together and establish a plan for implementing change. Most authorities have already started on some of these areas and a number are well advanced. The following Action Plan brings together the checklists at the end of each individual section and attempts to set these in the context of priorities and responsibilities. To help assess progress the Plan contains a set of potential performance indicators for managers.

189. The content of the Plan is only a suggestion. Local circumstances will be different and may require an alternative approach. Similarly, meeting some of the objectives will require more effort and time to implement than others. Authorities should ideally draw up their own Action Plan with a timetable for implementation which reflects their priorities, perhaps sharing this with their auditors to help act as a check on the progress made.
### Action plan for commissioning

<table>
<thead>
<tr>
<th>Action</th>
<th>Officer responsibility</th>
<th>Priority</th>
<th>Performance indicators for management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1: Reviewing the market and developing a strategy</strong></td>
<td></td>
<td></td>
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<tr>
<td>Mapping local needs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• profiling current service users</td>
<td>Finance</td>
<td>M</td>
<td>Data available on:</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td></td>
<td>• number/age/sex/ethnic profile of users and population</td>
</tr>
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<td></td>
<td>Contracts</td>
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<td></td>
<td>Inspection</td>
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<td></td>
<td>Care Mgt</td>
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<td>Providers</td>
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<td></td>
<td></td>
<td></td>
<td>• pattern of referrals</td>
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<td>• length of stay in different services</td>
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<tr>
<td>Supply mapping:</td>
<td></td>
<td>M</td>
<td>Data available on:</td>
</tr>
<tr>
<td>• compiling data on location and quality of providers and local market structure</td>
<td>Finance</td>
<td>M</td>
<td>• geographic coverage of provision</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td></td>
<td>• training and skills and wages of care staff</td>
</tr>
<tr>
<td></td>
<td>Contracts</td>
<td></td>
<td>• surplus capacity, number of new providers' exits</td>
</tr>
<tr>
<td></td>
<td>Inspection</td>
<td></td>
<td>• comparisons with other authorities</td>
</tr>
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<td></td>
<td>Care Mgt</td>
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<td>Providers</td>
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<td></td>
</tr>
<tr>
<td>Understanding market power:</td>
<td></td>
<td>M</td>
<td>Data available on:</td>
</tr>
<tr>
<td>• reviewing market share and funding sources</td>
<td>Finance</td>
<td>M</td>
<td>• market share in different service areas</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
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<td></td>
<td>Contracts</td>
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<td>Care Mgt</td>
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<td>Providers</td>
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<td></td>
</tr>
<tr>
<td>Understanding current resource allocation and purchasing arrangements:</td>
<td></td>
<td>M</td>
<td>Data available on:</td>
</tr>
<tr>
<td>• analysis of distribution of resources</td>
<td>Finance</td>
<td>M</td>
<td>• spend against SSA for different client groups</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td></td>
<td>• spend by different contract type</td>
</tr>
<tr>
<td></td>
<td>Contracts</td>
<td></td>
<td>• concentration of supply</td>
</tr>
<tr>
<td></td>
<td>Inspection</td>
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<td></td>
<td>Care Mgt</td>
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<td>Providers</td>
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<tr>
<td>Action</td>
<td>Officer responsibility</td>
<td>Priority</td>
<td>Performance indicators for management</td>
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</tr>
<tr>
<td>Section 1: Reviewing the market and developing a strategy (continued)</td>
<td></td>
<td>H</td>
<td></td>
</tr>
<tr>
<td>Developing an informed strategy:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• matching priorities to supply, demand and resource analysis</td>
<td>Finance</td>
<td></td>
<td>A formal commissioning strategy</td>
</tr>
<tr>
<td>• setting objectives and establishing targets</td>
<td>Planning</td>
<td></td>
<td>consulted and agreed with key</td>
</tr>
<tr>
<td>• producing a strategy agreed by all key participants</td>
<td>Contracts</td>
<td></td>
<td>participants</td>
</tr>
<tr>
<td>Planning for decommissioning:</td>
<td></td>
<td>H</td>
<td></td>
</tr>
<tr>
<td>• the development of exit strategies for services which are the least</td>
<td></td>
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<tr>
<td>efficient and effective in meeting needs</td>
<td>Inspections</td>
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<td></td>
<td>Care Mgt</td>
<td></td>
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<td></td>
<td>Providers</td>
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</tbody>
</table>

Financial projections modelled for the next three years
Policy statement identifying areas of service to be reduced
– agreed by members and discussed with providers and user groups
<table>
<thead>
<tr>
<th>Action</th>
<th>Officer responsibility</th>
<th>Priority</th>
<th>Performance indicators for management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2: Making commissioning user-led</td>
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<tr>
<td>Helping users understand the process:</td>
<td></td>
<td></td>
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<tr>
<td>• ensuring users receive copies of assessments and care plans</td>
<td>Finance</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>• supporting users in controlling their care:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• setting up direct payments schemes</td>
<td>Planning</td>
<td></td>
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<tr>
<td>• improving access to advocacy</td>
<td>Contracts</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Being responsive when things go wrong:</td>
<td></td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>• reviewing responsiveness of complaints procedures</td>
<td>Inspection</td>
<td></td>
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<tr>
<td>Providing information on services:</td>
<td></td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>• improving information for users in the care homes directory</td>
<td>Care Mgt.</td>
<td></td>
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<tr>
<td>• making better use of inspection reports</td>
<td>Providers</td>
<td></td>
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<tr>
<td>Helping ensure users receive a choice:</td>
<td></td>
<td></td>
<td>M</td>
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<tr>
<td>• recording choices made and reasons for choice</td>
<td></td>
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<tr>
<td>Promoting choice through contracting:</td>
<td></td>
<td></td>
<td>L</td>
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<tr>
<td>• reducing artificial boundaries to choice in respite care</td>
<td></td>
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<tr>
<td>Making users’ views really count:</td>
<td></td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>• undertaking regular user surveys and establish specific user forums for each client group</td>
<td></td>
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<tr>
<td>Action</td>
<td>Officer responsibility</td>
<td>Priority</td>
<td>Performance indicators for management</td>
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<tr>
<td><strong>Section 3: Enabling care managers to play a more effective commissioning role</strong></td>
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<tr>
<td>Developing flexible services:</td>
<td>Finance</td>
<td>Planning</td>
<td>Contracts</td>
</tr>
<tr>
<td>• renegotiating staff contracts to enable providers to deliver intensive care packages</td>
<td>•</td>
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<tr>
<td>Establishing a single purchasing framework:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• all services properly costed for financial limit purposes</td>
<td>Finance</td>
<td>Planning</td>
<td>Contracts</td>
</tr>
<tr>
<td>Effective organisation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• analysis of workload and activity of care managers</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Giving enough priority to reviewing needs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• review existing home care packages to ensure they are still appropriate to needs</td>
<td></td>
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<tr>
<td>Organising budget holders:</td>
<td></td>
<td></td>
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<tr>
<td>• review budget structures to achieve a better alignment of financial and managerial responsibility</td>
<td></td>
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<tr>
<td>Action</td>
<td>Officer responsibility</td>
<td>Priority</td>
<td>Performance indicators for management</td>
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</tr>
<tr>
<td><strong>Section 4: Getting a better service from providers</strong></td>
<td>Finance Planning</td>
<td></td>
<td>* A comprehensive service level agreement (SLA) for in-house services</td>
</tr>
<tr>
<td>A clear role for in-house services:</td>
<td>Planning Contracts</td>
<td></td>
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<tr>
<td>• specifying the role of in-house services</td>
<td>Inspection Care Mgt</td>
<td></td>
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<tr>
<td><strong>Fair and open contracting:</strong></td>
<td></td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Ensure contract processes:</td>
<td></td>
<td></td>
<td>Results of provider feedback</td>
</tr>
<tr>
<td>• are sufficient to safeguard the authority’s and users’ interests</td>
<td></td>
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<tr>
<td>• do not require information that is not used</td>
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<tr>
<td>• are as consistent as possible with other purchasers’ procedures</td>
<td></td>
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<tr>
<td>• make use of front-line feedback</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• offer sufficient incentives to providers</td>
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<td></td>
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</tr>
<tr>
<td><strong>Developing better contracts:</strong></td>
<td></td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>• increasing the range of different types of contracts used</td>
<td></td>
<td></td>
<td>Proportion of expenditure by service and contract type</td>
</tr>
<tr>
<td><strong>Specifying quality in contracts:</strong></td>
<td></td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>• develop measurable indicators on which to monitor quality</td>
<td></td>
<td></td>
<td>Data available on:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>reliability and continuity of home care workers</td>
</tr>
<tr>
<td>Action</td>
<td>Officer responsibility</td>
<td>Priority</td>
<td>Performance indicators for management</td>
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<tr>
<td>Section 4: Getting a better service from providers (continued)</td>
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<tr>
<td>Contract monitoring and compliance:</td>
<td>Finance</td>
<td>Planning</td>
<td>Contracts</td>
</tr>
<tr>
<td>• co-ordinate the roles and responsibilities of those involved in monitoring</td>
<td>•</td>
<td>•</td>
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<tr>
<td>• ensure standards are applicable to all providers to allow comparability</td>
<td></td>
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<td>•</td>
</tr>
<tr>
<td>Communicating with providers:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• canvass views of providers on commissioning issues</td>
<td></td>
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</tbody>
</table>

Results of user survey on provider performance

Comparative data on performance of all providers produced for care managers

Results of provider surveys
### Section 5: Supporting the process centrally

<table>
<thead>
<tr>
<th>Action</th>
<th>Officer responsibility</th>
<th>Priority</th>
<th>Performance indicators for management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing commissioning skills:</td>
<td></td>
<td>High (H)</td>
<td>Number of staff with purchasing/business management qualifications</td>
</tr>
<tr>
<td>- ensure sufficient skills are available</td>
<td>Finance</td>
<td>Medium (M)</td>
<td>Comparable number of contracts staff per £ expenditure with other local authorities.</td>
</tr>
<tr>
<td>- ensure staff numbers are appropriate</td>
<td>Planning</td>
<td>Low (L)</td>
<td></td>
</tr>
<tr>
<td>Financial support systems:</td>
<td>Contracts</td>
<td></td>
<td></td>
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<tr>
<td>- calculate accurate unit costs</td>
<td>Inspection</td>
<td></td>
<td></td>
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<tr>
<td>- improve timeliness and accuracy of budget monitoring data</td>
<td>Care Mgt</td>
<td></td>
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<tr>
<td>- provide activity as well as financial data</td>
<td>Providers</td>
<td></td>
<td></td>
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<tr>
<td>- make payments process responsive to provider needs</td>
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<td></td>
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<tr>
<td>Information strategy and systems:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- develop list of information needs, current information sources and information gaps</td>
<td></td>
<td></td>
<td>Formal information strategy</td>
</tr>
<tr>
<td>Regulation and market management:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- develop proactive approach to managing the market to deliver commissioning objectives</td>
<td></td>
<td>Low (L)</td>
<td>Specific initiatives established to achieve objectives specified in the commissioning strategy</td>
</tr>
</tbody>
</table>
District Audit has undertaken work looking at the financial management of local authorities' Part III residential homes. As part of this work it sent out a questionnaire to all authorities requesting information on the costs of Part III residential accommodation. The following cost trees have been compiled using these data.

The cost trees are intended to provide a simple benchmark for reviewing the components of costs and in particular the major element – pay. Authorities may find it useful to examine their own costs using such a format and compare this against the relevant cost tree. A District Audit audit guide has been developed to allow authorities to review both costs and the factors that influence them, such as overtime and sickness absence, in more detail. This product is available to all authorities through their local external audit team.

Assumptions
Total gross annual cost per place has been calculated using occupancy data provided by authorities in the RAC5 Department of Health return. An adjustment was also made to account for the cost of daycare provided at residential homes. Based on a regression analysis of costs an additional residential place was added to the occupancy figure for every ten daycare places provided.
Local authority Part III residential accommodation

All authorities

- Total annual cost per occupied place: £14,637
- Pay cost: £10,053
  - Managers: £2,178
    - Number of staff (wte): 0.0967
    - Pay per staff member: £22,522
  - Care assistants: £5,436
    - Number of staff (wte): 0.3876
    - Pay per staff member: £14,025
  - Agency/others: £2,439
    - Number of staff (wte): 0.21
    - Pay per staff member: £11,614
- Non-pay cost: £4,584
- Supplies and services: £1,166
- Transport: £97
- Premises: £1,088
- Capital charges: £946
- Overheads: £1,287

Sample: 547 residential homes
Local authority Part III residential accommodation
County Councils

Total annual cost per occupied place
£13,729

Pay cost
£9,576

Managers
£2,117
Number of staff (wte)
0.0899
Pay per staff member
£23,551

Care assistants
£5,120
Number of staff (wte)
0.3591
Pay per staff member
£14,256

Agency/others
£2,339
Number of staff (wte)
0.2147
Pay per staff member
£10,893

Supplies and services
£1,082

Transport
£85

Non-pay cost
£4,153

Premises
£1,068

Capital charges
£843

Overheads
£1,075

Sample: 333 residential homes
Local authority Part III residential accommodation
Metropolitan Borough Councils

Sample: 180 residential homes
Local authority Part III residential accommodation
London Boroughs

Sample: 16 residential homes
Local authority Part III residential accommodation

Unitaries

Sample: 18 residential homes
References


5. R Warburton, *Home and Away – a review of recent research evidence to explain why some elderly people enter residential care homes while others stay at home*, Department of Health, 1994


Glossary

Assessment
The process of defining an individual's needs and determining eligibility for assistance against stated criteria.

Care package
A combination of services designed to meet a person's assessed needs.

Carer
A person, usually a relative or friend, who provides care on a voluntary basis in excess of that implicit in relationships between family members.

Care management
The process of co-ordinating, managing and reviewing the care of an individual to ensure that it meets that individual's assessed needs.

Care manager
A practitioner who as part of their role undertakes care management.

Commissioning
The process of specifying, securing and monitoring services to meet individuals' needs. Commissioning is more commonly used to describe the strategic, long-term process by which this takes place as opposed to the short-term, operational, purchasing process.

Commissioning framework
The organisation of the commissioning process.

Decommissioning
The process of planning and managing a reduction in service activity in line with commissioning objectives.

Direction on Choice
A Statutory Direction which places a duty on local authorities to arrange places for people in the home of their choice subject to certain conditions, principally cost and compliance with the authority's usual terms and conditions.

Independent sector
Privately owned and voluntary not-for-profit organisations.

Internal trading system
A system in which budgets for in-house services are transferred to purchaser budget holders – preferably either care managers or team managers – a cost is calculated for units of service from in-house providers and an appropriate charge is made to budget holders when they choose to use these services.

Managing the market
Using contracting and other processes to influence the supply of services to achieve commissioning strategy objectives.

Mapping the market
The process of identifying and analysing the factors influencing the existing and likely future demand for and supply of care services to inform commissioning plans.

Northwest Business Management Working Group (NWBMWG)
A group composed of local authorities and health authorities in the North West who have been undertaking regular surveys of the effects of community care on the residential and nursing home market in the region.
<table>
<thead>
<tr>
<th>Providers</th>
<th>Organisations, or designated parts of organisations which provide community care services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSSRU</td>
<td>Personal Social Services Research Unit based at the University of Kent and the London School of Economics.</td>
</tr>
<tr>
<td>Service Level Agreement (SLA)</td>
<td>A written specification usually for in-house services, agreed by the purchaser, preferably the head of care management and the provider. The specification should outline in detail what the service is, its cost, the volume purchased and quality standards.</td>
</tr>
<tr>
<td>Single purchasing framework</td>
<td>A purchasing system in which the unit costs and prices of all providers and services are explicitly specified and taken into account in determining the total cost of care packages.</td>
</tr>
<tr>
<td>Users</td>
<td>Individuals who use care services.</td>
</tr>
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The Audit Commission has produced a number of studies covering issues related to personal social services and community healthcare. The following may be of interest to readers of this report:

**The Coming of Age**
Improving Care Services for Older People

**Balancing the Care Equation**
Progress with Community Care
Bulletin, 1996, 40 pages, 0118864319, £8

**Misspent Youth**
Young People and Crime
Summary, 1996, 36 pages, 1862400067, £8

**Finding a Place**
A Review of Mental Health Services for Adults
National Report, 1994, 96 pages, 0118861433, £11
Executive Summary, 1994, 20 pages, 0118861441, £6

**Taking Stock**
Progress with Community Care
Bulletin, 1994, 28 pages, 0118861360, £6

**Taking Care**
Progress with Care in the Community
Bulletin, 1993, 16 pages, 0118861204, £6

**Seen But Not Heard**
Co-ordinating Community Child Health and Social Services for Children in Need
National Report, 1994, 98 pages, 0118861131, £11
Executive Summary, 1994, 94 pages, 0118861255, £7.50

**Community Care**
Managing the Cascade of Change
National Report, 1992, 48 pages, 0118864864, £8.50

**Community Revolution**
Personal Social Services and Community Care
National Report, 1992, 72 pages, 0118860917, £9.50

**Developing Community Care for Adults with a Mental Handicap**
Occasional Paper, 1989, 19 pages, 0117014532, £4.25

**Making a Reality of Community Care**
National Report, 1986, 0117013234, 132 pages, £9.60

**Joint Reviews of Social Services**
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The commissioning role of social services departments has increased in line with their greater responsibilities and resources under the recent community care reforms. Most authorities adopted a cautious approach in the early stages of the reforms. However, social services departments now need to develop their commissioning approaches to be able to meet the current and future needs of users and carers efficiently and effectively. With pressure on resources, this is not an easy challenge to meet.

This management handbook aims to help authorities to improve their commissioning, taking up the issues raised in the recent Audit Commission national report, *The Coming of Age: Improving Care Services for Older People*. It is intended primarily for the lead officer for community care and officers responsible for contracting and commissioning.

The handbook sets out a framework to help authorities to review their own arrangements, drawing on case study examples to illustrate how some authorities have approached the issues raised. Key areas that are addressed include:

- mapping the market and developing a strategy;
- making commissioning more user-led;
- enabling care managers to play a more effective commissioning role;
- getting the most from providers; and
- supporting the process centrally.