PSSRU

Recruitment and Retention of a Social Care Workforce for Older People

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RECRUITMENT AND RETENTION OF A SOCIAL CARE WORKFORCE FOR OLDER PEOPLE

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PREFACE

The reforms necessary to make a reality of the goal of the personalisation of social care require major changes in the nature of provision and the capacity of the workforce within older people's services. One of the requirements to achieve this is a greater understanding of the factors which influence the ability of the workforce to deliver high quality services. This requires increased knowledge of commissioning and contracting arrangements within local authorities and, associated with this, the factors which influence the recruitment and retention of staff employed in the domiciliary care and care home sectors.

In this report, findings from the first of a three phase research project: *Recruitment and Retention of a Care Workforce for Older People* are described. Findings from a national survey of commissioning, contracting and care management arrangements are reported and from this a typology is constructed to inform the selection of sites for phases II and III of the study. These will be reported separately by colleagues in the European Work and Employment Research Centre also at the University of Manchester.

In the early stages of the study we consulted with Louise Sutton and Mike Wyatt, senior local authority managers, from Wigan and St Helens respectively. Additionally, the advisory board for the research project, involving lay persons, assisted in the interpretation of the findings from the questionnaire. At the PSSRU Helen Chester and Jane Hughes were primarily responsible for the compilation of the report. In addition, Irene Pedersen helped to ensure the good response rate, Linda Gordon contributed to the data preparation process and Sue Martin assisted with data entry and helped to prepare the manuscript.

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EXECUTIVE SUMMARY

This report presents the findings from research undertaken by the Personal Social Services Research Unit (PSSRU) at the University of Manchester. It is the first part of a three-phase study entitled *Recruitment and Retention of a Social Care Workforce for Older People*. This study sought to identify factors within local authority commissioning, contracting, and care management arrangements which influence the recruitment and retention of staff in domiciliary care services and care homes. These factors are likely to affect the quality of care received by older people. They are also integral to the changes required to achieve the goal of more personalised care within the wider policy agenda to transform adult social care services.

The increased use of independent sector care provision has placed an emphasis on local authority commissioning and contracting arrangements as a means to influence human resource policies in provider organisations. Additionally, the requirement to develop more personalised care with its emphasis on older people and their families assuming greater responsibility for arranging services, heralds changes within care management arrangements and the nature of service provision.

Data was collected from local authorities with responsibility for social services through a postal survey distributed in 2008. It comprised questions relating to the commissioning and contracting arrangements for domiciliary care and care home provision and care management (care coordination) arrangements for older people. Ninety two of a total of 149 local authorities returned completed questionnaires, a response rate of 62 per cent. The findings have been utilised in two ways: to describe current arrangements and provide the basis for the systematic selection of sites for the remainder of the study.

Current arrangements and a personalised social care system

There was evidence to suggest that workforce issues were taken into account in service commissioning, particularly in relation to training. Increased emphasis on joint commissioning with health colleagues was another noticeable feature, with likely implications for the workforce in terms of conditions of service. In terms of contracting, with regard to the independent sector in particular, the data suggested that attention was paid to content and monitoring. Human resource policies were an important component of this, and therefore provide a means of monitoring the impact on the workforce of changes in the content and range of services consequent on the requirement for greater flexibility in provision. Whilst block contracted services, particularly with regard to domiciliary care, provide stability for the agency with obvious implications for conditions of staff service, the new vision for social care requires greater flexibility and therefore potentially less stability in provider organisations which will impact on conditions of service for staff. Changes are also anticipated in the manner in which arrangements for care are made, with this task being undertaken by service users and their families, as well as care managers. The implications of this for both agencies and their staff, in terms of expectations, are as yet unknown.

Overall, therefore, in the light of recently established targets for the transformation of social care, the present study suggests that there is considerable scope for change and development with regard to commissioning arrangements, contracting processes and care management arrangements with consequent implications for the workforce. This study provides a significant baseline, or template, against which the achievements of the personalisation agenda in terms of commissioning and contracting arrangements and the consequent implications for the workforce may be measured in the future.

Selection of sites for phase II

Arrangements expected to influence the recruitment and retention of the workforce in domiciliary care agencies and care homes in the national survey were investigated. Fourteen questions describing variations in arrangements for both domiciliary care and care home provision and care management arrangements were selected to create indicators. These were assigned to three domains of interest: commissioning and contracting arrangements; employment practices; and flexibility in service provision at the level of the service user. Seven types of local authority were identified and were found to vary in the level of activity in each domain of interest.

This typology, summarised below, suggests that local authorities in type 7 were seeking to develop their commissioning activities, particularly in partnership with health, and the processes associated with contracting; sought to reflect employment practices in this context; and were striving to promote flexibility in service provision. Conversely, the opposite appears to be the case in type 4 authorities. The remaining two thirds of the sample displayed varying levels of activity in each of the three domains of interest. We surmise that this typology constitutes an ideal type. However, in the use of the term 'ideal' there is no suggestion that ideal types are states that organisations (local authorities in this instance) should be trying to attain. Rather they are conceived of as a means describing differences in organisational arrangements.

Type (No. of authorities)	Commissioning and contracting arrangements	Employment practices	Flexibility in service provision at the level of the service user
1 (15)	Medium	Medium	Medium
2 (19)	Medium	Medium	Low
3 (11)	High	Medium	High
4 (15)	Low	Low	Low
5 (6)	Medium	High	Medium
6 (13)	Medium	Low	Medium
7 (13)	High	High	High

This typology has informed the selection of sites for subsequent work which, using a case study approach, will explore the influence on recruitment and retention issues within the workforce of different approaches to commissioning and contracting services for older people. This constitutes phases II and III of the research project which is being undertaken by the European Work and Employment Research Centre also at Manchester University.

CHAPTER ONE: POLICY CONTEXT, CONCEPTUAL FRAMEWORK AND SELECTIVE LITERATURE REVIEW

This chapter comprises two parts. In the first, the policy guidance which shapes current commissioning and contracting arrangements for social care is summarised. The second part is a selective literature review designed to inform both the development and reporting of the questionnaire.

Policy context

In the first part policy initiatives associated with commissioning, contracting, Best Value and procurement and care management arrangements with a particular emphasis on policy developments following the 1998 White Paper *Modernising Social Services* (Cm 4169, 1998) will be reviewed. Initially, however, this chapter will discuss the origins of current commissioning and contracting arrangements for adult social care services in local authorities, detailed in the 1989 White Paper *Caring for People* (Cm 849, 1989). The 'enabling role' of local authorities and the development of partnership working between health and social care provide the orientation for examining subsequent policy relating to commissioning and 'Best Value', the framework for current contracting arrangements in adult social care services.

The enabling role and joint working between health and social care services

The 1989 White Paper *Caring for People* outlined a new enabling role for local government, summarised in Box 1.1 below. There was a clear expectation that local authorities would have in place arrangements for the assessment and purchasing of care services consistent with the purchaser/commissioner and provider separation in 1993 (Department of Health, 1990). Shortly after the introduction of these reforms, further clarification of purchaser and provider roles within social services departments and the development of care management were described as areas for *"continuing and longer-term development"* (Wistow et al., 1994 p12).

Box 1.1: The enabling role

- To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible.
- To ensure that service providers make practical support for carers a high priority.
- To make proper assessment of need and good case management the cornerstone of high quality care.
- To promote the development of a flourishing independent sector alongside good quality public services.
- To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance.
- To secure better value for taxpayers' money by introducing a new funding structure for social care.

Source: Cm 849, 1989

National Service Frameworks were established to improve services through setting national standards to drive up quality and tackle existing variations in health and social care (Cm 3807, 1997). The National Service Framework for Older People (NSFOP) was described as the key vehicle for ensuring that the needs of older

people were at the heart of the reform programme for health and social services (Department of Health, 2001a).

Almost concurrently, the reorganisation of the NHS around Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) was partly envisaged as an opportunity to promote partnership working between health and social services to provide 'joined-up' services. The internal market was to be replaced by a system of 'integrated care' based on partnership and driven by performance. Organisations with responsibilities for planning and providing health and social care services would be required to work to a jointly agreed local health improvement programme (Cm 3807, 1997). Subsequently, the government reaffirmed its commitment to abolishing the internal market replacing it with a new relationship between centre, region and locality (Cm 4818-I, 2000).

Commissioning

One of the national objectives for adult social services outlined in the 1998 White Paper was "*to plan, commission, purchase and monitor an adequate supply of appropriate, cost effective and safe social care provision for those eligible for local authority support"* (Cm 4169, 1998 p111). The importance of commissioning within social care was endorsed in subsequent policy guidance (Cm 6499, 2005; Cm 6737, 2006). Four elements of commissioning have been identified which are summarised in Box 1.2.

Box 1.2: Elements of commissioning

- Needs analysis: where commissioning should be based on assessment of need within the local population.
- Strategic planning: where information about need, supply and service use, the views and wishes of users and carers should be collected by commissioners and fed into the planning process.
- Contract setting and market management: a variety of contract types should be used to deliver positive outcomes for users and reasonable security for good providers. Good commissioners should have mechanisms for stimulating new services where needs have been identified, and services are not available. Contract prices should not be set mechanistically but with regard to providers' costs and planned outcomes for users.
- Contract monitoring: general contracts and specific contracts should be monitored to ensure that providers are providing acceptable standards of care, and that individuals are receiving appropriate help at agreed prices. Commissioners should ensure that providers have their own quality assurance and control systems in place.

Source: Cm 4169, 1998

The legislative framework surrounding commissioning now has an increasingly local component, reflected in the government's definition of commissioning as: "*the process whereby public resources are used effectively to meet the needs of local people*" and the recommendation that the involvement of local people is an important way of improving this process (Cm 6737, 2006 p161). This local concept also found expression in the introduction of Local Strategic Partnerships (LSPs) (Department of Health, 2001b), and its importance was reiterated with the introduction of Local Area Agreements (LAAs) which established a single set of priorities for local partners (Cm 6499, 2005; Cm 6737, 2006; Cm 6939-I, 2006). The White Paper *Our Health, Our Care, Our Say* sets out proposals for strengthening local commissioning to ensure it

is responsive to localities. Local people are expected to play a full part in the planning, design and delivery of services and local authorities will be required to provide information on how they engage with the public as well as conducting regular needs assessment of the population (Cm 6737, 2006). This is reflected in another policy document entitled *A Stronger Local Voice*. Local Involvement Networks (LINks) are seen as at the heart of the new arrangements. By gathering and analysing information, encouraging and supporting users and the public to participate in commissioning, and through the scrutiny and review of health and social care services, it is envisaged that LINks will inform commissioners and providers of social care. It is also expected that they will assist particularly in joint commissioning arrangements (Department of Health, 2006a). The five elements of this framework are summarised in Box 1.3 below.

Box 1.3: Local interests in commissioning arrangements

- The establishment of new Local Involvement Networks.
- A strong relationship between Local Involvement Networks and existing Overview and Scrutiny Committees.
- The strengthening of current legislation in relation to duties of NHS trusts and Primary Care Trusts to involve and consult patients and the public in the planning and development of health services.
- The creation of a national network of patient and user organisations to provide a more systematic approach to involving patients, service users and members of the public in the development of national policy.
- User involvement in regulation and the regulation of the involvement of users of services to ensure NHS organisations comply with and fulfil their duties to involve and consult.

Source: Department of Health, 2006a

As well as more localised commissioning, there has been a concurrent shift towards a greater emphasis on outcomes (Cm 6737, 2006). Policy guidance has suggested that outcomes for adult social care services should be based on the concept of well being. The components of this were described as: improved health and emotional well being; improved quality of life; making a positive contribution; choice and control; freedom from discrimination; economic well being and personal dignity. It was anticipated that these outcome measures would extend to goal setting for health, social care and related activity in LAAs (Cm 6737, 2006).

Joint commissioning

Central government increasingly defines commissioning in joint terms. For example, it has been described as:

"the full set of activities that local authorities and Primary Care Trusts (PCTs) undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively" (Cm 6737, 2006 p210).

As noted previously, there has been a policy drive away from single agency commissioning towards joint commissioning between health and social care. In 1997 the Labour government made one of its top priorities to bring down the *"Berlin Wall"* between health and social care in order to create a system of integrated care that

puts users at the centre of service provision (Cm 4169, 1998 p97). Joint working at all levels throughout the country was identified as the means to achieve this goal. A series of government initiatives were announced to improve joint commissioning between health and social services which are summarised in Box 1.4. Most of these initiatives have been discussed in the previous section and relate to strategic planning and the monitoring of performance. However the first three relate to mechanisms to promote joint commissioning and service provision and were enacted in 2000, further endorsed by subsequent legislation in 2006. More recently, government issued a consultation document, a commissioning framework for health and well being across health and social care services (Department of Health, 2007a). It had a particular focus on partnership and identified eight steps to more effective (joint) commissioning which are summarised in Box 1.5.

Box 1.4: Initiatives to promote joint commissioning

- Pooled budgets: where health and social services put a proportion of their funds into a mutually accessible joint budget to enable more integrated care.
- Lead commissioning: where one authority transfers funds to the other who will then take responsibility for purchasing both health and social care.
- Integrated provision: where one organisation provides both health and social care.
- Introduction of practice based commissioning.
- Creation of Care Trusts: to commission and deliver primary and community health and social care for older people and other client groups.
- Duty of partnership: local health and social care planners to achieve both national standards and local milestones.
- Local Strategic Partnerships: councils to work with other local agencies to improve economic, social and environmental well being followed by the introduction of Local Area Agreements to facilitate the work of government, local authority and its partners by agreeing the design and delivery of outcome targets which reflect national and local priorities.
- The introduction of national service frameworks, in partnership with the NHS: to create a greater level of consistency and fairness in social care.
- Requirement for Primary Care Trusts and local authorities to produce a joint strategic needs assessment of the health and well being of its local community.
- Streamline budgets and planning cycles between Primary Care Trusts and local authorities, based on a shared, outcome-based performance framework.

Sources: Cm 4169, 1998; Cm 4818-1, 2000; Cm 6499, 2005; Cm 6737, 2006; Department of Health, 2007a

Box 1.5: Promotion of partnership between health and social care services in commissioning

- Putting people at the centre of commissioning.
- Understanding the needs of populations and individuals.
- Sharing and using information more effectively.
- Assuring high quality providers for all services.
- Recognising the interdependence between work, health and well-being.
- Developing incentives for commissioning for health and well-being.
- Making it happen: local accountability within a single health and social care vision.
- Making it happen: enhancing the skills of commissioners within localities.

Source: Department of Health, 2007a

Recently a number of initiatives have been introduced to promote joint working in localities (Department of Health, 2008a; b). These include the establishment of Regional Improvement and Efficiency Partnerships (RIEPs) and Joint Improvement

Partnerships (JIPs); the development of joint performance indicators for local authorities and partners; and the new social care reform grant. RIEPs will support councils and partners to take increased responsibility for a range of improvement issues. They will have a key role in identifying where resources should be spent and will work with recently established JIPs, to facilitate regional implementation and local activity and provide local leadership (Department of Health, 2008a). Adult social care JIPs are already working with RIEPs in several regions to tackle shared regional social care issues (DCLG, 2008). The performance of councils across health and social care services will be measured against new national indicators in the new Performance Framework for Local Authorities and Local Authority Partnerships. This information will inform the joint health and social care performance assessment undertaken by the new joint inspectorate, the Care Quality Commission, and the Comprehensive Area Assessment. The new social care reform ring fenced grant available to local authorities will be spent on regional improvement initiatives agreed by Regional Deputy Directors for Social Care and Local Partnerships in consultation with the RIEP and JIP. By 2011 councils will be expected to have made significant steps towards redesigning and reshaping their adult social care services, with most of the core components summarised in Box 1.6 in place (Department of Health, 2008a).

Box 1.6: Core components of a redesigned adult social care service

- An integrated approach to working with the NHS and wider local government partners.
- A commissioning strategy which includes incentives to stimulate development of high quality services as well as balancing investment in prevention, early intervention/re-ablement, and providing intensive care and support for those with high-level complex needs.
- Universal joined-up information and advice available for all individuals and carers, enabling people to access information from all strategic partners.
- A framework for proportionate contact and social care needs assessment to deliver more effective joined-up processes.
- Person centred planning and self-directed support to become mainstream with individuals having choice and control over how best to meet their needs.
- A simple straightforward personal budget system as well as support to increase the uptake of direct payments.
- Mechanisms to involve family members and other carers as care partners with appropriate training to enable carers to develop their skills and confidence.
- An enabling framework to ensure people can exercise choice and control with accessible advocacy, peer support, and brokerage systems with strong links to user led organisations.
- An effective and established mechanism to enable people to make supported decisions built on appropriate safeguarding arrangements.
- Active membership of the local/regional personalisation networks to ensure access to the latest information, advice, and support.

Source: Department of Health, 2008a

Best Value

The Labour government in 1998 announced its intention to abolish compulsory competitive tendering (CCT) and replace it with Best Value (Cm 4014, 1998). As part of this process, local authorities were required to conduct Best Value reviews, the key elements of which are contained in Box 1.7 below. The government has also published twelve key principles underlying Best Value and guidance on how these should steer the provision of services by or on behalf of local authorities. Both are

summarised in Boxes 1.8 and 1.9 respectively. Unlike the previous government, the incoming labour government had *"no preconception about whether the public or the voluntary or private sector should be the preferred providers"* (Cm 4169, 1998 p119). Rather choice amongst in-house, voluntary or private sector providers was to be based on judgements about Best Value and optimum outcomes for individual service users and local authorities are required to demonstrate that their contracting arrangements deliver this (Cm 4169, 1998).

Box 1.7: Key elements of Best Value review

- Challenge: is this service needed? Are there better ways to achieve objectives?
- Compare: benchmarking and dialogue with users/ potential suppliers.
- Consult: on ambitions for service, performance targets and means.
- Compete: provide for competition where it makes sense to do so.

Source: DETR, 1998a

Box 1.8: Best Value – 12 principles

- The duty of Best Value is one that local authorities will owe to local people, both as taxpayers and the customers of local authority services.
- Achieving Best Value is not just about economy and efficiency, but also about effectiveness and the quality of local services.
- The duty will apply to a wider range of services than those covered by CCT.
- No presumption that services must be privatised, but no reason why services should be delivered directly if other more efficient means are available. What matters is what works.
- Competition will continue to be an important management tool but it is not in itself enough to demonstrate that best value is being achieved.
- Central government will continue to set the basic framework for service provision.
- Detailed local targets should have regard to any national targets, and specified indicators to support comparisons between authorities.
- Both national and local targets should be built on the performance information.
- Audit processes should confirm the integrity and comparability of performance information.
- Auditors will report publicly on whether Best Value has been achieved, and should contribute constructively to plans for remedial action.
- There should be provision for intervention at the direction of the secretary of state on the advice of the audit commission when an authority has failed to deliver Best Value.
- The form of intervention should be appropriate to the nature of failure.

Source: DETR,1998b

Box 1.9: Best Value and the provision of social care services

"A duty to deliver services to clear standards - covering both quality and cost - by the most effective, economic and efficient means available" (p113).

To be achieved by:

- Investigation of local citizens' social care needs.
- Monitoring of user and carer experience and satisfaction with social services.
- A national performance assessment framework.
- Identification of targets for annual improvement in local performance plans.
- Continuation of independent inspections of authorities and joint reviews of local health and social care services.

Source: Cm 4169, 1998

Procurement

The 1998 White Paper *Modern Local Government in Touch with the People* stated that *"good procurement practice is essential if local government is to obtain real improvements to service cost and quality"* (Cm 4014, 1998 p56). Subsequently, it stated that *"procurement is an essential element of cost effective and efficient services"* (ODPM/LGA, 2003 p9) and a national procurement strategy was developed, which is summarised in Box 1.10 below. The Gershon (2004) review of public sector efficiency identified local government procurement as one of the main areas where greater efficiency could be achieved. In particular, it advocated increased standardisation through procurement and contracting in order to reduce bureaucratic costs to both commissioners and providers of social care. Subsequently, a series of voluntary procurement performance indicators have been developed, to help authorities measure their progress against the national procurement strategy for local government in England and the developing agenda for modern procurement practice (I&DeA/Audit Commission, 2005).

Box 1.10: National procurement strategy - objectives for local authorities 2003-06

- Delivering better quality public services that meet the needs of all local citizens through sustainable partnerships with a range of public, private, social enterprise and voluntary sector organisations.
- Confidently operating a mixed economy of service provision, with ready access to a diverse, competitive range of suppliers providing quality services, including small firms, social enterprises, minority businesses and voluntary and community sector groups.
- Achieving continuous improvement from all categories of procurement expenditure, by putting in place an appropriate procurement strategy and the necessary resources for implementation.
- Obtaining greater value for money through collaboration with partners at local, regional, national and European levels.
- Realising economic, social and environmental benefits for their communities through their procurement activities.
- Demonstrating improvement in equality and opportunity for businesses, service users and council staff.
- Stimulating markets and using their buying power creatively to drive innovation in the design, construction and delivery of services.

Source: ODPM/LGA, 2003

Recent guidance has urged local authorities to consider social and environmental issues when purchasing services leading to a consideration of both efficiency and sustainability. It is believed that 'sustainable procurement' would ensure that businesses take these issues into account in the provision of services (DEFRA, 2006). This has been defined as:

"a process whereby organisations meet their needs for goods, services, works and utilities in a way that achieves value for money on a whole life basis in terms of generating benefits not only to the organisation, but also to society and the economy, whilst minimising damage to the environment" (DEFRA, 2006 p10).

In June 2006, based on level of expenditure, public sector market/supplier share and projected future spend, the Sustainable Procurement Task Force identified ten national priority spend areas which included health and social work (operating costs

of hospitals, care homes, social care provision). The government indicated their broad acceptance with these plans (DEFRA, 2007) and in response to this national initiative, local government has identified social care provision as a priority area for the development of sustainable procurement. Local authorities, working with local partners, are required to pursue the achievement of social, economic and environmental benefits through the Sustainable Community Strategy, LSPs and LAAs (I&DeA/LGA, 2007). Sustainable procurement has also been identified by the NHS Purchasing and Supply Agency as an important component of commissioning, with health and local government sectors being encouraged to work together towards this goal (NHS PASA/DH, 2007).

Care standards and the workforce

The 1998 White Paper *Modernising Social Services* outlined the government's intention to establish Commission for Care Standards (CCS) at regional level to regulate care services including residential care homes for adults, nursing homes and domiciliary social care providers (Cm 4169, 1998). From 2002, the National Care Standards Commission (NCSC) performed the functions of the CCS and merged with the Social Services Inspectorate (SSI) in 2004 to form the Commission for Social Care Inspection (CSCI) (Better Regulation Commission, 1998). This body regulates social care services in respect to a set of statutory regulations underpinning National Minimum Standards (NMS) for social care which are under review (Cm 6737, 2006). Currently care home standards include requirements relating to: choice of home; health and personal care; daily life and social activities; complaints and protection; environment; staffing; and management and administration (Department of Health, 2003a). Standards relating to domiciliary care relate to: user focused services; personal care; protection; managers and staff; and organisation and running of the business (Department of Health, 2003b). The standards themselves are not enforceable by law, however, they are considered by the CSCI in assessing whether registered providers are meeting the statutory regulations noted above (CSCI, 2008a). Both domiciliary care agencies and care homes are currently required to register with the CSCI (CSCI, 2008a). In addition, persons are legally required to register with the CSCI in order to manage care homes or domiciliary care agencies registerable under the Care Standards Act (CSCI, 2008b).

To regulate the training of social workers and set conduct and practice standards for all social services staff, a new General Social Care Council (GSCC) was established in 2001. Social workers are currently required to register with the GSCC, over time other social care workers will be required to register, starting with home care workers and managers, followed by those working in care homes. Regular training and development is expected to play a key part in this process (GSCC, 2008). The government has also recently announced its commitment to the registration of domiciliary care workers (Department of Health, 2008c).

The National Training Organisation for Personal Social Services (TOPSS) was established in 1999 to: maintain the occupational standards underpinning the qualifications recognised by social care staff and employers; to carry out workforce analysis; and to identify training needs and ensure they are met (Cm 4169, 1998). It identified a serious shortage of data on skills of the people who work in social care;

the need to develop an appropriate key skills framework; and to support and train new entrants to the workforce (TOPSS England, 2000). The Training Support Programme (TSP) grant was identified as a means of achieving future training targets outlined in the NMS for domiciliary and residential care (Cm 4169, 1998; Department of Health, 2003a; b). With respect to care home provision, these targets included: a minimum ratio of 50 per cent of care staff trained to NVQ level two or equivalent by 2005. For domiciliary care, they included a requirement that at least 50 per cent of all personal care was to be delivered by workers with a NVQ qualification or its equivalent, by 2008 (Department of Health, 2003a; b).

The purpose of the TSP was to improve the quality of social care services, by encouraging a planned approach to training, and by increasing the proportion of staff with appropriate qualifications, through supplementing the local authority's own training resources. For the independent sector, price setting through the contractual process was identified as the most appropriate means of securing the provision of training. Whilst local authorities were permitted to charge for the provision of training, they were encouraged to fund it from their TSP grant from central government (Department of Health, 1998). Two new ring fenced sources of money linked to training were introduced in the financial year 2003/04: the National Training Strategy (grant) and the Human Resources Development Strategy (grant) (Department of Health, 2003c; 2003d). The former was introduced in part to support the training of social care staff towards the NMS and the latter to reduce vacancy rates and encourage new entrants into the workforce (Department of Health, 2003c; d; 2005a). From 2004 these were no longer ring fenced, but an emphasis was placed on ensuring that those commissioning services have the necessary skills required for workforce development and for improving service quality (Department of Health, 2003d; 2007b).

Contract setting and market management

As well as encouraging local authorities to use registered providers of social care to ensure service quality (Cm 4014, 1998), policy guidance has also sought to improve the quality of care services through better contracting and market management (Cm 6499, 2005; Cm 6737, 2006). Whilst central government has emphasised the importance of contracting as a way of managing and supporting the social care market, references to it in policy guidance are few and often implicit. For ease of reference, guidance issued to local authorities is summarised in Box 1.11 below. Other guidance from central government has included domiciliary and care home provision model contracts for intermediate care services. These are summarised in Appendix 2 (Boxes A2.1 and A2.2). In response to concerns about contracting arrangements with the voluntary sector, guidance for the provision of social care services was developed for this sector which is included in Box A2.3. These principles of contracting are envisaged as a prelude to a national recommended model for contracting for social care services (Department of Health, 2006b). The Care Services Improvement Partnership have also issued guides to fairer contracting and service specification (key points of which are summarised in Boxes A2.4-A2.6) and those relating to market development, tendering and the selection process are expected in early 2008 (CSIP, 2005; 2007a). Since 2005, the Office of Government Commerce has been developing a model contract for procuring services in the drive

towards greater efficiency, and more consistent, effective procurement methods and standards. A final version of the model contract was expected in 2008 (OGC, 2008).

Box 1.11: Contracting and market management guidance for local social care commissioners

- Undertake needs assessment to provide the information required to stimulate and develop the social care market.
- Use of open tendering to promote innovation, quality and choice to service users.
- Avoid too many short-term contracts which prevent providers from making the longer-term investments that are required to raise service quality.
- Contract for services with the local voluntary community sector in a way which allows them compete with other providers (in respect of contract size and length, monitoring, reporting and audit processes).
- Support local providers to redesign and refocus services.
- Develop markets to ensure that individual budget holders have an appropriate range of services to choose from.

Source: Cm 6499, 2005; Cm 6737, 2006

Simultaneously, work has been undertaken to develop a consultation draft of the commissioning framework for health and well being and it contains several recommendations relating to the contracting and market management process. These are summarised in Box 1.12 below. Additional considerations relating to contracting include contract length, upholding the principles of *"fair and reasonable trading"*, and the proportionate assignment of risk between commissioner and provider (Department of Health, 2007a p43).

Box 1.12: Commissioning for health and well being - recommendations relating to contracting and market management

- Commission for outcomes and outputs.
- Involve current and potential providers in needs assessment.
- Engage the provider community in discussion of priorities and issues for market shaping and development.
- Develop better market intelligence and greater understanding of the role of all providers.
- Provide easily accessible information and guidance, to help people choose between providers.
- Review the range of providers available to meet the needs of the community and consider how best to incentivise providers to improve their services or meet gaps in provision.
- Build a market and develop enough opportunities for different providers to ensure genuine choices for users.
- Adopt procurement practices that are fair and open – minimising transaction costs and allowing providers to frame realistic economic tenders.
- Make a clear distinction between grants and legally binding contracts, and the role each has to play in service and market development.
- Adopt appropriate and proportionate contractual mechanisms.
- Actively encourage a strong provider market, based on a diverse supply community from all sectors.

Source: Department of Health, 2007a

Care management arrangements

The 1989 White Paper Caring for People outlined a number of changes to the way that social care was to be delivered and funded. In relation to care management, local authorities became responsible *"for assessing individual need, designing care arrangements and securing their delivery within available resources"* (Cm 849, 1989 p6). Case (care) managers were seen as a means of ensuring that resources were targeted effectively and that services were planned to meet specific needs of individuals. It was envisaged that effective case management (now known as care management) would include seven components which are summarised in Box 1.13. Government saw an advantage in linking care management with devolved budgets as this was *"an important way of enabling those closest to the identification of client needs to make the best possible use of the resources available"* (Cm 849, 1989 p22).

Box 1.13: The care management process

- **Stage 1 Publishing information**: making public the needs for which assistance is offered and the arrangements and resources for meeting those needs.
- **Stage 2 Determining the level of assessment:** making an initial identification of need and matching the appropriate level of assessment to that need.
- **Stage 3 Assessing need**: understanding individual needs, relating them to agency policies and priorities, and agreeing the objectives for any intervention.
- **Stage 4 Care planning**: negotiating the most appropriate ways of achieving the objectives identified by the assessment of need and incorporating them into an individual care plan.
- **Stage 5 Implementing the care plan**: securing the necessary resources or service.
- **Stage 6 Monitoring**: supporting and controlling the delivery of the care plan on a continuing basis.
- **Stage 7 Reviewing**: reassessing needs and the service outcomes with a view to revising the care plan at specified intervals.

Source: Cm 849, 1989

The development of assessment processes and practice after the introduction of the community care reforms raised several concerns, including the multidisciplinary assessment of older people (Department of Health, 1993a; b; 1997). The *NHS Plan: A Plan for Investment, A Plan for Reform* specified the development of a Single Assessment Process (SAP) for older people and the NSFOP clarified the types and domains of this assessment (Department of Health, 2001a; Cm 4818-I, 2000). Overall, the SAP was designed to ensure that:

"…a more standardised assessment is in place across all areas and agencies; standards of assessment practice are raised; and that older people's needs are assessed in the round" (Department of Health, 2001c).

Preventative services

There is a growing emphasis on the importance of preventative services in policy guidance. In the period following the introduction of the community care reforms it was noted that whilst local authorities were focussing increasingly on the most dependent people living in their community, people who would benefit from purposeful intervention at a lower level of service were not receiving any assistance

and local authorities were encouraged to develop low level support for people most at risk of losing their independence via the prevention grant (Cm 4169, 1998). This issue was brought into sharper focus with guidance issued subsequently by central government. It required that local authorities operate a single eligibility decision for all adults seeking social care support derived from a national framework and existing legislation and based on risks arising from needs associated with various forms of disability, impairment and difficulty. This guidance encouraged local authorities:

"*to act where it is difficult to estimate the likely benefit to a particular individual, but where there is evidence of the likely preventative benefits from non-intensive or other help to certain populations or groups"* (Department of Health, 2002 p5-6).

Moreover, councils were required to include in their published eligibility criteria how they were addressing 'preventative issues' including the provision of assistance to those whose risk of loss of independence appears low but might become more serious over time (Department of Health, 2002). It was suggested that local authorities develop these initiatives in partnership with other local agencies and subsequent policy has endorsed this approach in the guidance given in the commissioning of these services (Department of Health, 2002; Cm 6499, 2005).

Subsequently, government has identified a growing evidence base in respect of social care for inexpensive adaptations and equipment and the provision of preventative services. It was suggested that local authorities develop these initiatives in partnership with other local agencies and has endorsed this approach in the guidance given in the commissioning of these services. This is part of the transformation agenda in adult social care which seeks "*to make personalisation, including a strategic shift to early intervention, the cornerstone of public services"* (Department of Health, 2008a p2) (Department of Health, 2008a; Cm 6499, 2005).

Support to carers

There has been an acknowledgement that carers need greater help and support to enable them to fulfil their role. The White Paper *Caring for People* (Cm 849, 1989) began to make explicit the crucial contribution of carers to the care of vulnerable adults. It emphasised the importance of taking into account the wishes of carers in the formulation of a care plan and the importance of community based services responding flexibly and sensitively to the needs of users and their carers. However, it did not recognise carers as service users in their own right. This did not occur until 1995 with the Carers (Recognition and Services) Act which was strengthened five years later by the Carers and Disabled Children Act. Recent guidance now states that carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their current role (HM government, 2008b).

Personalisation of care

Direct payments were introduced in 1997 and were subsequently extended to include adults over 65 years (Cm 4169, 1998; Department of Health, 2003e). They provide *"monetary help for people who want to manage their own support to improve their quality of life"* (Department of Health, 2003e p5). Local authorities are able to

offer cash to users assessed as eligible for assistance and also equipment to enable them to make their own decisions about how their care is provided and the equipment they purchase. The 2006 White Paper *Our Health, Our Care, Our Say* reaffirmed the government's commitment to increasing the uptake of direct payments. It required councils to make a direct payment to people who can consent to have them and to discuss this as a first option with everyone, at each assessment and review (Cm 6737, 2006). Since 2004, the take-up of direct payments has been an indicator in CSCI's performance assessment regime, and contributor to the overall star rating of a local authority (Cm 6737, 2006; Leece, 2007).

The 2005 Green Paper *Independence, Well Being and Choice* outlined government proposals to introduce individual budgets and increase the take up of direct payments, particularly amongst older people, one of the groups where uptake was perceived to be low, from existing funds for social services. Individual budgets were initially conceived of as having the capacity to bring together resources from different funding streams (including local authority social care, housing-related support services, adaptations and equipment budgets) (Cm 6499, 2005). Subsequently the individual budgets pilot schemes were introduced building on the model of the In Control pilots for people with learning disabilities. An individual budget can be held by the user or carer, by an agent where they do not have the capacity to manage this themselves or held by the local authority. It is envisaged that this latter option would extend the benefits but not the potential burdens of direct payments to those who would find managing this finance difficult (Cm 6499, 2005). As part of the government's approach to the transformation of social care it was reported that *"the Individual Budget…pilots have begun to demonstrate what works as well as identifying barriers to progress"* (HM Government, 2008a p5).

The use of different ways of supporting service users was advocated to identify the most promising and cost-effective means of providing support (Box 1.14). Personal budgets have been described as an allocation of funding to enable users of social care services *"to make informed choices about how best to meet their needs"* (Department of Health, 2008a p5). It is intended that this allocation of resources be a transparent process. Individuals will be able to use their resources flexibly and innovatively thereby shaping their own care plan rather than being offered services (Department of Health, 2008a).

Box 1.14: Models of support for service users

- A person centred planning facilitator to support the person to develop their own aspirations as the basis for future service plans.
- A care manager working alongside the person who may need services to undertake the needs assessment and act as lead professional to case manage the care package. This model might be particularly valuable to support those with very complex needs and provide continuity of skilled social work input. The role might also be undertaken by another professional as part of the multidisciplinary team, for example a community matron.
- A care navigator with knowledge of mainstream and specialist services, working with the person using services to develop a sustained pathway of care.
- A care broker who might help the individual formulate the care plan, negotiate funding and help organise and monitor services.

Source: Cm 6499, 2005 p36

Hospital discharge and intermediate care services

Steiner (2001) categorised intermediate care as having two essential elements: crisis intervention to prevent unnecessary admissions for those at short term risk of admission to hospital for acute care, and recuperation and rehabilitation for post acute patients. These services are designed primarily for older people. Typically they are time limited and targeted at people who would otherwise face unnecessarily prolonged hospital stays in acute beds, or inappropriate admission to acute inpatient care, long term residential care, or NHS Continuing Healthcare. Policy guidance suggests that these services offered are characterised by comprehensive assessment, care plans and cross professional working (Cm 4818-I, 2000; Department of Health, 2001a; b). Possible service models are summarised in Box 1.15.

Box 1.15: Intermediate care services

- Rapid response: a service designated to prevent avoidable acute admissions by providing rapid assessment for patients who are referred from the health service.
- Hospital at home: where patients receive intensive support in their own home, as a way of avoiding admission to an acute hospital and enable early discharge from hospital.
- Residential rehabilitation: people who need a short period of rehabilitation to enable them to return safely to their own home, are provided with a short term programme of therapy and enablement in a residential setting.
- Supported discharge: where older people are provided with nursing and/or therapeutic support over a short period of time in their own home or in sheltered accommodation.
- Day rehabilitation: a short-term programme of therapeutic support provided at a day hospital or day centre.

Source: Department of Health, 2001d

The Community Care (Delayed Discharges etc.) Act 2003 placed new duties upon both councils with social services responsibilities in England and the NHS, in respect of communications between both agencies locally, and communication with patients and carers. The Act seeks to: strengthen joint working by encouraging clear and timely communication between the two agencies; improve assessment and the provision of community care services for hospital patients by the introduction of financial incentives; and encourage the development of new services to facilitate patient transfer to community settings which promote independence or prevent unnecessary hospital admission. These issues were emphasised in the implementation guidance which accompanied the legislation (Department of Health, 2003f). Intermediate care is regarded as a function rather than a specific set of services, and involves a care planning approach to encourage return home or placement in the least restrictive care home setting. It aims to: avoid unnecessary hospital admission and support timely discharge; promote faster recovery from illness; prevent avoidable deterioration; maximise residual skills and independent living; support discharge following an inpatient stay; optimise choice and placement; and avoid inappropriate admissions to care homes (Department of Health/CSIP, 2005). These objectives place an emphasis on providing care in people's own homes.

Old age mental health services

Policy guidance has expressed concern that older people with mental health problems are often excluded from mainstream intermediate care, particularly if they have a diagnosis of dementia and it is believed that the number of older people with mental health problems admitted to care home or hospital could be reduced with the provision of enhanced community services (Department of Health/CSIP, 2005; Department of Health, 1997; Audit Commission, 2000). However, there has also been recognition of the need to improve services and support for people with dementia (House of Commons, 2008). A summary of those issues relating to the provision of care and an appropriately skilled social care workforce are summarised below (Box 1.16). The Audit Commission have made a series of recommendations in relation to providing good quality care in residential and nursing settings including the recommendation that: *"some dementia training will be needed in all residential homes, though, as they are all likely to care for some people with dementia"* (Audit Commission, 2000 p81).

Box 1.16: People with dementia – key issues in service provision

- There are over 560,000 people in the UK with dementia.
- Between a half and two-thirds of people with dementia never receive a formal diagnosis.
- There is poor awareness amongst the public and some professionals of dementia and what can be done to help people with the disease.
- People with dementia require support from multiple health and social care providers but this is often difficult to manage.
- 62% of care home residents are currently estimated to have dementia but less than 28% of care home places are registered to provide specialist dementia care.
- Hospital care for people with dementia is often not well managed, increasing the risk of admission to a care home.

Source: House of Commons, 2008

The NSFOP aimed to reduce the variation in the services provided for older people with mental health problems and improve care provision, by setting out a ten year programme of action and reform (Department of Health, 2001a). Its specification for community based old age mental health services is summarised in Box 1.17. In relation to residential care the NSFOP states that:

"The NHS and local councils should work with care home providers in their areas to develop a range of services to meet the needs of older people with mental health problems, including specialist residential care places for older people with dementia" (Department of Health, 2001a p93).

Box 1.17: Components of community based old age mental health services

- Domiciliary care
- Outpatient facilities
- Outreach facilities e.g. assistive technologies
- Day care
- Support to carers including residential respite and 24*7 home based support

Source: Department of Health, 2001a

Recently, the Department of Health has highlighted the need for agencies to work together; for improved skills and competencies of staff in all mainstream care settings to enhance detection and management of mental health problems; and for appropriate investment to support a comprehensive specialist mental health service for older adults (Department of Health, 2005b). Subsequently, best practice guidance was issued which is summarised in Boxes 1.18 and 1.19, with the latter focussing on workforce issues. In conjunction with relevant stakeholders, all LITs are required to produce a coherent joint workforce plan as part of the local delivery planning processes. As well as recruiting new staff, services must develop and retain existing workers by commissioning suitable training and providing regular supervision and support to all staff (Department of Health, 2003g; Department of Health/CSIP, 2005).

Box 1.18: Old age mental health services – best practice guidance

- Recognise the dignity of individual service users, respect and value their diversity and acknowledge their role in planning and developing services.
- Respect all those people who engage with these services including users, supporters and carers.
- Provide practical advice and information that service users and their carers need and develop a consistently high quality, comprehensive package of care and support.
- Ensure that the best and most effective treatments are widely and consistently available.
- Respond to people on the basis of need not age and ensure that older people with mental health problems are not discriminated against.
- Employ properly trained and committed staff and have appropriate training systems that can deliver an age-inclusive and holistic service.

Source: Department of Health/CSIP, 2005

Box 1.19: Framework for workforce development in old age mental health services

- Address the specific cultural needs of elders within black and minority ethnic communities.
- Ensure that staff the have appropriate language skills to communicate effectively with service users.
- Enhance the skills of all staff working in generic, non-specialist areas to better meet the requirements of older people with mental health problems across the board.
- Ensure staff who work with older people with high levels of mental health problems (such as home carers and care home workers) receive more in-depth training and development.
- Incorporate the 10 essential shared capabilities into pre- and post-registration education and training for all mental health staff.
- Explore working in new ways and with new roles (e.g. through multidisciplinary liaison teams involving graduate primary care workers, support, time and recovery workers and community development workers).
- Consider leadership needs, both in terms of training and new roles.
- Reflect collaboration with human resources/local higher education institutions co-ordinating all resources.

Source: Department of Health/CSIP, 2005

The draft national dementia strategy published in 2007 reaffirmed the government's commitment to improving awareness of dementia amongst the public and professionals, and improving the quality of care for dementia by focussing on building better skills and understanding of dementia in the health and social care workforce. Guidance produced as part of the strategy aimed to inform commissioners by providing information on a range of models of respite (short

breaks) as alternatives to the traditional model of providing short breaks through residential care (Box 1.20). It also sought to build on previous guidance about involving service users and their carers in the planning, delivery and evaluation of care by providing key messages for commissioners (Box 1.21) (CSIP, 2008, 2007b). Following a consultation process, the Department of Health expect to publish the final national dementia strategy in 2008 (Department of Health, 2008d).

Box 1.20: Respite care arrangements for people with dementia

- Day care – wide variety of services provided outside the home in day care facilities.
- Support provided in the person's own home – either by the hour, day, or longer period, sometimes known as 'sitting service'.
- Overnight care away from home (care home or hospital) – normally planned and commonly for one or two week placements.
- Host family care – carer and person with dementia both stay with another family.
- Adult placements – where the person with dementia goes to stay with a host family.
- Emergency breaks – usually at home and commonly linked to Crisis Response Teams or intermediate care services, but may be the more traditional placement in a care setting overnight.

Source: CSIP, 2008

Box 1.21: Involving service users and their carers in the planning, delivery and evaluation of care - key messages for commissioners

Involving people who use services is a policy requirement. It can:

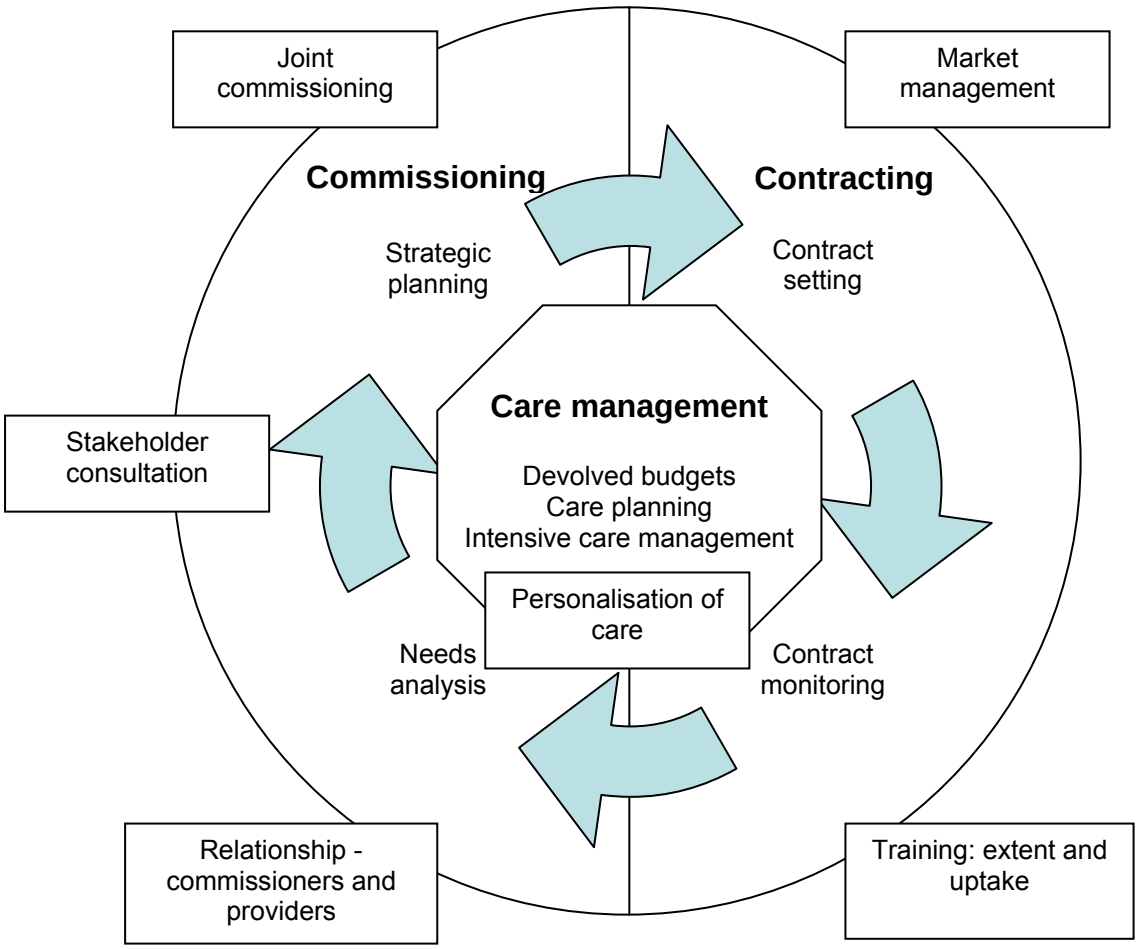
- Evidence where services are no longer required and identify how new services should be shaped thereby optimising the value of available resources.
- Provide feedback for audit and evaluation purposes and feed into performance assessment frameworks.
- Promote fair access to public services and benefits.
- Ensure equality of treatment and protection.
- Improve standards and responsiveness.
- Generate new ideas.

Source: CSIP, 2007b

Literature review

The focus of this literature review is on commissioning and contracting and the influence of care management arrangements and practice on these processes. A conceptual framework has been employed to provide a structure for it. Despite often being perceived as one in the literature, we attempt to make a clear distinction between commissioning and contracting in discussing these, although as a whole they are conceived of as a cyclical process. Figure 1.1 illustrates this and identifies two elements of commissioning (needs analysis and strategic planning) and two components of contracting (contract setting and contract monitoring). Linked to these are six overarching themes: joint commissioning; stakeholder consultation; the local authority's relationship with independent providers; market management; the extent and uptake of training amongst independent providers; and the personalisation of care.

Figure 1.1: The commissioning and contracting process



This review, together with the summary of the policy context given above, aims to provide a context for the description of variations in local authority commissioning and contracting arrangements which may impact on the recruitment and retention of the workforce providing care to older people in their own home or care homes. It is based on the elements of the conceptual framework described above and reflects areas of enquiry in the questionnaire. In order to provide acceptable scientific quality for the evidence the review is drawn from peer-reviewed articles. The inclusion and exclusion criteria are contained within Box 1.22 and articles were selected for inclusion in the review in March 2008. Studies are discussed under three main headings: commissioning, contracting and care management arrangements. Under these are a series of subheadings, relating to each component of the conceptual framework, overarching themes being addressed first in order to provide the context for the discussion of the elements of commissioning and the components of contracting. Note that contract monitoring is excluded from this literature review as there were found to be no articles relating to this that met the inclusion criteria, and that market management and contract setting are further subdivided for clarity.

Box 1.22: Inclusion and exclusion criteria

Inclusion criteria

Participants/care recipient group
Primarily older people (65+)[1]

Service
Social care or social services for older people[2] and
Community based including intermediate care and old age mental health services
(Voluntary sector could be included if social care is likely to be commissioned/purchased by lead social care agency)

Location
Completed in the UK (including Northern Ireland).

Dates
Data collected 1991 or later (The NHS and Community Care Act passed)
Published 1997 or later

Design/study type
Empirical (quantitative and qualitative) work[3] using both primary and secondary data and a variety of methodologies including case studies and national surveys.

Focus of study
Commissioning, contracting and care management arrangements for older people

Study design/nature of reference
Peer reviewed literature

Exclusion criteria

Participants/care recipient group
Adults (18-64)

Location
Non UK references

Study design/nature of reference
Individual client case studies
Book reviews
Commentaries/opinion articles
Dissertation/PhD theses
Non-peer reviewed literature

[1]Relaxation of this inclusion criteria to include all adult groups for direct payments and individual budgets due to the newness of these concepts and their centrality to the study.
[2] An operational definition of social care for older people was produced: 'Social care for older people comprises of the management of their care and ensuring that a coordinated approach is adopted across the local authority, the independent sector and other agencies' (adapted from Reilly et al., 2008).
[3] We only included studies that reported findings rather than theoretical or conceptual pieces. Thus, as Mays et al., (2001) stated, *"the simple test of relevance for inclusion is to specify that each reference must relate to some form of research, inquiry, investigation or study"* (p196).

Commissioning

Joint commissioning

Hudson (1999a) identified five factors associated with effective joint commissioning: engaging in wide consultation; securing trust and commitment; articulating desired ends; developing facilitating structures; and identifying clear responsibilities. Trust was frequently mentioned as a precondition of effective joint commissioning and he concluded that although effective joint commissioning was attainable, there could be no 'quick fix' at local level. In another paper, Hudson (1999b) reported how progress was being made in bringing together the agendas and activities of PCGs and social services and found evidence to suggest that the latter were beginning to play their part in developing PCG activities with regard to commissioning, service delivery, and health improvement. Continuing obstacles to joint working were considered to remain, identified as: the presence of existing interagency and inter-professional arrangements which could sometimes impede the implementation agenda of PCGs; agenda overload; and reactive decision making resulting from being subject to many different immediate national and local priorities.

In a later study, Glendinning et al. (2001) noted that only half of PCGs were aiming to develop integrated services for older people and nearly half did not routinely consult with social services when commissioning community health services. Social services representatives identified structural and organisational differences between their organisation and PCTs as hindering the development of partnership working. They identified changes in health and social care, such as the merging of PCGs and their development into trusts, as potentially threatening the development of robust partnerships. Subsequently, Glendinning et al. (2002) suggested a considerable amount of cultural change, organisational development and 'learning' were still required before PCGs could seize the opportunities they were presented with. Glendinning (2003) reporting a later phase of the same study noted that more PCG/Ts (78 per cent) collaborated with social services partners in the commissioning of services for older people. The removal or relaxation of structural, organisational, and financial boundaries through the new Health Act flexibilities was regarded as having assisted in the integration of services. This was viewed as having led to greater transparency and efficiency in the use of resources which had resulted in several advantages. These included enabling health and social care organisations to organise very complex packages of services for people with exceptionally high support needs. The removal of structural barriers however, was viewed as a necessary, but not sufficient condition for integration. Also required were changes in the culture and traditions of professional groups involved in the commissioning of health and social care services, along with a supportive local and national policy environment.

Rummery and Coleman (2003) argued that in order for partnership working to be successful, health and social care organisations have to manage their inter-professional differences and be committed to working in partnership. Moreover, it should be a joint activity to ensure that it has benefits to both partners. Hultberg et al. (2005) noted that despite successful informal partnerships which viewed the legal and financial frameworks as unnecessarily formal, and as a potential threat to their success, managers did appreciate the importance of the latter when setting up

pooled budgets. However, some resources proved difficult to manage within this framework, and pooled budgets were also viewed as reducing the financial flexibility of partners as any surplus within it could not be used on services outside of it.

Relationship between commissioners and providers

Filinson (1998) reported that the majority of nursing and residential care providers did not participate in the planning of community care services. Furthermore, several providers believed that they were not competing on a level playing field and saw social services departments as giving priority to local authority owned residential care homes when referring clients, by providing the easiest clients to care for. Subsequently, Andrews and Phillips (2002) concluded that although they found considerable dissatisfaction among proprietors of care homes regarding the actions and local policies of their local authority, the relationship between purchasers and providers was found to be improving. Matosevic et al. (2008) explored the flow of information between commissioners and providers. They concluded that although commissioners felt they had very good or reasonably good relationships with providers they did recognise a need for improvement in sharing information with providers and some authorities had already taken action to improve this. Additionally, they noted how longer term commissioning arrangements for care home services had been adopted by some commissioners in order to improve relationships with providers. In particular, commissioners were generally in favour of a preferred provider system rather than open purchasing because it fostered long term relationships with care home providers.

Wistow and Hardy (1999) reported a lack of information sharing between local authorities and domiciliary care providers, with less than half of the latter being consulted about the former's community care plans or purchasing intentions. Curtice and Fraser (2000) noted that long-term relationships of trust and stable purchasing patterns had not developed between local authority purchasers and private sector providers of domiciliary care, although purchasers appeared to have stronger relationships with voluntary providers in some areas. Ware et al. (2001) identified an ongoing need for local authorities and independent providers to share information in order to develop good working relationships and provide the latter with sufficient information to aid business and workload planning. Whilst forums for information exchange were more common than previously, there was also a widespread view amongst providers that these meetings often revealed only limited partnership or trust between themselves and the local authority.

Wistow and Hardy (1999) and Ware et al. (2001) both described a common perception amongst independent sector providers that in-house domiciliary services received favourable treatment and conditions. In addition, Ware et al. (2001) reported a suggestion that purchasers were prejudiced against private, for profit providers. It was also noted that, where there was an adequate supply of providers, some local authorities were aiming to develop good working relationships with selected and proven providers by reducing the numbers of providers overall with whom they contracted.

Stakeholder consultation

Raynes et al. (1998) described how the views of quality expressed by users of residential care services could be incorporated into service specifications and how quality standards in contracts were subsequently revised to reflect the concerns of residents. Factors that appeared to promote user involvement in service specification and development were identified and included attention to practical issues such as transport and venues together with ensuring all relevant stakeholders participated in a steering group. Barnes and Bennett (1998) reported how both officials and users benefitted from the establishment of a panel designed to obtain the views of users of social care services. Benefits to older people included: personal development; enhanced self esteem; capacity to influence change; social contact; and the sharing of experiences. Agencies also regarded the initiative as an innovative way of accessing the views of older people. Abbey et al. (1999) noted that obtaining the views of frequent visitors to residential care homes could be beneficial and present an untapped source of knowledge about the quality of care in residential homes. With regard to British minority ethnic groups, Temple et al. (2002) reported that some quality issues were specific to these groups. Moreover, Bowes and Wilkinson (2003) noted the benefits of obtaining views and experiences of specific groups of service users and non-users such as South Asian people with dementia.

Bamford and Bruce (2000) reported two findings of note. First, although there was found to be considerable agreement between people with dementia and their carers on outcomes, there were a number of limitations associated with relying solely on carers as proxy respondents. For example carers rarely regarded maintaining a sense of personal identity as an important outcome of care which was important to people with dementia. Second, the desired outcomes identified in the study relating to service delivery were found to bear little resemblance to those commonly used to evaluate community care services and were seen as potentially offering a new approach to their evaluation based on the perspectives of service users. More generally, Tucker et al. (2007) reported significant differences in the elements of old age mental health services that various stakeholder groups prioritised for development and in views of how services should be organised. In addition, a wide variety of views were found to be held by members of any one stakeholder group.

Strategic planning

The concept of the balance of care is used in strategic planning and *"relates to the relative priority accorded to services provided in the community compared to those provided in long-term care settings, such as care homes or hospital"* (Hughes and Challis, 2004 p155). Bennett et al. (2000) noted that despite the introduction of community care reforms in 1993, one third of nursing home placements were inappropriate and considered not to meet individuals care needs. Challis et al. (2000) reported that 31 per cent of those admitted to nursing homes and 71 per cent of those in residential homes were of low dependency, raising questions about how effectively resources had been targeted and whether diverting older people to home-based care was feasible. In another study Challis and Hughes (2002) considered 60 per cent of older people admitted to care homes for whom community-based care was a feasible alternative. Evidence from this suggested that intensive care management could provide a means of supporting frail and vulnerable people in their

own homes. They concluded that there remained *"capacity to shift the balance of care from institutional to home based care within reasonable cost parameters, particularly with more integrated services*" (Challis and Hughes, 2002 p126).

Clarkson et al. (2003) reported how the removal of the residential allowance (Cm 4169, 1998) had only a minimal impact on diverting older people from residential/nursing home care to community-based care. Wider organisational factors other than price were considered to be of greater importance in this context. In particular, a lack of devolved budgets meant that costs were not a major element in the decision making of front line staff and concerns about the capacity of the independent sector to expand domiciliary care provision, particularly for the very dependent elderly, limited the scope of diversion. Clarkson et al. (2005) further described how there were several influences on care home admission other than price which included: the needs or demands of users; the influence of carers and professionals; the role of system variables (such as bed supply and the availability of domiciliary resources); and local policy factors (eligibility criteria, purchasing arrangements and local interpretations of need). They concluded that these were likely to lead to significant variability between local authorities in the impact of the removal of the residential allowance on care home admissions.

Needs analysis

Gordon et al. (1997) described how a multiservice census and a stratified random sample survey were utilised to assess the care needs of the population with dementia in order to provide locally relevant data for service planning. Blackman (1998) reported how the introduction of a needs based formula had been used to allocate a local authority's budget for home care services, based on data from the census and a residents' survey. Box 1.23 lists the indicators that were used in order to create this formula. A follow up survey was also used to investigate whether services had reached the people they were intended to benefit, by comparing a sample of service users with a sample of non users. It concluded that resources had been reasonably well targeted. Gould (2001) also devised a methodology for needs analysis that drew heavily on the use of population needs indicators in conjunction with local authority social services departments and incorporated elements of strategic planning as described above. Five stages of needs assessment were identified which are summarised in Box 1.24. Preston-Shoot (2004) reported how needs and unmet need within a local authority could be identified from a sample of older people. One in ten people aged 65 and over living in the community were identified as having high dependency needs; those aged 85 and over were much more likely to be in this category and 17 per cent of this age group had needs that were not being met. With regard to older people in residential or nursing homes, it was reported that three quarters had high dependency scores compared with only one in ten of those living in the community.

Box 1.23: A needs-based formula for budget allocation – use of indicators

- Population in area.
- Number of people aged 85 or older.
- Number of people aged 75 or older.
- Number of people aged 65 or older.
- Number of people with long term illness or disability.
- Number of people in non-white ethnic groups.
- Deprivation indicators (non-car ownership, number of people who moved house in the last year, lone parent households, unemployed people, local authority tenants).

Source: Blackman, 1998

Box 1.24: Stages of population needs assessment

- Predicting the numbers of people in need, categorised by level of severity, type of disability and age.
- Profiling people who currently receive services from the local authority in order to estimate the proportion of those receiving services, out of the total potential population in need.
- Analysing the cost of packages of care in order to project the costs of services which might hypothetically be incurred were more or less of the population to receive a service.
- Consulting with service users and providers (including operational staff) to identify internal and external factors which might locally influence the allocation of packages of care.
- Modelling the relationship between objective measures of need, existing patterns of service provision and local operational factors influencing the allocation of resources.

Source: Gould, 2001

Contracting

Market management

Local authority influence on the social care market

Several studies have reported examples of how local authorities have advertently or inadvertently influenced the market through the use of price setting and contracting. In respect of residential/nursing home care, Forder and Netten (2000) concluded that local authorities could influence the price of residential and nursing home care through the balance of in-house and independent sector provision, and type of contract. Netten et al. (2003) described how contractual arrangements by local authorities were regarded as influencing home closures. Block contracts were being offered to larger homes and this was seen as favouring them, putting pressure on smaller homes found to be overrepresented amongst recently closed nursing homes. Local authorities, by purchasing places in residential homes at a high dependency fee for residents who would be previously placed in nursing homes, were reported as prompting the closure of some nursing homes.

In relation to domiciliary care, Ware et al. (2001) reported how a local authority purchaser indicated that one of the criteria for choosing agencies to contract with was their ability to expand and provide for 1200 hours per week. Furthermore, it was described how another commissioner noted that the three year block contracts that they had put out to tender had been won by larger organisations. They stated that commissioners were aware that small providers were struggling as a result of local authorities increasing their expectations in relation to quality standards. Drake and

Davies (2006) noted that the use of block contracts to make major changes in the amount of domiciliary care outsourced was likely to have a major impact on the future of small agencies, and desired plurality of providers in the market place. They gave examples of where a local authority had offered higher prices to small local organisations to ensure their survival; of where a local authority was planning to employ two providers per geographic area in order to avoid monopolies forming; and of another which had changed the balance of independent and local authority provision in order to regain control over the price of domiciliary care in the independent sector.

Research has suggested that local authorities can also have an influence on markets outside their locality. Haynes et al. (2006) reported how some local authorities, particularly those in inner London, placed clients in residential homes outside of their area. Studies have also provided evidence of how national policy can impact on the domiciliary care market and introduce factors that are beyond the control of local authorities. Examples are: the introduction of the residential care allowance and its subsequent withdrawal noted above; the establishment of national minimum standards; the implementation of a minimum wage; and the enactment of the European Working Time Directive into UK law (Andrews and Phillips, 2002; Netten et al., 2003; Clarkson et al., 2005).

Balance of local authority and independent sector provision

With regard to care home provision, Andrews and Phillips (2000) noted that the private residential care sector increased substantially during the 1980s. Forder and Netten (2000) reported that the independent sector accounted for nearly 85 per cent of all care home provision. Netten et al. (2003) described how few local authority supported residents of nursing/residential homes were placed in council run establishments and that in two of their study sites there were no such establishments. Darton et al. (2003) noted that between 1986 and 1996 the average size of local authority run homes had fallen while the average size of private residential and nursing homes increased. The balance of local authority and independent sector residential care provision was found to vary across the country. London was found to have the highest rate of decline in residents being placed in local authority owned care homes but did not have the growth in the independent sector to compensate for it. Furthermore, the decline was found to be greatest in Conservative controlled compared to other authorities, although this was not a statistically significant finding. Haynes et al. (2006) reported a decline in the number of both homes and residents, along with a large reduction in the number of local authority owned homes.

Curtice and Fraser (2000) noted that the proportion of weekly care hours provided by the independent sector was small in Scotland compared with the position in England, and that the majority of domiciliary care was purchased in-house. Moreover, whilst Scottish local authorities varied little in relation to the proportion of domiciliary care purchased from the independent sector, they did vary in terms of the proportion purchased from the voluntary or private sector. Ware et al. (2001) reported that whilst there were still considerable differences between local authorities in the split between in-house and independent domiciliary care services, there had been an overall increase in the independent sector share of the home care market since 1995. In a later study, Drake and Davies (2006) recorded that some local authorities

had outsourced all of their domiciliary care and that block contracts were used by others to achieve a large step increase in the amount being outsourced. There were examples of where local authorities had turned to single national providers to take over their in-house provision. Six strategies for creating a mixed economy of care where local authorities had retained some of their domiciliary care in-house were identified (listed in Box 1.25). Local authorities were found to vary in the number and the types of contracts they had with independent providers.

Box 1.25: Categorisation of local authority strategies for domiciliary care provision

- Outsourcing domiciliary care but providing specialist services in house (re-enablement was identified as the main specialism that was kept in-house).
- Providing a full range of skills in-house and through outsourcing so that the in-house resource complements the capacity of the independent providers, forming a single pool of providers.
- Outsourcing domiciliary care, providing specialist services in house but outsourcing certain specialist skills from specialist providers.
- Providing a full range of skills in-house and out of house, as well outsourcing certain specialist skills from specialist providers.
- Only outsourcing certain specialist skills.
- Maintaining very low levels of outsourcing to provide top up capacity as required.

Source: Drake and Davies, 2006

Focus of provision

Andrews and Phillips (2000) noted that the majority of independent sector residential homes were registered to care for elderly people, with the remainder multi-registered to care for a variety of clients. A substantial number of homes were either considering, or in the process of changing their registration to allow them to care for more dependent clients. Darton et al. (2003) concluded that levels of dependency were greater in all types of home in 1996 than in 1986, but that changes in the level of dependency were greater for voluntary sector residential homes and nursing homes. As reported above, Netten et al. (2003) noted that residents who would have previously been placed in nursing homes were being placed in residential care at an enhanced high dependency fee.

In relation to domiciliary care, Curtice and Fraser (2000) described how independent providers were viewed as offering useful supplementary services, particularly where specialist services were required, and were not perceived to be in competition with statutory services for the provision of core domiciliary care services. One local authority distinguished between domestic and personal care services, choosing to contract out the former and retain the latter in-house. Ware et al. (2001) noted that the majority of independent sector providers of domiciliary care sought to offer a range of services, rather than specialise for particular groups of users. Drake and Davies (2006) found that whilst some local authorities had outsourced all their domiciliary care services to the independent sector, there was evidence that some local authorities identified reablement services as a core, specialist competency which continued to be provided in-house. However, where all domiciliary care had been outsourced, this function was undertaken by the independent sector.

Characteristics of independent sector providers

Netten et al. (2000) reported that recently closed homes were smaller than the national average and were likely to be the only home owned by the organisation. This finding is supported in research by Andrews and Phillips (2002) who noted that smaller homes were more likely to be in financial difficulty and at risk of closure, with medium and larger sized companies in a more secure financial position, thought to be due to their ability to withstand lower demand. Subsequently, Darton et al. (2003) detailed how the ownership of private residential homes was concentrated among small organisations, with 80 per cent of private residential homes being the only home run by the organisation, but with a growing number of homes owned by major providers.

Wistow and Hardy (1999) concluded that whilst the domiciliary care market was dominated by new and small scale organisations, there was some evidence of consolidation in the home care industry. Similarly, Ware et al. (2001) noted that the majority of domiciliary care providers were increasingly likely to be fairly new to the market. They were also more likely to cover a more closely defined locality rather than the whole of the local authority area. Many providers operated on a small scale but there had been an increase in the number of care hours being provided by agencies, and in the number of organisations operating in more than one authority, as a result of the market consolidating into larger organisations.

Training: extent and uptake

For residential/nursing care, Netten et al. (2003) noted that a lack of qualified nursing staff was frequently cited as a reason for the closure of nursing homes. In relation to domiciliary care, Wistow and Hardy (1999) reported how care work applicants were often untrained and unqualified and returning to the labour market after long periods away from paid employment. Social care providers, because they were competing in the wider labour market with other employers, found they had to invest in staff training, but with little guarantee that staff would remain in their employment as they often moved to higher paying agencies after being trained. McFarlene and McLean (2003) reported that a higher percentage of residential workers compared to domiciliary care workers possessed an educational qualification, 63 compared to 34 per cent. Domiciliary care workers were also found to be less well informed about training courses than residential care staff. Of domiciliary and care home workers who had been unable to attend training, this was due to a number of different reasons including: not being able to get time off work; lack of available funding; or not being selected for training. A third of workers with older people reported that they had unmet training needs. Where care workers had received training, employers had met the fees of over 90 per cent of employees who had undertaken training achieving a qualification.

Francis and Netten (2004) reviewed the training provided by domiciliary care agencies and confirmed how they had long provided in-house training to care workers, including lifting and handling and mental health awareness. They did, however, identify resistance amongst providers to the idea of formal training of their workforce and fears that shortages of domiciliary care workers would worsen in the face of additional demands for training. The costs of training were also viewed as an inhibiting factor because of the low prices paid by local authorities for domiciliary

care services. Fleming and Taylor (2006) noted that less than half of domiciliary care workers had been given training when they were first appointed. However, a quarter of them had received specialist training for some aspect of their job. Despite the low proportion of workers holding recognised qualifications, domiciliary care workers generally considered that they had all the training they needed and many did not believe they needed more supervision. However, they did identify the need for better support systems and those workers who had considered leaving the service reported a lack of support and supervision as key factors. Timonen and Doyle (2007) noted that whilst all the private domiciliary care agency managers interviewed insisted that carers were required to have certain minimum training qualifications, this was not always enforced. They were reported to be disinclined to pay for the training of care staff. As a consequence, many workers were found to be completing and paying for training courses before they approached the private sector companies for employment.

More generally, Balloch et al. (2004) reported how less than a third of providers of nursing and residential care homes, day centres, and domiciliary care services had care staff that had (or were working towards) care qualifications of National Vocational Qualification level two or above. A third of the organisations studied were found to have no staff qualified to this level and domiciliary care providers were particularly likely to lack qualified staff, with only six per cent qualified to this standard. Several barriers to training were identified by employers and managers. However, finding cover for staff whilst training was considered by the majority to be a key barrier due to staff shortages and the cost of replacement staff. There were also perceived to be problems in organising in-house training due to workload pressures and the problems associated with releasing several members of staff to attend a course at one time. Other providers preferred in-house training, viewing it as more flexible and convenient than college courses. Training providers reported how drop out rates were significantly higher among private social care providers with pressures of work, long working hours and poor workplace support cited by way of explanation.

Contract setting

Type of contract

For nursing and residential care, Filinson (1998) reported that few nursing and residential homes had block contracts with local authorities. Forder and Netten (2000) similarly noted that spot contracting was the most common way for local authorities to purchase places in residential/nursing care with block contracting less likely to be used. Kendall (2001) reported a higher degree of support for spot contracting amongst residential care providers than anticipated, believed to be because these were viewed as less of a constraint on their autonomy and allowed them to be selective in accepting clients. Less than half of providers reported a preference for a block or a cost and volume contract. In a later study, Matosevic et al. (2008) found that in seven out of the eight local authorities studied, services were solely or mainly purchased using spot contracts, with block contracts mainly used for purchasing more specialised services such as respite care. Although the majority of commissioners were satisfied with the contracts, some authorities were considering the possibility of changing from spot to block contracting for purchasing residential care.

For domiciliary care, Wistow and Hardy (1999) noted that the majority of providers only had spot contracts and the proportion of providers solely in receipt of these was steadily rising. Curtice and Fraser (2000) concluded that block contracts tended to be offered to the voluntary sector, with spot purchasing more commonly used with the private sector. Subsequently, Ware et al. (2001) reported that whilst spot or call off contracts were the most common form of contract used for purchasing domiciliary care there were moves towards a greater use of block or cost and volume purchasing and, more generally, towards a greater range of contracting arrangements. It was also noted that despite the greater use of block contracts, they have reduced in popularity amongst providers, with cost and volume contracts becoming more popular. Forder et al. (2004) identified five contract types for domiciliary care which are detailed in Box 1.26. Many providers were found to have a mix of contract types and less than half had a block or cost and volume contract. One tenth of providers were found to operate solely with these contract types. Over half of providers had only spot or call off contracting arrangements with the local authority. In a later study, Drake and Davies (2006) reported that both the number of domiciliary care providers and the type and mix of contracts used varied considerably across authorities. A minority of authorities were found to use cost and volume contracts; spot contracts were more likely to be in operation but the use of block contracts was increasing. It was also noted that a greater use of block contracts was viewed positively by some domiciliary care providers because the hours of service were guaranteed.

Box 1.26: Types of contract - domiciliary care

- Block contract – payment is agreed in advance and made for a quantity of service regardless of whether that service is actually consumed by users.
- Cost and volume contract – a hybrid of block and call-off arrangements – payment is agreed and made for a block of supply, but additional payment is only made for service units beyond this level if they are actually consumed.
- Spot contract – a price per case arrangement where prices and other terms are agreed in relation to individual units of service, usually around the person receiving care, and thus payments are made for services used by individual clients.
- Call-off contracts – differ from spot contracts in that the price per unit of supplied service is set in advance and fixed for the contract period.
- Grant – providers are paid a lump sum with the expectation of meeting the service needs of a nominal number of clients. Actual level of supply is not explicitly agreed and only broad service specifications are laid out.

Source: Forder et al., 2004

Price

In relation to residential care, Forder (1997) reported that the majority of care homes were operating in local authorities that offered a fixed price for placements. However, they found evidence to suggest that where prices could be negotiated, some homes exaggerated a client's level of dependency in order to increase revenue. Forder and Netten (2000) concluded that prices varied by type of contract, with a higher cost for residential or nursing home care when purchased under spot contracting arrangements. Spot contacts with non-approved as opposed to approved providers, were found to have higher relative prices, and lower prices were found to be associated with block contracting. More generally, higher prices were associated with high dependency residents and also with nursing compared to residential home

care. The number of providers within the local authority area was found to have a negative effect on the price, but the size of the relationship was small, suggesting modest provider market power. Where there was a higher than average level of local authority care home provision, there was a reduction in independent sector prices.

In a later study, Darton et al. (2003) divided factors associated with the price paid for care home placements into two groups: those related to cost and those related to demand. The former comprised: resident and home characteristics and local area costs of inputs; and the latter, market characteristics and commissioning/purchasing arrangements. However, the effect of the local labour market (a cost related factor) was found to have the most significant effect on prices with the relationship between wages and prices being particularly sensitive in residential care, with a one per cent rise in wages associated with a 0.81 per cent rise in prices. In particular it was noted that that the prices paid by local authorities had not kept up with the increase in wages necessitated by the national minimum wage and the European working time directive which had impacted negatively on the profits obtained by providers. Netten et al. (2003) reported that three quarters of homes that had closed claimed that this was due to local authority prices not covering their costs following the introduction of these policies.

Ware et al. (2001) noted how the policies detailed above had led to higher staffing costs for domiciliary care which had not been reflected in increased local authority prices. Quality standards had put further pressure on prices, leading to staff effectively taking pay cuts through a lower hourly wage, or through mileage allowances being reduced. Some local authority commissioners agreed that although the level of fees paid by the local authority would cover care workers hours, they did not cover the running costs of many small businesses. Forder et al. (2004) reported on the variability of prices paid for domiciliary care. Over two thirds of providers operated with a single fixed price per hour of service and negotiable pricing arrangements were rare and limited to negotiations based on specific user needs. Block contracts were found to be associated with lower prices but only for organisations that had been in business for a relatively short time and grant funding was found to be associated with higher prices (Drake and Davies, 2006). The cost of independent domiciliary care provision was also found to be lower than in-house although this differential varied between local authorities. It was also noted that pricing structures were simpler with the use of block contracts.

Care management arrangements and practice

Care management, coordinated care, as noted in the policy section was implemented in 1993 in England as part of the community care reforms. Early research demonstrated a number of criteria of variation in care management arrangements (Challis, et al., 1998), three of which have been selected for further exploration because of their relevance to commissioning and contracting arrangements (Challis, et al., 1998). These are: devolved budgets; care planning, as it is of particular relevance to continuity in assessment and care management tasks; and intensive care management. However, first more recent developments indicative of the government's personalisation agenda within social care: direct payments and

individual budgets are discussed, because of their relationship to commissioning and contracting procedures within older people's services.

Personalisation of care

There was a dearth of empirical evidence concerning the use of direct payments and individual budgets specifically for older people reflecting the fact that this initiative was only introduced into older people's services in 2000, later than for other adult user groups (Department of Health, 2000). Therefore, as noted in Box 1.22, in this section the inclusion criteria regarding the care recipient group have been relaxed to include other adult groups. Whilst the developments discussed below are not specific to older people, as these initiatives develop, they are likely to have resonance in older people services although the extent is not known at present.

Glendinning et al. (2000) reported how those in receipt of direct payments were able to purchase some services that crossed the health and social care divide. Direct payment users reported purchasing help with health care (such as physiotherapy, chiropody) from their personal assistants because statutory services had been unavailable or had been withdrawn or because purchasing these services themselves enabled them to retain greater independence and control over these aspects of care. They also wanted the scope of direct payments to be extended to cover health care and nearly half believed that with appropriate training, personal assistants could provide these services, whilst acknowledging some may not want or be able to do so. Fernández et al. (2007) found wide variation between local authorities and between service groups within local authorities in the uptake of direct payments. Factors both within and beyond the control of local authorities were associated with this. Firstly, those authorities with a low proportion of home care, a high level of take up of direct payments by people with physical disabilities, and larger and wealthier compared to other authorities, were found to have a higher take up of direct payments by older people. This was ascribed to a greater capacity to meet the costs of setting up a direct payments system. Secondly, local authorities that assessed a greater proportion of older people provided fewer with direct payments, believed to be because they were likely to provide less intensive packages of care which may make the trade off between responsibilities and benefits too great, making direct payments less attractive to service users. Third, authorities focussing more resources on community based care than on residential care were found to provide more intensive average direct payment packages. Leece (2007) reported that direct payments were more likely to provide continuity of care and to give users more control over the care received. Although the employment responsibilities that came with the receipt of a direct payment did appear to deter those interviewed from this option, concerns were raised about the risks associated with employing personal assistants, such as not knowing whether personal assistants possessed a criminal record.

Duffy (2004) described how six local authorities were being helped by the 'In Control' resource allocation mechanism to shift existing social care delivery in learning disability services towards a model of self directed support. This included working out and informing users of the level of funding they can plan with; supported decision making and ensuring decisions were made as close to the user as possible; and giving people the opportunity to plan and explore different options. Subsequently,

Duffy (2005) described how this resource allocation system had been implemented in seven local authorities. Early findings from this process revealed that *"actual funding levels seemed to reflect the relative generosity of different localities and the history of commissioning practices, rather than the underlying economies of the locality"* (p12).

Glendinning et al. (2007) reported how thirteen local authorities were piloting individual budgets, with different sites involving different numbers and combinations of user groups, including older people. They argued that *"major questions need to be answered before a decision can be taken about 'rolling out' individual budgets more widely"* (p123). Rabiee et al. (2008) concluded that individual budgets *"had potential"*, however, achieving this potential was seen as dependent on a range of other factors, including changes in the routine practices and organisational culture of adult social care services, and ensuring users have access to appropriate documentation and support. The most important benefits associated with individual budgets were: that they offered users more choice and control; gave users more independence; and enhanced their sense of identity and self-esteem. Concerns raised about individual budgets were: their sustainability; potential misuse; and that they might not meet the higher costs of providing support in remote areas. One to one support with the assessment and planning processes, and on-going help with managing individual budgets, were identified as a means of assisting budget holders to benefit from the potential opportunities that they offered. Some budget holders expected individual budgets to shift the power between users and service providers, and felt that in the longer term this would result in better quality support. However, others believed that the level of their individual budget would be lower than the value of previous support arrangements, and this would reduce their choice of services and level of control over decisions. Manthorpe et al. (2008) reported how individual budgets had the potential to empower people using services, but that they also presented potential risks to service users due to a lack of regulation of those being employed by individual budget holders. A lack of control over who was employed, lack of registration and enforcement of Criminal Record Bureau and Protection of Vulnerable Adult checks; and possible abuse of the system by family members were amongst these concerns. It was also suggested that service users could become isolated and lose their collective impact on commissioning and the regulation of services; and that those persons employed through individual budgets would lose entitlements such as sickness and pension benefits. In terms of support specifically for older people, a major randomised trial found relatively little benefit accrued to older people (Glendinning et al, 2008a).

Devolved budgets

For Challis et al. (2001a) devolved budgets were considered to exist where "*care managers were able to commit finance to and/or allocate services, such as domiciliary care, as part of a care package without consultation with a first-line manager or other more senior person"* (Challis et al., 2001a p410). Lewis et al. (1996; 1997) noted a lack of devolved budgetary arrangements and reported that a failure of authorities to devolve budgets or provide a range of services had limited care managers' choice of services.

Problems associated with arriving at a formula by which to distribute money to a large number of care managers was cited as one of the reasons for a lack of devolved budgeting. Leat and Perkins (1998) described how control over budgets for total spending on purchasing care packages varied between and within authorities. Some care managers did not have the information or training to manage budgets. As well as financial information, care managers required specific information about the availability of the service, minimum charges, and whether or not the specific cost for domiciliary care included travel costs. Furthermore, the availability of information on unit costs of both in-house and independent sector services varied between authorities. Challis et al. (1998) also found budgetary devolution to vary substantially between local authorities. Of the five authorities studied, two devolved budgets to front line staff or care managers, two to first line managers, and in one authority, budgetary devolution was not evident except in the intensive care management service. Subsequently, Challis et al. (2001a) reported how devolved budgets were not present in the majority of authorities surveyed as part of a national study. Weiner et al. (2002) in an analysis of data from the same study reported how care managers were only able to purchase or allocate all external services in six per cent of authorities and in over half of authorities they were not permitted to commit any funds to external services. Therefore they concluded that even where the power to purchase services was devolved to frontline staff, this applied to only a limited range of services.

Care planning

"Care planning…incorporates two elements: negotiating the most appropriate means to achieve the goals identified in the assessment and securing the necessary services or resources to meet them" (Hughes et al. 2005 p202). In terms of care planning, Andrew et al. (2000) identified the provision of home care, day care and family support as being of crucial importance in preventing admission to long term care.

With regard to care planning, Lewis et al. (1996) reported how a narrow administrative approach to care management prevailed. This was supported by subsequent research that confirmed how local authorities pursued an administrative approach to care management of older people's services in which care planning played only a small part. Weinberg et al. (2003) reported how, of the activities undertaken by care managers of older people, care planning and arranging services to meet identified needs took 13 per cent of their time. This was compared to 32 per cent spent on administrative tasks; 27 per cent on assessment; seven per cent monitoring and reviewing activities; and four per cent on liaising with health staff. Jacobs et al. (2006) confirmed that assessment activities predominated in older people's services and left little time for other activities such as the monitoring and review of services. They concluded that care managers in older peoples services exercised an administrative form of care management focussing mainly on assessment.

In respect to choice of care services, Lewis et al. (1997) described how restricting staff to purchasing mainly from block contractors limited their ability to create a needs led service. Subsequently, Ware et al. (2003) reported how the choice of services care managers were able to offer was limited. With regard to domiciliary

care, care managers in several authorities would have liked to offer shopping, bathing or housework services (on their own) and the inability to offer these services was deemed to restrict the ability of older people to maintain their independence. It was also reported that care managers were often given insufficient information about services and that they viewed giving a choice between care providers to users as making little sense without them having prior knowledge of what services were available.

Similarly, Preston-Shoot (2003) reported how users' and carers' lack of knowledge of service availability was perceived as hindering their capacity to make informed choices about what options would meet their needs. Users were sometimes unclear about who provided services and about the distinction between social services, voluntary agencies, and private providers. Furthermore, users, carers, and practitioners were found to have different perceptions of needs and the extent to which these were met by available services. Social workers prioritised needs differently to users and carers, emphasising personal assistance, communication and management of medication, with users and carers prioritising cleaning and household tasks. Ware et al. (2003) noted that in addition to concerns about a lack of information about current capacity, the availability of care providers, particularly in rural areas, was also viewed as restricting the choice of services. The same study noted that users had more choice over providers of residential and nursing home care than domiciliary care. The availability of residential and nursing respite care was also of concern and one particular area of unmet need identified was overnight care. Furthermore, block contracting, 'cheapest-first' or 'in-house first' policies were viewed as restricting choice of domiciliary care services in some authorities.

Nicholas (2003) described how a focus on outcomes may lead to improved care planning, particularly in relation to respite breaks, and could stimulate different service responses.

Intensive care management

Andrew et al. (2000) demonstrated that mainstream home care and day care provided by social services departments can assist older people with cognitive impairment to remain at home. For example in regard to home care, for every additional hour per week of home care the odds of entering long term care were found to decline by a factor of 0.89.

Intensive care management has been defined as "*the presence of a specialist care management service working exclusively with people with high needs or at high risk, carried out by staff with small caseloads"* (Challis et al., 2001a p410). Seven indicators associated with the presence of intensive care management have been identified and are listed in Box 1.27. Challis et al. (2001a) reported that although most social service departments were found to have an explicit policy of diverting people from residential to home-based care, the presence of other key features of intensive care management were uncommon: devolved budgets, health service care managers, small caseloads, and clear eligibility criteria. It was also noted by Challis et al. (2001b) that only five per cent of social services departments had specialist intensive care management services for older people.

Box 1.27: Indicators associated with the presence of intensive care management

- Specialist targeted service for older people.
- Specialist teams for older peoples' services.
- Devolved budgets to purchase social care.
- Presence of health service care managers.
- Small caseloads.
- Clear eligibility criteria.
- Policy of diversion from residential care.

Source: Challis et al., 2001a p410

In the next chapter the methodology for this study is described and in subsequent chapters the findings are reported and discussed.

CHAPTER 2: METHODOLOGY

Introduction

The information presented in this report is based on the items included in a questionnaire sent to local authorities in England as part of the first phase of the study: *Recruitment and Retention of a Social Care Workforce for Older People*. As noted in the preface, this research study has three phases and this report describes the first of these. In this there are two stages. First, a postal survey of local authorities' commissioning and contracting arrangements, and second, an exploration of different sets of approaches to commissioning and contracting arrangements. The methodology for each of these is described below.

Approval for the entire study was obtained from the Association of Directors of Adult Social Services (ADASS) Research Group, and for this phase of the research, the University Research Ethics Committee at the University of Manchester.

Stage 1 national survey

Questionnaire development

Prior to the drafting of the questionnaire for phase I of the study, meetings were arranged with social services commissioners in two local authorities, to develop a greater understanding of the issues relating to the interrelationship between commissioning, contracting and care management arrangements. These were held in November and December 2007 and focussed particularly on workforce issues. The development of the questionnaire was also informed by a relevant, purposive review of literature and policy.

The questionnaire covered services for people aged 65 and over including those with mental health problems. In terms of commissioning and contracting the focus was on domiciliary care provision and residential and nursing care including joint commissioning arrangements. The broad domains covered by the questionnaire were as follows:

- Background information
- Commissioning
- Contracting – domiciliary care services
- Contracting – residential/nursing home care
- Commissioning within care management arrangements.

The questionnaire contained 53 questions, and is included as Appendix 1.

Fieldwork

The questionnaire was sent to the Directors of Adult Social Care Services in mid January 2008. Respondents were requested to nominate the most appropriate officers to complete the questionnaire. Telephone contacts were commenced on the 4th February and this process was repeated 5th May. The last questionnaire was received on the 23rd June 2008.

Data and report preparation

The information collected from the questionnaires was entered into an SPSS database. For the open-ended questions, coding frames were prepared from the responses provided, and categorical variables defined for entry of the data into the database.

Stage 2 typology of local authorities

Local authorities were categorised through a cluster analysis using a number of key variables selected from the first phase of the research programme. The cluster analysis required three sequential steps: the selection of variables; hierarchical cluster analysis; and non-hierarchical cluster analysis. These are described below with the methods employed to determine the appropriateness of this approach.

Selection of variables

Questions spanning both domiciliary care and care home provision were selected from the national survey to create variables for the analysis. These were grouped into three domains of interest:

- Commissioning and contracting arrangements
- Employment practices
- Flexibility in service provision at the level of the service user.

Hierarchical cluster analysis

A hierarchical cluster analysis was used to identify groups of similar authorities, by using a measure of the similarity between them based on the values of the variables selected. To ensure that at this stage the maximum number of authorities in the sample were included in the analysis; variables were excluded if they had a considerable number of missing values relative to other variables. A series of different clustering methods were compared before obtaining a final cluster solution (Everitt, 1993). Of the methods used, Ward's method appeared to result in a manageable number of clusters where the cases within each cluster were relatively similar to one another.

Non-hierarchical cluster analysis

Once the number of clusters in the data had been identified, a non-hierarchical (k-means) cluster analysis was conducted to refine the classification. This method is often used in order to build on the results from a hierarchical cluster analysis (Campbell, 2001). For example, the Office for National Statistics classification of local authorities provides an example of such an approach (ONS, 2008). It also allowed the inclusion of local authorities with missing data. In this study the majority of questionnaires (20 of 30) had data missing for only one variable. These were assigned to the cluster they matched most closely, based on the variables for which data were available. This was regarded as an efficient way of assigning those without complete data and making the best possible use of the information provided.

Appropriateness of typology

To determine the appropriateness of this typology, three approaches were used: an assessment of its ecological validity or relevance to current structures and practice, one employing relevant statistical tests and finally one assessing the appropriateness of the theoretical construct.

Ecological validity

In order to achieve *"ecological validity"*, *"to make the research fitting to the real world"* (Banister et al., 1994 p. 5) and to ensure that the resulting classification of local authorities had resonance for those in receipt of or involved in the commissioning of social services for older people, the results of preliminary analysis of the data were presented at a meeting of the advisory board for the research, whose membership included: lay older people; representatives of older people; and members of other stakeholder groups. The views of those present at this meeting, as well as a series of further discussions with colleagues in the Manchester Business School responsible for subsequent phases of the research, influenced the final selection of the domains of interest and their constituent variables presented in Chapter 3.

Statistical tests

A one-way analysis of variance test was used to assess whether the domains of interest were useful discriminators between the cluster types. In addition, 'post hoc multiple comparisons' were carried out using the Scheffe test, the most commonly used method (Argyrous, 2002), in order to identify which clusters were significantly different from each other, using the domains of interest as a basis for comparison. In order to conduct these tests, domain scores were computed for each local authority. Where they had missing data for one or more key indicators within a domain it was not possible to compute a domain score, although it could be determined how they scored with respect to those indicators for which they had data. Where this has affected the sample size it is noted.

Ideal type

Once the typology had been finalised following this process, it was further validated by verifying that it possessed the characteristics of an ideal type (Psathas, 2005). An ideal type:

"*is a construct developed by the analyst for particular purposes (and) represents a selection of features or elements considered significant, essential or exemplary…it systematizes and organises a number of features by drawing out or focusing on these and selectively excluding others"* (Psathas, 2005 p. 147).

CHAPTER 3: FINDINGS

This chapter is organised into two parts. First, findings from the national survey will be described. This will include a representative selection of the free text comments made by respondents, summarised and categorised. Following this a typology of local authority commissioning and contracting arrangements will be presented. Appendix 3 contains data relevant to this analysis and will be referred to where appropriate. Data for the figures contained within this chapter are also included within this. Overall local authorities completed questionnaires with diligence; however one respondent did not supply the name of their authority. Where this affects the sample size it is noted.

Part 1 Survey findings

Response rate

Ninety two of the 149 authorities to whom questionnaires were distributed returned completed questionnaires, representing a response rate of 62 per cent. As Table 3.1 indicates, the completion rate for inner London (54%) and outer London boroughs (50%) was lower than for other types of authorities, with principal metropolitan cities having the highest response rate (83%). In the analysis that follows, inner and outer London boroughs are referred to as 'London boroughs,' and principal metropolitan cities and other metropolitan districts are combined together. However, where issues of scale may be relevant, they are treated separately as categorised below.

Table 3.1: Response rate by authority type

	Authority type*						All
	Inner London	Outer London	Principal metropolitan cities	Other metropolitan districts	Shire counties	Shire unitary authorities	
Total authorities	13	20	6	30	34	46	149
No. distributed	13	20	6	30	34	46	149
No. responding	7	10	5	18	22	29	91
% completion rate	54	50	83	60	65	63	61

*One response could not be classified.

Background information

As shown in Table 3.2, of the local authorities surveyed, 42 per cent were under Conservative control. Of the remaining authorities, 27 per cent were controlled by Labour, with a tenth (10%) of local authorities being under Liberal Democrat control. Just over a fifth of local authorities (21%) were under no overall control. Shire counties were more likely to be under Conservative control (77%), and metropolitan cities/districts under Labour control (44%) (see Table A3.1).

Table 3.2: Political control at 31st May 2007 (n=92)

	No.	%
Conservative	39	42
Labour	25	27
No overall control	19	21
Liberal Democrats	9	10

Source: Question 1 – What was the political control of your authority at 31/5/2007?

Table 3.3 demonstrates that for the majority of local authorities (60%), the social services department formed part of a combined rather than a single organisation. Out of the 56 combined organisations, 50 provided details of their organisation, the majority of these described their services being located within a community services directorate. London boroughs were most likely to have a social services department combined with other departments (81%), and shire counties were least likely (32%) (see Table A3.2).

Table 3.3: Structure of social services department (n=91)

	No.	%
Combined	55	60
Single	36	40

Source: Question 2 – Does the social services department form a single department or part of a combined organisation e.g. housing/social services, PCT/Social Services?

As illustrated in Table 3.4, the majority of local authorities (80%) negotiated with only one Primary Care Trust (PCT), with most of the remaining authorities negotiating with two (16%). Very few (4%) negotiated with more than two PCTs.

Table 3.4: Number of primary care trusts negotiated with (n=90)

	No.	%
One	72	80
Two	14	16
Three	2	2
Four	1	1
Five	1	1

Source: Question 3 – How many primary care trusts does your authority routinely negotiate with?

Organisational arrangements

Local authorities were asked for details of their organisational arrangements for the commissioning of social care for older people. The findings are reported in Tables 3.5 and 3.6 below. The organisational level at which managers had responsibility for commissioning and contracting was 3rd tier or above in over two thirds of local authorities (71%). Responsibility for assessment of need, purchasing of services and managing of in-house services was for the majority (82%), combined in a single manager at 2nd tier or above.

Table 3.5: Level at which responsibility for commissioning and contracting is combined (n=88)

	No.	%
3rd tier or above	62	71
2nd tier	18	21
Not applicable	8	9

Source: Question 4 – At what level in the local authority is responsibility for commissioning and contracting combined in a single manager?

Table 3.6: Level at which responsibility for assessment of need, purchasing of services and managing of in-house services is combined (n=87)

	No.	%
2nd tier or above	71	82
Not applicable	10	12
1st tier	6	7

Source: Question 5 – At what level in the local authority is responsibility for assessment of need purchasing of services and managing of in-house services combined in a single manager?

Table 3.7 indicates that only five per cent of authorities had an integrated provider for services for older people for all provision. As Table 3.8 illustrates, where local authorities had an integrated health and social care provider for older people for selected services and specified these, these were most likely to include intermediate care and old age mental health services. These categories were post coded from local authorities' responses.

Table 3.7: Integrated health and social care provider (n=86)

	No.	%
Selected services	66	77
Neither	16	19
All provision	4	5

Source: Question 6a and b - Does your authority have an integrated health and social care provider for older people for all provision or selected services?

Table 3.8: Integrated health and social care provider – selected services (n=61)

	No.	%
Intermediate care	39	64
Old age mental health	27	44
Community equipment	9	15
Older people with learning disabilities	8	13
Assessment	3	5
Residential care	3	5
Domiciliary care	3	5
Other	5	8

Source: Question 6a and b - Does your authority have an integrated health and social care provider for older people for all provision or selected services?

Table 3.9 suggests that for the majority of local authorities (85%) the local authority contracting unit was located solely in the adult social care services department. Examples of other locations included a business management unit.

Table 3.9: Location of contracting unit (n=92)

	No.	%
Adult social care services	78	85
Adult social care plus other department	4	4
Adult social care and primary care trust	3	3
Chief Executives department	1	1
Other	6	7

Source: Question 7 – Is your contracting unit located in?

Relationship between commissioners and providers

Ninety four per cent (86) of local authorities had a provider forum. Local authorities were asked how frequently their provider forum held meetings. The findings are reported in Table 3.10. Half of local authorities (50%) reported that their provider forum(s) met three or four times a year, with a similar proportion (46%) meeting six times a year or more. In a small minority of local authorities (5%), provider forums met only once a year.

Table 3.10: Frequency of provider forum meetings (n=86)

	No.	%
Three or four times a year	43	50
Six times a year	28	33
More than six times a year	11	13
Once a year	4	5

Source: Question Q8b - If have a provider forum how frequently does it meet?

Eighty-four per cent (76 out of 91) of local authorities formed part of a training partnership with other agencies. As shown in Table 3.11, most were formed with independent providers (86%), with around a half linking with partners in the NHS (49%). Around a third of local authorities were in partnership with other local authorities (34%). Examples of other agency partnerships included: the voluntary sector; Skills for Care; and training organisations/centres. It should be noted that these three categories were post coded whilst all others were listed on the questionnaire.

Table 3.11: Training partners (n=76)

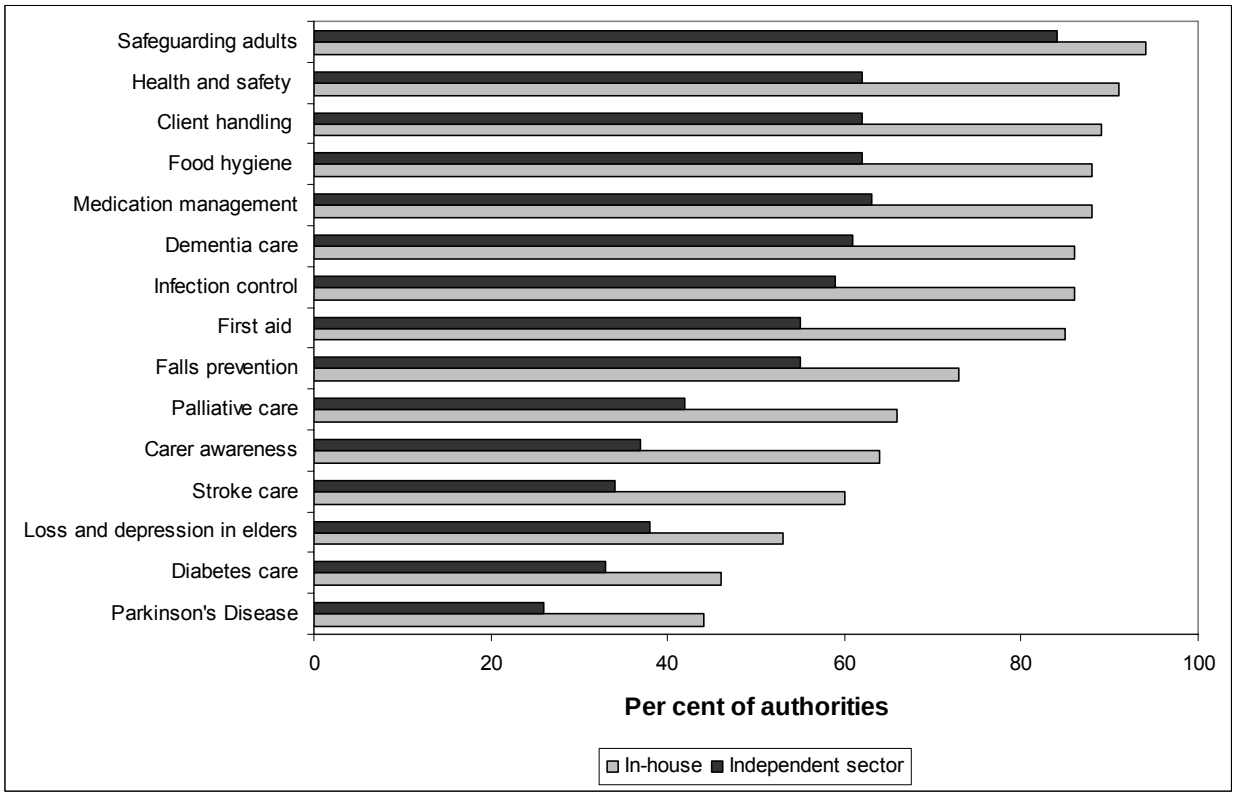
	No.	%
Independent providers	65	86
NHS	37	49
Other local authorities	26	34
Voluntary sector	6	8
Skills for care	3	4
Training organisations/centres	3	4
Other	5	7

Source: Question Q9b - If yes, is this a partnership with?

Local authorities were asked what types of training they provided to care staff in the in-house and independent sector. As Figure 3.1 demonstrates, of the courses provided to care staff, safeguarding adults was the training most likely to be provided to all staff. Courses least likely to be provided to care staff related to: Parkinson's

Disease; diabetes care; and loss and depression in elders. All types of training were more likely to be received by in-house staff than those in the independent sector.

Figure 3.1: Workforce training – in-house and independent sector (minimum n=85, maximum n=86)



Source: Question Q10 – What type of training do you provide to domiciliary/care home staff and is it available to in- house staff and independent sector staff? Tick all that apply.

Table 3.12 explores the responses made by local authorities in more detail. A distinction was made between those respondents which reported that in-house and independent sector staff had equal access to training, and those which favoured either of the two sectors. This suggested that more than a half (56%) of local authorities provided more training to in-house care staff. However, this also indicated that in nearly two fifths (38%) of authorities both independent and in-house sector workers had equal access to the same training courses (38%).

Table 3.12: Availability of training (n=85)

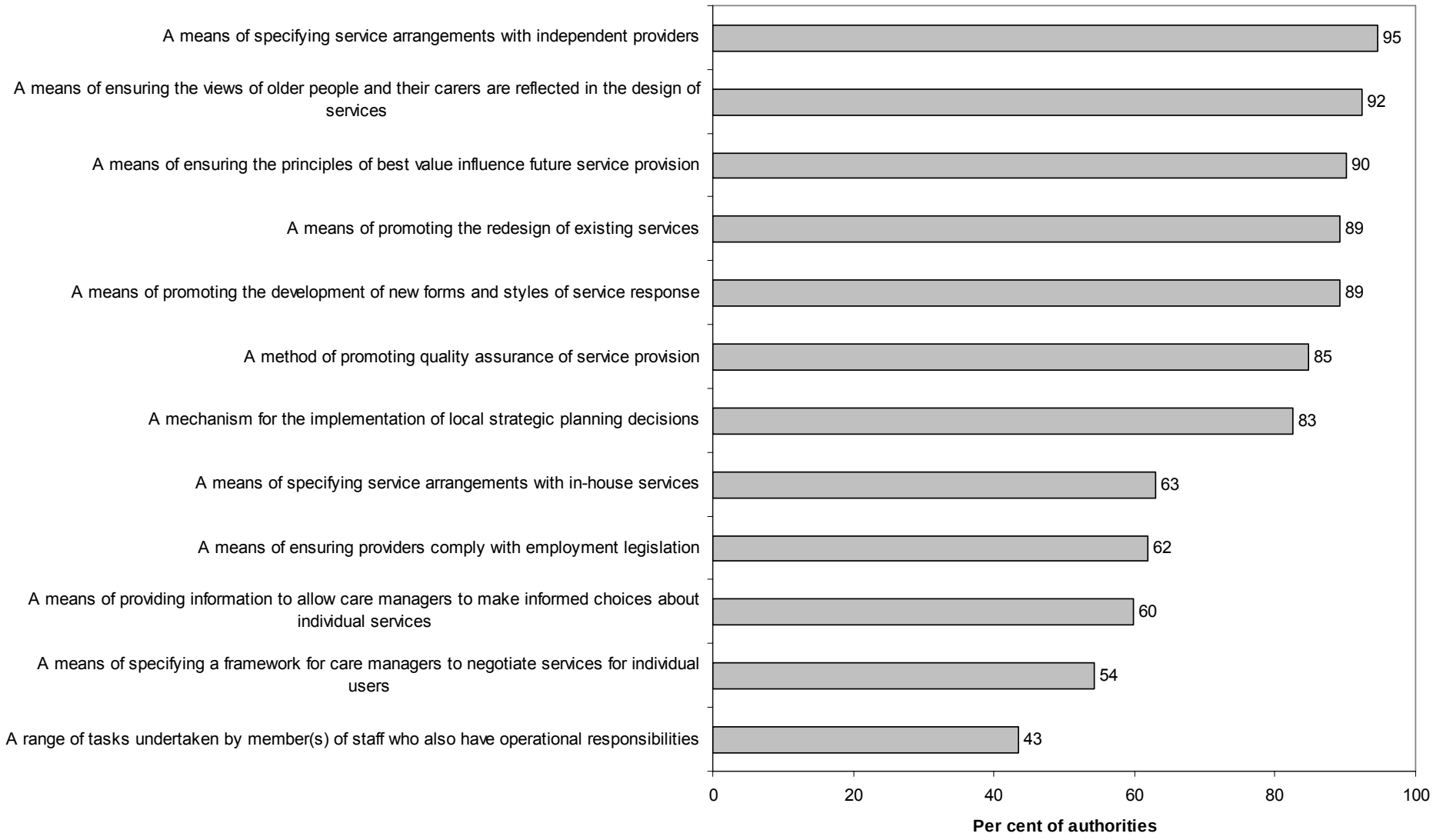
	No.	%
More training provided to in-house staff	47	56
Same training provided to independent and in-house staff	32	38
Less training courses provided to in-house staff	4	5
No training courses provided to any staff regardless of sector	2	2

Source: Question Q10 – What type of training do you provide to domiciliary/care home staff and is it available to in-house staff and independent sector staff? Tick all that apply.

Commissioning

Authorities were requested to describe their commissioning arrangements for older people's services. As illustrated in Figure 3.2, whilst the majority of authorities selected most of the statements, the descriptions most frequently selected were 'a means of specifying service arrangements with independent providers' (95%), and 'a means of ensuring the views of older people and their carers are reflected in the design of services' (92%). The statements least frequently selected were 'a range of tasks undertaken by member(s) of staff who also have operational responsibilities' (43%) and 'a means of specifying a framework for care managers to negotiate services for individual users' (54%). Interestingly, whilst most respondents emphasised the strategic aspects of commissioning relating to the provision of services and the involvement of stakeholders, they were less likely to emphasise the 'micro-commissioning' elements of commissioning such as the role of care managers. Furthermore, there did appear to be differences by authority type. For example, shire unitaries were most likely to see their commissioning arrangements as 'a range of tasks undertaken by member(s) of staff who also have operational responsibilities' (52%). London boroughs were least likely to view them as 'a means of specifying service arrangements with in-house services' (53%) but more likely than all other types of authority, to view them as 'a means of ensuring providers comply with employment legislation' (71%) (see Table A3.5).

Figure 3.2: Local authority commissioning arrangements (n=92)



Source: Q11 – Which of these statements describe your department's commissioning arrangements for older people?

Stakeholder consultation

Authorities were asked which stakeholder groups they routinely involved in the commissioning of older peoples services. The findings are reported in Table 3.13. They were most likely to consult care managers (94%), PCTs (92%), and current service users (91%). On the other hand, they were least likely to consult employee representatives (40%) and next generation older people (48%). Three quarters of local authorities (75%) consulted with more than half of stakeholder groups listed (see Table A3.6).

Table 3.13: Involvement of stakeholders in commissioning (n=90)

	No.	%
Care managers	85	94
Primary Care Trusts	83	92
Current service users	82	91
Carers	82	91
Providers of social care services	78	87
Older people's champions	71	79
Older people from minority ethnic or religious groups	64	71
Housing department	56	62
Scrutiny groups	53	59
Potential or former users of services	49	54
Local Implementation Teams	49	54
CSCI reports	44	49
Next generation older people i.e. people less than 65 years of age	43	48
Employee representatives	36	40

Source: Q12 – Which of the following groups do you routinely involve in the commissioning of new older people's services and the redesign of existing ones? Tick all that apply.

Strategic planning

As illustrated in Table 3.14, almost all authorities (91%) commissioned domiciliary care and all types of care home including specialist provision (98%). In contrast only two thirds of authorities (67%) commissioned adult placement schemes. Around half of local authorities (52%) commissioned specialist domiciliary care services. Examples of specialism included: old age mental health services; intermediate care; supported housing; and services for specialist groups defined by illness or ethnicity (see Table A3.7). Other examples of older people's social services were given. These were post coded and occupy the last seven rows of the table below and for this reason may be under represented. Of these services, the most likely to be mentioned was day care (24%). In terms of the principal services commissioned, there were differences by type of authority. London boroughs were most likely to commission specialist domiciliary care provision (71%), with shire unitaries least likely (36%). Shire counties were most likely to have adult placement schemes (82%), and London boroughs were least likely to commission these types of services (41%) (see Table A3.8).

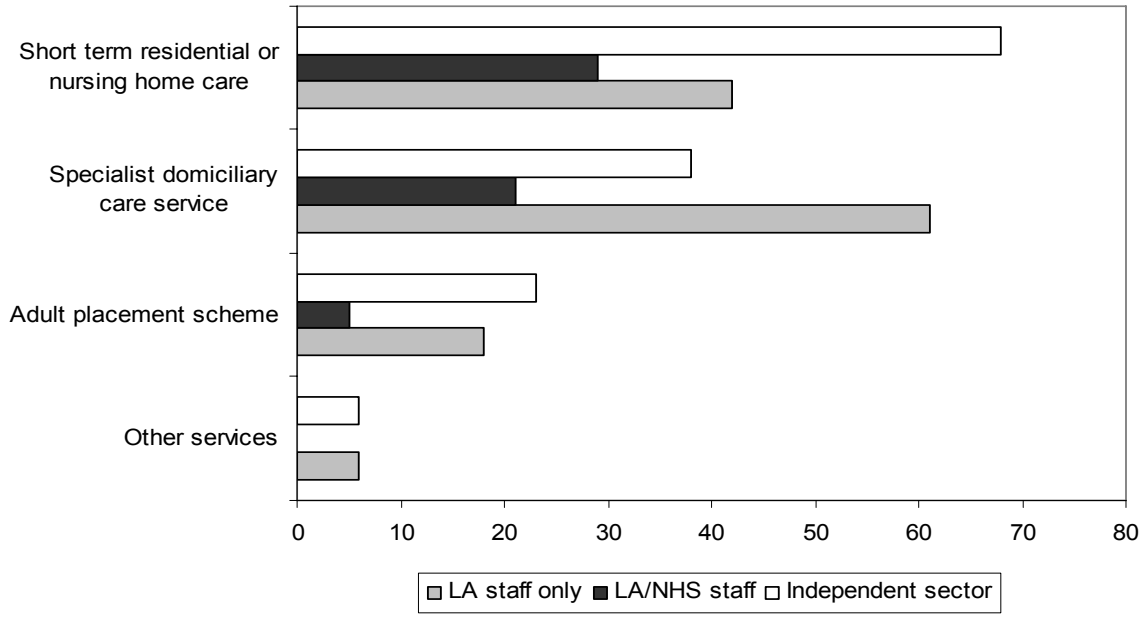
Table 3.14: Range of services commissioned (n=91)

	No.	%
Care homes dementia	90	99
Care home	89	98
Care home with nursing	89	98
Respite care	89	98
Care homes with dementia nursing	86	95
Domiciliary care	83	91
Adult placement	61	67
Specialist domiciliary provision	47	52
Day care	22	24
Intermediate care	8	9
Extra care housing	7	8
Advice/advocacy/support services	7	8
Meals	6	7
Support for carers	6	7
Other	10	11

Source: Q13 – Which of these older people's social services does your local authority commission?

Seventy four per cent (66) of local authorities, reported that they commissioned or provided specialist services dedicated to hospital discharge, outside of the intermediate care sector. Figure 3.3 demonstrates that short term residential or nursing home care and adult placement schemes were most likely to be provided by staff from the independent sector (68%). In contrast, specialist domiciliary care services were most likely to be provided by staff employed directly by the local authority (61%). Examples of other hospital discharge services were supported housing and home from hospital schemes.

Figure 3.3: Hospital discharge services by service sector (n=66)



Source: Q14b – If yes, please specify the services and the type of staff who provide these services. Tick all that apply.

Joint commissioning

Table 3.15 reveals that the most common tools for joint commissioning were joint plans and planning processes, with 79 per cent of authorities utilising these. About a half of authorities (45%) undertook joint specification and overseeing of contracts, and a similar number pooled ring fenced monies (45%). Just six authorities (7%) had pooled their total agency budgets for older people's services.

Table 3.15: Joint commissioning arrangements (n=89)

	No.	%
Joint plans and planning processes	70	79
Joint specification and overseeing of contracts	40	45
Pooling of ring fenced monies	40	45
Single lead commissioner for health and social care	26	29
Pooling of total agency budgets for older people's services	6	7

Source: Q15a – Which of these arrangements does your local authority have for the joint commissioning of older people's services? Tick all that apply.

As illustrated in Table 3.16, the majority of local authorities (65%) reported that they commissioned 20 per cent or less of their older people's services in conjunction with their PCT. On the other hand, a small minority (8%) stated that they jointly commissioned all their older people's services.

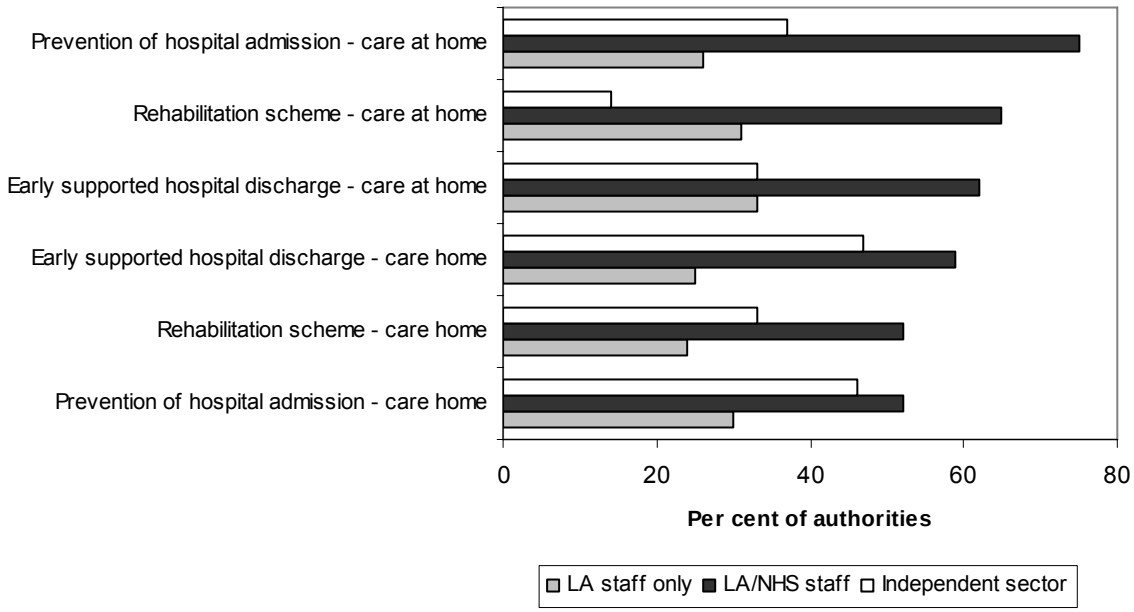
Table 3.16: Commissioning in conjunction with PCT (n=85)

	No.	%
0-20%	55	65
21-40%	13	15
41-60%	5	6
60-80%	0	0
81-99%	5	6
100%	7	8

Source: Q15b – What proportion of your local authority's commissioning for older people's services is done in conjunction with your PCT (i.e. jointly commissioned)?

Ninety-one per cent (84) of local authorities jointly commissioned with the NHS for intermediate care, with local authority/NHS staff most likely to provide these services. For those who supplied additional details, Figure 3.4 demonstrates that where independent sector staff provided intermediate care services, they were most likely to be providing residential nursing home services to prevent hospital admission (46%) and facilitate the early supported hospital discharge of older people (47%). All intermediate care services were most likely to be provided jointly by NHS and local authority staff. Independent sector providers were least likely to provide rehabilitation at home (14%).

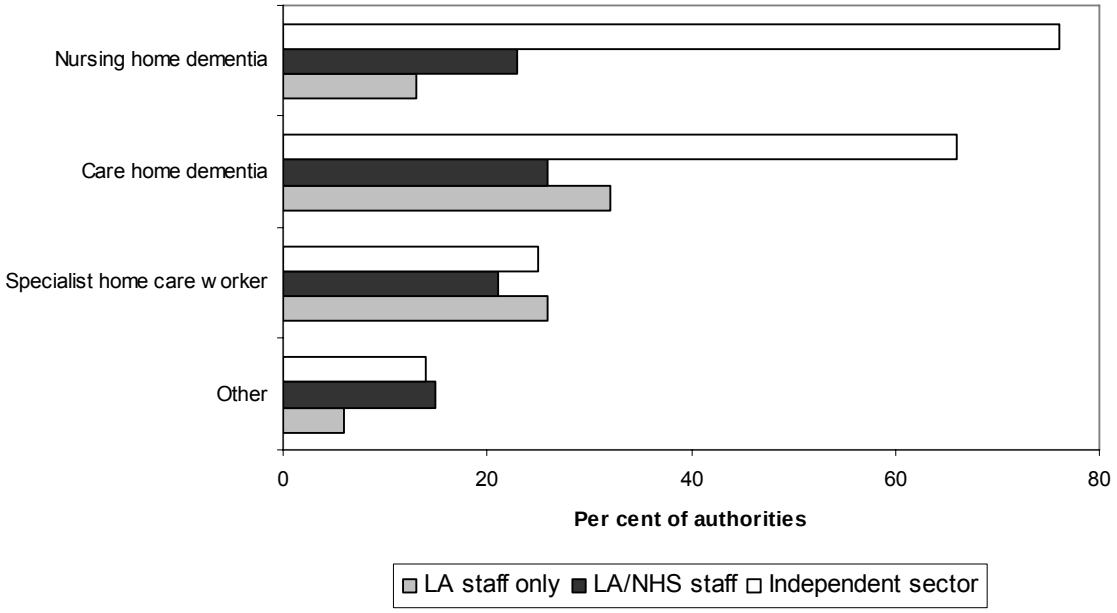
Figure 3.4: Intermediate care services by service sector (n=81)



Source: Q16b – If yes, please specify the type of services and staff that provide them.

Sixty per cent (54 out of 90) of local authorities jointly commissioned with the NHS for old age mental health services. For those who supplied additional information, Figure 3.5 demonstrates, in contrast to findings regarding intermediate care, the independent sector was most likely to provide much of the old age mental health services. Examples of other services included: day care; extra care housing; adult placement; integrated community mental health teams; and short term care.

Figure 3.5: Old age mental health services by service sector (n=52)



Source: Q17b – If yes, please specify the type of services and staff that provide them. Tick all that apply.

Contracting

Domiciliary care

Table 3.17 reveals that half of local authorities contracted out the majority of their domiciliary care services to the independent sector between 2000 and 2004. Around a quarter (26%) did this before 1999 and a similar number (23%) in 2005 or later. Shire counties were most likely to have contracted out domiciliary care services to the independent sector before 1999 (30%), with metropolitan cities and districts least likely (17%) (see Table A3.12).

Table 3.17: Date domiciliary care services contracted to the independent sector (n=90)

	No.	%
Before 1999	23	26
Between 2000 and 2004	46	51
2005 or later	21	23

Source: Q18 – When did you contract out the majority of your domiciliary care services to the independent sector?

Six local authorities reported that they did not have in-house domiciliary care provision meaning that all of their expenditure on domiciliary care services was allocated to independent providers. However, ninety four per cent (86 out of 92) of authorities still had in-house domiciliary care provision. Nevertheless, as Table 3.18 indicates, almost three quarters (72%) allocated over 60 per cent of their expenditure on domiciliary care to independent providers.

Table 3.18: Proportion of expenditure on domiciliary care allocated to independent providers (n=89)

	No.	%
0-20%	5	6
21-40%	1	1
41-60%	19	21
61-80%	34	38
81% or more	24	27
100%	6	7

Source: Q19b – If yes, what proportion of the expenditure on domiciliary care is contracted to independent providers?

Fifty five per cent (47 out of 85) of respondents reported that their contracting/commissioning sections monitored their in-house domiciliary care service. Of those authorities that did not, two indicated that this was because the in-house domiciliary care service was so small this function was undertaken by care managers. Approaches to monitoring in-house provision were post coded and are listed in Table 3.19 below. These included: monitoring through the use of a contractual framework (43%); and the use of quality assurance systems (34%).

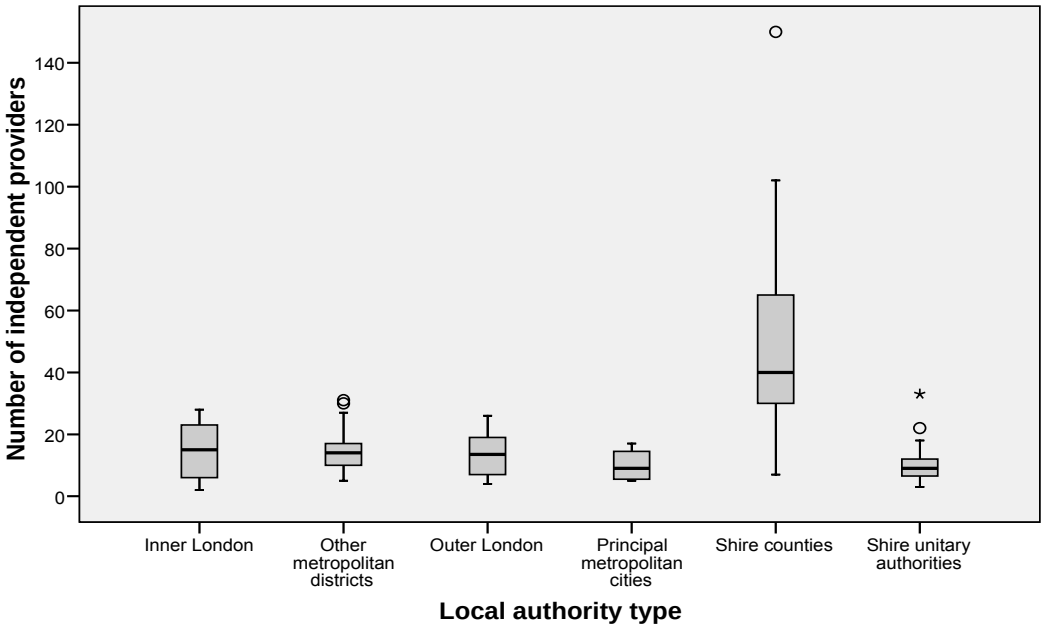
Table 3.19: Monitoring in-house domiciliary care provision (n=47)

	No.	%
Contractual framework	20	43
Quality assurance systems	16	34
Service performance	10	21
Same approach as independent sector	5	11
Worker performance	3	6
Human resources policies	2	4
Other	5	11

Source: Q19c – If yes, what approaches to monitoring in-house provision does the contracting/commissioning section of your authority employ?

Local authorities were asked how many independent providers of domiciliary care they currently contracted with. The information that was provided is shown in Figure 3.6. The number of independent providers of domiciliary care contracted with ranged from two to 150. Unsurprisingly Shire counties had the highest median number of independent providers (40), with principal metropolitan cities (9) and shire unitary authorities having the lowest (9) (see Table A3.13).

Figure 3.6: Number of independent providers of domiciliary care, by authority type (n=87)



Source: Q20a - How many independent providers of domiciliary care do you currently contract with?

In addition, local authorities were asked how many of the independent providers they contracted with operated solely within their local authority. This number was then divided by the total number of providers contracted with, to determine what proportion of the independent domiciliary care providers with whom they contracted, operated solely within the local authority area. Using this calculation, as Table 3.20 illustrates, more than a quarter were found to have no independent providers of domiciliary care operating solely within their local authority (29%). About a fifth (21%) appeared to have 50 per cent or more providers operating solely within the local authority boundary. These figures varied by authority type, with London boroughs appearing least (1, 6%) and shire counties (44%) most likely to have 50 per cent or

more of their providers operating solely in their local authority area (see Table A3.14).

Table 3.20: Independent domiciliary care providers – proportion operating solely within authority (n=80)

	No.	%
None	23	29
1 to 24.99% (up to a quarter)	26	33
25 to 49.99% (up to a half)	14	18
50% or more (a half or more)	17	21

Source: Q20a - How many independent providers of domiciliary care do you currently contract with? Q20b – How many of these operate solely within your authority?

Local authorities were also asked with how many of the independent providers with whom they contracted they had block contracts. Thirty-nine per cent of local authorities reported having no block contracts with their independent providers. Where local authorities did have these, they gave details of the number of these providers. This information has not been reported as this question appeared to have varying interpretations between authorities. In particular, there was evidence that some local authorities interpreted those they 'contract' with and those they 'block contract' with as one of the same. Therefore a measure using the proportion of domiciliary care hours provided through block contracting is regarded as much more reliable and is reported in Table 3.21. A small number of local authorities (2) reported that all of their domiciliary care hours were provided through block contracts. Shire counties were most likely to block contract (74%), with shire unitaries and metropolitan cities/districts least likely to do so (57%) (see Table A3.15).

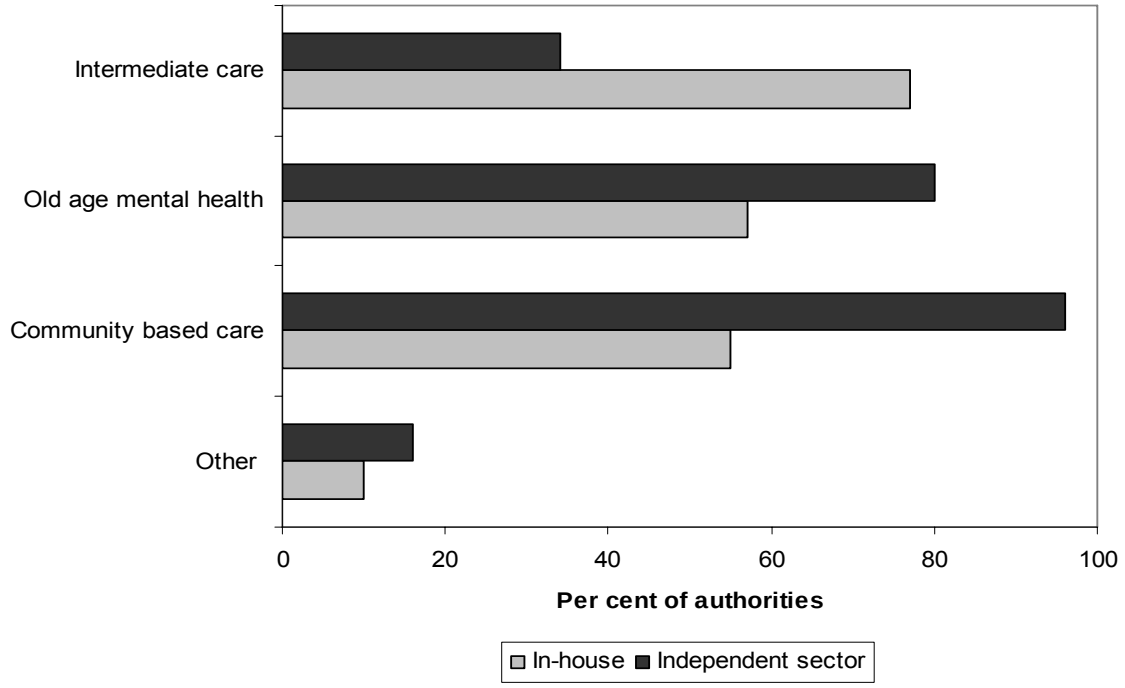
Table 3.21: Block contracts - proportion of independent sector domiciliary care hours (n=88)

	No.	%
None	34	39
1-20%	7	8
21-40%	6	7
41-60%	8	9
61-80%	21	24
81-99%	10	11
100%	2	2

Source: Q20d - Of the domiciliary care hours provided by independent providers estimate the proportion provided through block contracting

Local authorities were asked to indicate what were the foci of their domiciliary services for older people. As Figure 3.7 illustrates, in-house domiciliary care services focused mainly on intermediate care, with independent sector services predominantly focusing on community based and specialist old age mental health provision. Examples of other foci included: minority ethnic specific services; carers support; extra care housing; and palliative care.

Figure 3.7: Foci of domiciliary care services (minimum n=84, maximum n=88)



Source: Q21a – Please indicate what are the foci of your domiciliary services for older people. Tick all that apply.

Local authorities were asked to state the number of providers of each type of specialist domiciliary care. Table 3.22 indicates that they were more likely to have multiple providers of old age mental health domiciliary care services than they were within their intermediate care service.

Table 3.22: Number of independent providers of specialist domiciliary care services

	Intermediate care		Old age mental health care		Other	
	No.	%	No.	%	No.	%
1 or two providers	11	52	10	18	3	38
3 or more providers	10	48	47	83	5	63
No. of authorities	21		57		10	

Source: Q21b – For the independent sector please state the number of providers who provide each of these services.

Details of the availability of domiciliary care providers during the working week are provided in Table 3.23. This indicates that domiciliary care providers, irrespective of whether they are from the in-house or independent sector, are less likely to be available at night time than other times of the day or week.

Table 3.23: Availability of domiciliary care providers

	In house providers		All independent providers		Some independent providers	
	No.	%	No.	%	No.	%
Day time Monday-Friday	79	96	83	95	3	4
Evenings Monday-Friday	71	87	74	85	10	12
Night time	44	54	36	41	34	39
Weekends	72	88	77	89	8	9
No. of authorities	82		87		87	

Source: Q22 – What is the availability of your domiciliary care providers during the working week? Tick all that apply.

Local authorities were asked when they last tendered for domiciliary care services. Table 3.24 demonstrates that this was most likely to have occurred between 2005 and 2006 (39%). Around a third (31%) had tendered in 2004 or earlier and a similar number (30%) had only recently undergone a tendering process for domiciliary care (2007 or later).

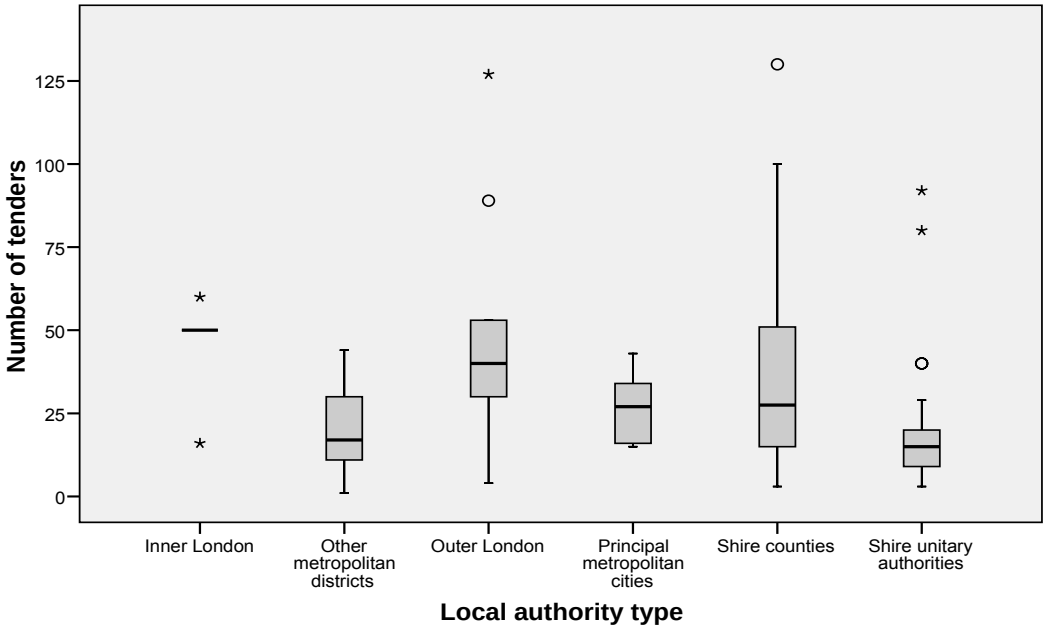
Table 3.24: Last date of tender for domiciliary care services (n=84)

	No.	%
2004 or earlier	26	31
Between 2005 and 2006	33	39
2007 or later	25	30

Source: Q23a - When did you last put out a tender for domiciliary care services? Please state the year.

The number of tenders/expressions of interest received by local authorities ranged from 1 to 130, with shire unitary authorities having the lowest (15), and Inner London authorities the highest median number of tenders (50), as illustrated in Figure 3.8.

Figure 3.8: Tenders received for domiciliary care services, by authority type (n=78)



Source: Q23b – On this occasion, how many tenders/expressions of interest did you have?

Generally most local authorities (75%) considered the supply of potential providers to have been 'about right' when they last tendered for domiciliary care services. However, as illustrated in Table 3.25, almost a fifth (17%) considered there to have been too many providers submitting tenders. Only a few local authorities (6) felt that there had been too few potential providers at the time of tendering.

Table 3.25: Supply of potential domiciliary care providers (n=81)

	No.	%
About right	61	75
Too many	14	17
Too few	6	7

Source: Q23c - On this occasion was the supply of potential providers?

Thirty-nine per cent (24 out of 61) of authorities had a guide price in their tendering documentation for block contracts. Of these, all included travel time in the guide price and most included the following elements: weekend and bank holiday enhanced rates; mileage cost; sickness and training payments; and holiday entitlements; as indicated in Table 3.26.

Table 3.26: Elements included in guide price for domiciliary care (n=24)

	No.	%
Travel time	24	100
Mileage cost	23	96
Weekend enhanced rates	22	92
Bank holiday enhanced rates	22	92
Sickness payments	22	92
Training payments	22	92
Holiday entitlements	22	92

Source: Q24b – If yes, was it inclusive of?

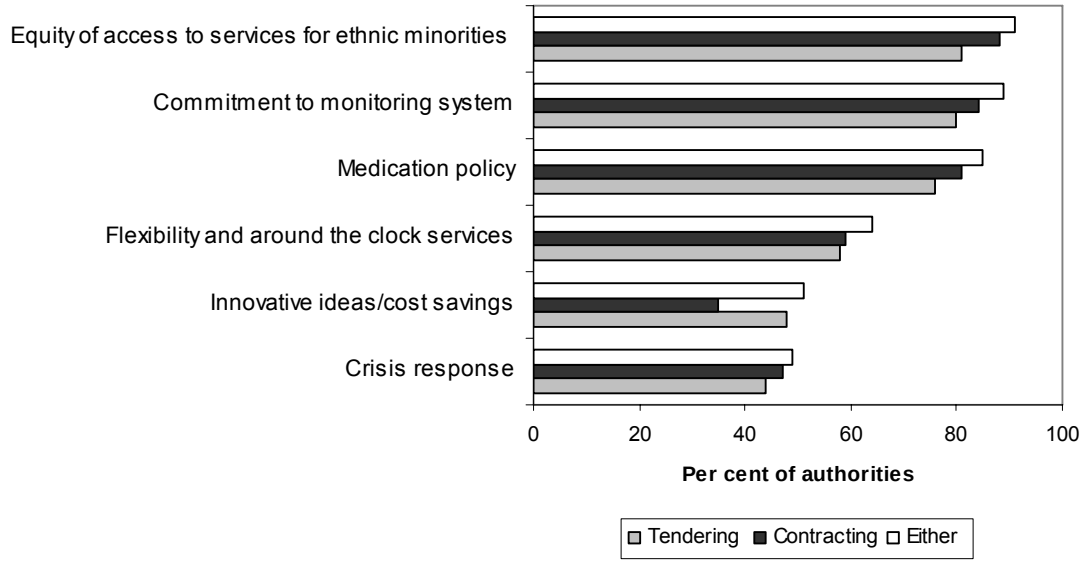
Figure 3.9 demonstrates that, with regard to the deployment and training of staff, items most likely to be specified in tendering and contracting for domiciliary care were: induction and training for new staff (91%); staff development and appraisal (88%); and supervision of staff (85%). Least likely to be specified were: provision of sick pay (27%); payment for staff attending training (31%); payment of mileage (34%); and payment for travel time (40%).

Figure 3.9: Specifications for staff deployment and training in tendering and contracting for domiciliary care (minimum n=82, maximum n=86)

Source: Q25 – With regard to the deployment and training of staff do you specify in your tendering and contracting with independent providers of domiciliary care the following? Tick all that apply separately for tendering and contracting.

In respect of the provision of services, Figure 3.10 demonstrates that equity of access to services for ethnic minorities (91%), and commitment to monitoring system (89%) were most likely to be specified in the tendering and contracting process. Least likely to be included were: crisis response (49%) and innovative ideas/cost savings (51%).

Figure 3.10: Specifications for service provision in tendering and contracting for domiciliary care (minimum n=82, maximum n=86)



Source: Q26 – With regard to the provision of services do you specify in your tendering and contracting with independent providers of domiciliary care the following? Tick all that apply separately for tendering and contracting.

Thirty-six per cent (32 out of 90) of local authorities had a standard price for domiciliary care within their current contracts. Where there was no standard price (as was the case for 58 local authorities), Table 3.27 reveals that this was most likely to vary by different providers (90%). It was least likely to vary by individual user (10%) or local labour markets within the authority (14%).

Table 3.27: Criteria for variations in price for domiciliary care (n=58)

	No.	%
By different providers	52	90
Type of contract	27	47
Day of week	19	33
Time of day	18	31
Additional hours over and above contracted hours	18	31
Ease of travel to area	11	19
Local labour markets within the authority	8	14
By individual user	6	10

Source: Q27b – If no, does it vary by? Tick all that apply.

Just over two fifths of local authorities (42%) required domiciliary care providers to separate the wages element from other costs in the tendering/contracting process, as demonstrated in Table 3.28.

Table 3.28: Separation of wages from other costs in tendering/contracting for domiciliary care (n=85)

	No.	%
Yes	36	42
No	49	58

Source: Q28 - Do you require providers to separate the wages element from other costs in your tendering/contracting process?

As illustrated in Table 3.29, authorities were most likely to have two to three year contracts with independent providers of domiciliary care (52%), with contracts of length four years and over also being popular (42%). Contracts of one year or less were rare with only five authorities (6%) typically having this length of contract. London boroughs were most likely (56%) to have contracts of length four years and over and metropolitan cities/districts least likely (26%) (see Table A3.20).

Table 3.29: Length of domiciliary care contracts (n=88)

	No.	%
Up to one year	5	6
Two to three years	46	52
Four years and over	37	42

Source: Q29 – What time frame is typically specified in your contracts with independent providers? Tick one only.

Table 3.30 indicates that fixed term contracts were most popular amongst local authorities with nearly three quarters (72%) typically using these types of contract. Of the different types of authority, they were most likely to be used by London boroughs (88%) (see Table A3.21). Other types of contract used included: roll-on contracts with option to extend; spot purchase; and cost and volume contracts.

Table 3.30: Type of contract used in purchasing independent sector provided domiciliary care (n=87)

	No.	%
Fixed term	63	72
Roll on	15	17
Other	9	10

Source: Q30 – What type of contract do you typically use in contracting for care with independent providers of domiciliary care? Tick one only.

From Table 3.31 it is apparent that in contracting for domiciliary care, most local authorities (81%) used documents that were created within their local authority. However, around a fifth (18%) used a combination of their own design and model contract when designing contracting documents. When a combination of a bespoke and model contract was used, the latter was most frequently obtained from another local authority.

Table 3.31: Domiciliary care – standard or bespoke contract (n=90)

	No.	%
Created within your own authority	73	81
A combination of own design and model contract	16	18
A standard model contract designed elsewhere	1	1

Source: Q31a – When contracting for domiciliary care services do you use documents which are?

Ninety-six per cent (87 out of 91) of local authorities reported that the independent sector domiciliary care services were monitored by the contracting section. For most, services were monitored throughout the contract period, as illustrated in Table 3.32.

Table 3.32: Domiciliary care – time frame for monitoring (n=87)

	No.	%
Prior to renewal of contract	7	8
Throughout the contract period	86	99
In response to complaint	34	39

Source: Q32b – If yes, when do you monitor domiciliary care services provided by the independent sector?

Local authorities were asked what information they took into consideration in the monitoring and review of contracts with their independent domiciliary care providers. The findings are reported in Table 3.33. Commission for Social Care Inspection (CSCI) reports (97%) were most likely to be considered, with interviews with care managers less likely (69%). Examples of other information taken account of included: service performance; quality assurance; and information obtained from consultation with stakeholders (such as users of services or care staff). Note that the last six options were post coded categories and may therefore be underrepresented.

Table 3.33: Monitoring and review of domiciliary care contracts – information sources (n=90)

	No.	%
CSCI reports	87	97
Number of complaints	87	97
User satisfaction surveys	81	90
Returns from provider	73	81
Level of service use	69	77
Interviews with care managers	62	69
Service performance	8	9
Quality assurance	8	9
Stakeholder consultation	6	7
Worker performance	5	6
Human resource policies	4	4
Data on supply and demand	2	2

Source: Q33 – What information do you take into account in the monitoring and review of contracts with independent domiciliary care providers? Tick all that apply.

Seventy-eight per cent (68 out of 87) of local authorities monitored contracts with independent domiciliary care providers in relation to staffing and human resource policies. Examples of areas of review were post coded and are listed in Table 3.34. These included: staff development and training; recruitment procedures; retention of staff; and conditions of service (see also Box A3.1).

Table 3.34: Monitoring of domiciliary care contracts – staffing and human resource policies (n=68)

	No.	%
Staff development and training	56	82
Recruitment procedures	48	71
Retention of staff	20	29
Conditions of service	20	29
Staffing levels/availability	12	18
Policies and procedures of provider	8	11
Management structure	5	7
Other	6	9

Source: Q34 – If you monitor contracts with independent domiciliary care providers please specify areas of review in relation to staffing and human resource policies.

Residential care

Just over a quarter (27%) of local authorities no longer provided in-house residential care, with just less than three quarters (73%) reporting that they maintained this provision.

As indicated in Table 3.35, almost a fifth of local authorities had transferred the majority of their residential provision into the independent sector before 1993 (17%), and over two fifths had done this between 1994 and 2000 (44%). Almost a quarter (23%) of local authorities had transferred their in-house residential provision into the independent sector in 2001 or later, and a fifth (17%) were yet to do so. London boroughs (24%) were most likely to have transferred their residential care services to the independent sector before 1993, and metropolitan cities and districts least likely to have done so (4%) (see Table A3.22).

Table 3.35: Year of transfer of residential care services to the independent sector (n=91)

	No.	%
Before 1993	15	17
Between 1994 and 2000	40	44
2001 or later	21	23
Not applicable	15	17

Source: Q36 - When did you transfer the majority of local authority provision into the independent sector?

Table 3.36 demonstrates that in-house residential care typically focused on short term/respite intermediate care (79%) and dementia specific care, both long and short term, for around two thirds of local authorities (62%). Examples of other foci of in-house residential care services given by local authorities included: mainstream residential or nursing care; older people with mental health problems; older people with learning disabilities and ethnic group specific support. Note that these last four categories of the table were post coded from free text and therefore may be under represented.

Table 3.36: Focus of in-house residential care (n=66*)

	Long term		Short term/respite	
	No.	%	No.	%
Intermediate care			52	79
Dementia specific	41	62	41	62
Resource centre	16	24	22	33
Mainstream residential or nursing care	10	15	9	14
Mental health problems	1	2	2	3
Learning disabilities	1	2	1	2
Ethnic group specific	1	2	0	0

Source: Q35b – If yes, please indicate the focus of your in-house residential care for older people. Tick all that apply. *One authority did not specify the focus of their in-house provision.

A subset of local authorities provided information for Table 3.37. In their periodic reviews of in-house residential provision, authorities were most likely to consider CSCI reports (69%) and the fabric of the building (69%). They were least likely to consider the views of staff (53%). Other information considered included: quality

measures; market provision locally; and the views of stakeholders (e.g. next generation older people, citizens, carers and health colleagues).

Table 3.37: Review of service level agreements – information sources (n=61)

	No.	%
CSCI reports	42	69
Fabric of building/building standard	42	69
Views of residents	41	67
Cost of service	40	66
Needs analysis	36	59
Political mandate	33	54
Views of staff	32	53
Other	6	10

Source: Q35c – What information do you take into account in the review of service level agreements or their equivalent for in-house residential provision? Tick all that apply.

Seventy-five per cent (69) of local authorities had block purchase contracts for independent residential/nursing home services for older people. Table 3.38 reveals that the most common purposes for block purchase contracts were dementia care (75%) and respite care (67%). Other purposes for the block purchase of care were post coded for analysis. These were: standard mainstream residential or nursing care; carers support; and other short term needs.

Table 3.38: Block contracts for independent sector residential care – purpose (n=69)

	No.	%
Dementia care	52	75
Respite	46	67
Intermediate care	29	42
Standard mainstream residential or nursing care	19	28
Carers support	1	1
Other short term needs	1	1

Source: Q37b – If yes, for what purpose? Tick all that apply.

As demonstrated in Table 3.39, block purchasing formed only a small part of contracting arrangements for residential care, with the majority of local authorities (62%) purchasing less than 10 per cent of beds provided by the independent sector by this method.

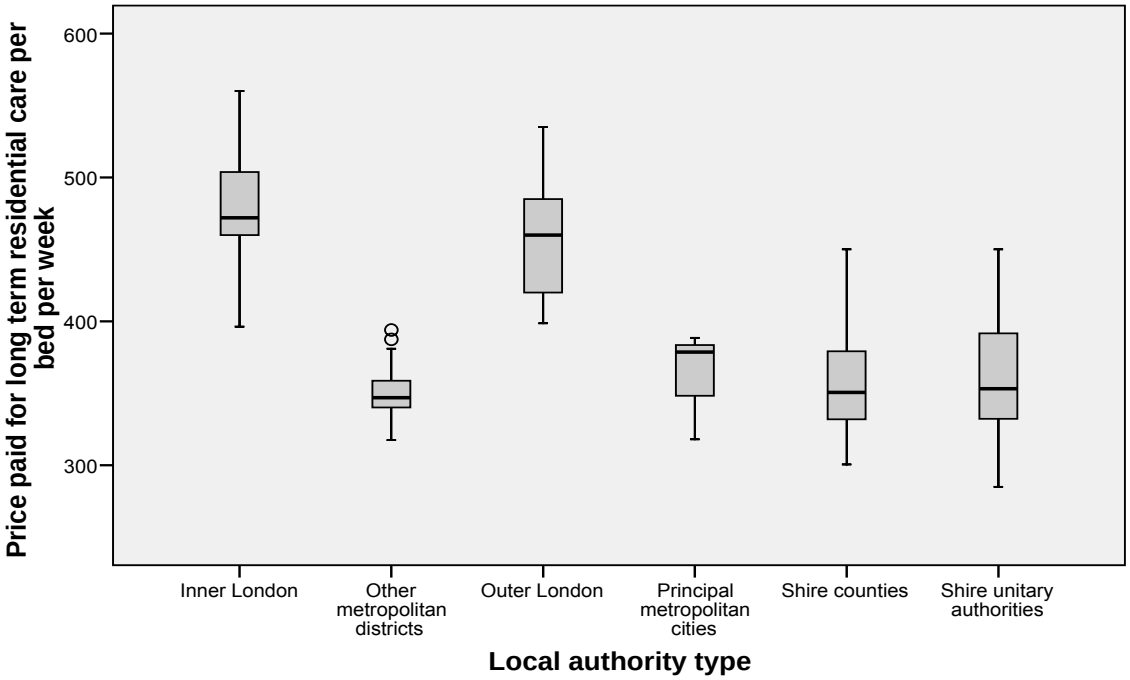
Table 3.39: Block contracts for independent sector residential care – proportion of beds (n=89)

	No.	%
0%	23	26
1-9%	32	36
10-19%	5	6
20-29%	10	11
30-39%	6	7
40-49%	6	7
50% or more	7	8

Source: Q37c – If yes, of the number of beds provided by independent providers, estimate the proportion provided through block contracting?

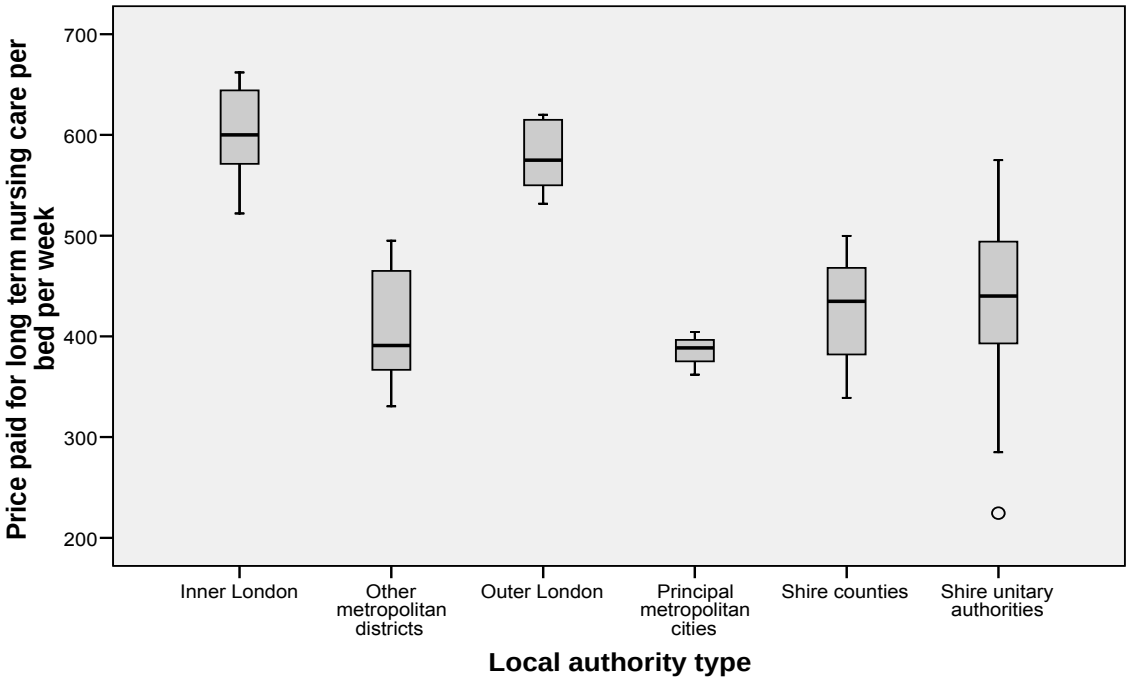
Local authorities were asked to indicate the price paid for independent sector residential, nursing, and dementia nursing care in the current financial year (2007/08). As illustrated in Figures 3.11, 3.12 and 3.13 (and A3.23-5), the price paid for independent sector care varied by authority type, with inner London authorities paying the highest (median) prices for long term residential (£472), nursing (£600) and dementia nursing care (£610). Figure 3.11 indicates that metropolitan districts paid the lowest (median) price for independent sector residential care (£347) and Figure 3.12 that principal metropolitan cities paid the lowest price for nursing care (£389). A comparison of Figures 3.11, 3.12, and 3.13 demonstrates that generally dementia nursing care was more expensive than nursing and residential care, with inner London boroughs paying the highest (£610), and principal metropolitan cities paying the lowest prices (£400) for this type of care.

Figure 3.11: Price - independent sector residential care, by authority type (n=75)



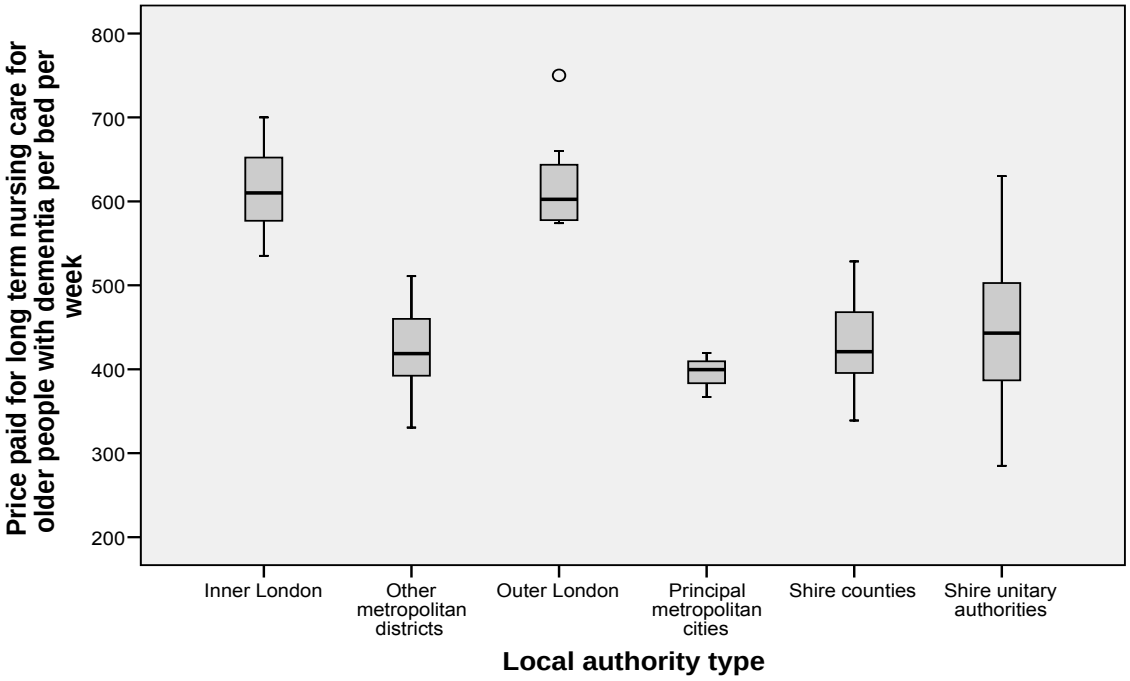
Source: Q38 – What is the price you pay for independent sector care in the current financial year (07/08)?

Figure 3.12: Price - independent sector nursing care, by authority type (n=62)



Source: Q38 – What is the price you pay for independent sector care in the current financial year (07/08)?

Figure 3.13: Price - independent sector dementia nursing care, by authority type (n=64)



Source: Q38 – What is the price you pay for independent sector care in the current financial year (07/08)?

Table 3.40 reveals that in almost a third of local authorities (31%) less than 20 per cent of independent sector care homes were owned by single proprietors. A similar proportion (35%) estimated this figure at between 20 and 39 per cent. Around a fifth of local authorities (18%) estimated that 60 per cent or more of the care homes they contracted with were personally owned and managed by single proprietors. London boroughs were least likely to contract with these types of homes (A3.26).

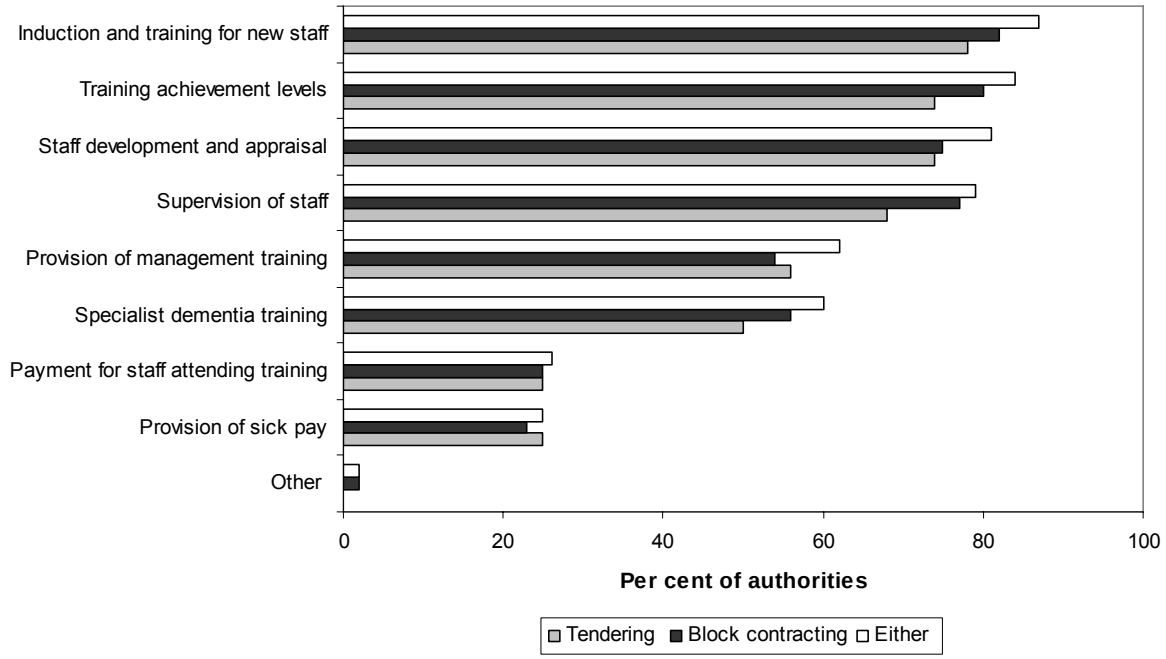
Table 3.40: Independent sector care homes – ownership and management (n=82)

	No.	%
0-19%	25	31
20-39%	29	35
40-59%	13	16
60% or more	15	18

Source: Q39 – What proportion to do you estimate of the independent sector care homes you currently contract with are personally owned and managed by single proprietors?

With regard to the deployment and training of staff, Figure 3.14 demonstrates that the issues most likely to be specified in tendering and contracting for residential care were: induction and training for new staff (87%); and training achievement levels against national training standards (84%). Least likely to be specified were: provision of sick pay (25%); and payment for staff attending training (26%). One local authority gave an example of 'valuing diversity' as another issue specified in contracting.

Figure 3.14: Specifications for staff deployment and training in tendering and contracting for residential care (minimum n=61, maximum n=77)



Source: Q40 – with regard to the deployment and training of staff do you specify in your tendering and contracting with external providers of residential/nursing home care the following. Tick all that apply separately for tendering and block contracting.

Table 3.41 indicates that the factors most likely to be taken account of in the monitoring and review of the quality of care in homes in which older people were placed were CSCI reports (97%); and the number of complaints (94%). Examples of

other information considered included: information collected through local authority monitoring or auditing procedures; staffing/human resource policies; and adult protection issues. These examples were post coded categories and might therefore be under represented in the table below.

Table 3.41: Monitoring and review of quality of care in care homes – information sources (n=89)

	No.	%
CSCI reports	86	97
Number of complaints	84	94
Information from care managers	79	89
Information from friends and family	70	79
User satisfaction surveys	66	74
Levels of service use	64	72
Home star ratings	64	72
Coroners reports	26	29
Monitoring/audit information	6	8
Human resource policies	6	8
Adult protection issues	5	6
Other information	2	2

Source: Q41 – In the monitoring and review of the quality of care in homes in which you place older people, what information do you take into account? Tick all that apply.

Seventy-three per cent (64 out of 88) of local authorities monitored contracts with independent providers of residential/nursing home care with respect to staffing and human resources policies. Examples of areas of review were post coded and are listed in Table 3.42. These included: staff development and training; recruitment procedures; and conditions of service (see also Box A3.2).

Table 3.42: Monitoring of contracts with residential care providers – staffing and human resource policies (n=64)

	No.	%
Staff development and training	52	81
Recruitment procedures	48	75
Conditions of service	25	39
Retention of staff	17	27
Staff/resident interface	10	16
Other	10	16

Source: Q42 – If you monitor contracts with independent sector providers of residential/nursing home care, please specify areas of review in relation to staffing and human resource policies.

Commissioning within care management arrangements

Care planning

Authorities were asked what kind of arrangements they had for outcome-based commissioning of domiciliary care as part of a package of care from specific providers. The possible arrangements ranged from the assessor purchasing the required services from the provider, to the provider assessing and allocating services. Table 3.43 indicates that the modal response, mentioned by 52 per cent of authorities, was that the 'assessor purchases required services from the provider', followed by the 'assessor prescribes and determines allocation provided', listed by

48 per cent per cent of authorities. Only a tenth of local authorities (10%) had the arrangement whereby the 'provider assesses and provider allocates' services.

Table 3.43: Outcome-based commissioning of domiciliary care - methods (n=82)

	No.	%
Assessor purchases required services from provider	43	52
Assessor prescribes and determines allocation provided	39	48
Assessor prescribes and negotiates content with provider	34	42
Assessor prescribes and commissioner negotiates content from specific external providers	29	35
Assessor recommends, provider determines allocation	13	16
Provider assesses and provider allocates	8	10

Source: Q43 – What arrangements do you have for outcome-based commissioning for domiciliary care as part of a package of care from specific providers? Tick all that apply.

Table 3.44 demonstrates that authorities were most likely to have only one arrangement (44%), with 16 per cent having two, and 23 per cent having three arrangements.

Table 3.44: Outcome-based commissioning of domiciliary care – number of methods (n=82)

	No.	%
None	4	5
1	36	44
2	13	16
3	19	23
4	5	6
5	3	4
6	2	2

Source: Q43 – What arrangements do you have for outcome-based commissioning for domiciliary care as part of a package of care from specific providers? Tick all that apply.

As shown in Table 3.45, where local authorities used only one method, this was most likely to be 'assessor prescribes and commissioner negotiates content from specific external providers' (36%). None of the local authorities used 'assessor recommends, provider determines allocation' or 'provider assesses and provider allocates' as sole methods of outcome-based commissioning.

Table 3.45: Outcome-based commissioning of domiciliary care – sole method (n=36)

	No.	%
Assessor prescribes and commissioner negotiates content from specific external providers	13	36
Assessor purchases required services from provider	10	28
Assessor prescribes and determines allocation provided	8	22
Assessor prescribes and negotiates content with provider	5	14
Assessor recommends, provider determines allocation	0	0
Provider assesses and provider allocates	0	0

Source: Q43 – What arrangements do you have for outcome-based commissioning for domiciliary care as part of a package of care from specific providers? Tick all that apply.

As illustrated in Table 3.46, only a tenth of local authorities (12%) surveyed, reported having a system for self assessment for older people in respect of domiciliary care. Different approaches were employed including: both paper and web based tools and

in different settings such as pilot self assessment projects, self assessment questionnaires as part of implementing self directed support/individual budgets and services for carers.

Table 3.46: Self assessment (n=89)

	No.	%
Yes	11	12
No	78	88

Source: Q44 - Do you have a system of self assessment for older people in respect of domiciliary care?

Thirty-four per cent (30 out of 88) of local authorities reported having intensive care management arrangements. Details of these are given in Table 3.47 and reveal that long term, on going community support, is most likely to be provided to older people with mental health problems. Conversely, short term, time limited intervention, is most likely to be provided to those with primarily physical, or either physical or mental health problems. Table A3.28 illustrates that of the 30 authorities with arrangements for intensive care management, 20 reported providing this service in both long term community support services and the intermediate care sector, with the remaining four having it in the former, and six in the latter only.

Table 3.47: Intensive care management arrangements (n=30)

	Older people with primarily mental health problems		Older people with primarily physical health problems		Older people with either physical or mental health problems	
	No.	%	No.	%	No.	%
Short term/time limited intervention (e.g. intermediate care)	11	37	19	63	18	60
Long term, on going community support	18	60	11	37	15	50

Source: Q45b – If yes, please tick box(es) which best describe service(s) offered.

Local authorities were asked if the domiciliary care component of a care package was costed for in-house (where applicable) and independent sector provided care. The findings are detailed in Table 3.48. For the majority of local authorities, the domiciliary care component of a package was costed for both local authority (81%), and independent sector (97%) provided services.

Table 3.48: Care packages – costing of domiciliary care (minimum n=73, maximum n=87)

	Local authority		Independent	
	No.	%	No.	%
Yes	59	81	84	97
No	14	19	3	3
No. of authorities	73		87	

Source: Q46 - Is the domiciliary care component of a package costed?

Table 3.49 indicates that care managers were able to commit finance to and/or allocate in-house services to implement a care package, without consultation with a first line manager in one quarter of local authorities (25%).

Table 3.49: Devolved budgetary arrangements (n=89)

	No.	%
Yes	22	25
No	67	75

Source: Q47 - Are care managers able to commit finance to and/or allocate externally provided domiciliary care services without consultation with a first line manager?

Of those services purchased from the independent sector or directly provided by the local authority in addition to personal care, help with meal preparation (95%) and shopping (81%) were most common. Furthermore, as illustrated in Table 3.50, of those that were not post coded (the first four options), all types of services were more likely to be provided to older people than to their carers. Other services identified by respondents included: laundry; sitting service; help with practical tasks; and medication prompting. As they were post coded from the free text responses of local authorities these may be underrepresented.

Table 3.50: Provision of community support services (n=76)

	Older person		Carer	
	No.	%	No.	%
Help with meal preparation	72	95	31	41
Shopping	61	80	34	45
Housework	49	65	29	38
Teleshopping	14	18	10	13
Laundry	4	5	3	4
Sitting service	4	5	7	9
Help with practical tasks	3	4	1	1
Medication prompting	3	4	0	0
Other	6	8	3	4

Source: Q48 - In additional to personal care, which of the following services are purchased or directly provided by the local authority for older people receiving long term community support or their carers? Tick all that apply.

Ninety seven per cent of authorities (89) had a direct payments support scheme for older people within the local authority. Where this was specified, support with direct payments was most likely to be provided through a local authority scheme (50%) and was least likely to be provided through an older people's organisation (6%) as indicated in Table 3.51.

Table 3.51: Direct payments support scheme (n=88)

	No.	%
Local authority	44	50
Disability organisation	28	32
Voluntary organisation	22	25
Charity	15	17
Centre for independent living	12	14
User led	10	11
Older people's organisation	5	6

Source: Q49b – If yes, what type of scheme is it?

As shown in Table 3.52, almost a quarter (24%) of local authorities had other arrangements for flexible budgets to access care for older people. Examples of these included individual budgets and vouchers for carers.

Table 3.52: Flexible budgets (n=88)

	No.	%
Yes	21	24
No	67	76

Source: Q50 - Apart from direct payments do you routinely use any other arrangements for flexible budgets to access care for older people?

Authorities were asked about how decisions were made to authorise entry into residential and nursing home care. This information is shown in Table 3.53. Forty eight per cent of authorities reported that a panel of local authority and health staff was used for authorisation. A similar proportion (42%) reported that a panel of social services staff alone authorised entry into care. A team quota was least likely to be used with only one local authority using this means of authorising the entry of older people into residential or nursing homes. Other methods of authorising entry included: decisions based on level of need in relation to local authority criteria and *Fair Access to Care Services* guidance; and decisions authorised daily at hospital by team leader to facilitate discharge with decisions reported to panel.

Table 3.53: Authorisation of care home admission (n=91)

	No.	%
Panel – LA and NHS staff	44	48
Panel – LA staff only	38	42
Senior manager	26	29
First line manager budget	19	21
Team quota	1	1
Other	2	2

Source: Q51 – How are care decisions for the entry of older people into residential and nursing home care authorised? Tick all that apply.

Respondents were asked what they thought were the strengths of their current commissioning processes. All their comments are documented in Box A3.3. Most commonly mentioned strengths related to: joint working and decision making with other agencies, particularly with health; the ability to maintain good working relationships with providers; the willingness and ability to respond to the personalisation agenda, and adaptability to new initiatives such as outcome based commissioning; and the involvement of stakeholders in the commissioning and contracting process. A selection of comments relating to these themes is included here.

> *"Integrated commissioning across health and social care. Pooled budget arrangements. Well developed contestability framework"*

> *"Strong joint working, within a single directorate, with housing colleagues, successful in bidding for extra care housing grants to reduce reliance on residential care"*

"Good relationships with providers. Well developed communication systems. Very detailed specifics in contracts"

"Long standing contracting arrangements in place so good relationships with providers"

"Have been able to move from institutionalised/residential agenda to personalisation agenda very quickly - reduced number of admissions"

"We are embracing personalisation and flexible care; we are using individual budgets and working closely with [name] PCT to work towards common aims"

"Good on-going engagement with older people, including representatives of British Minority Ethnic (BME) communities"

"Conscious efforts to involve service users at different stages of the process"

Finally, local authorities were asked whether they planned to make any changes to existing contracting arrangements for older people's services. All their responses are listed in Box A3.4. Frequently mentioned changes included moves towards: more flexible contracting arrangements in order to respond to the personalisation agenda; outcome based commissioning for older peoples services; and closer working and contracting arrangements with PCT's and housing departments. A selection comments relating to these themes is included here.

"Self directed care will lead to less 'cost and volume' contracting. Preferred lists will be used for service users to access choice. Outcome based initiatives will be used more"

"Working with providers to develop more flexible services to respond to personalised agenda. Commissioning for outcomes rather than outputs"

"Re-tender for domiciliary care to reflect personalisation agenda and outcomes based contracting, exploration of joint contracting/commissioning with PCT"

"Introduction of self directed support, flexible, non-block contracts, outcome-based contracting, greater joint commissioning with PCT and housing"

"'Moving towards closer cooperation with PCT commissioners and contracting staff. Working together to prepare for the contracting implications of self directed support"

"New joint commissioning and contracting structure being put in place currently. Development of new arrangements such as frameworks replacing blocks to respond to personalisation"

Part 2 Typology of local authorities

In developing this typology the aims were threefold. Firstly, to explore the nature of local authority commissioning and contracting arrangements for older people's services. Secondly, to identify factors within these processes which influence employment practices within domiciliary care services and care homes and, particularly, the recruitment and retention of staff. Thirdly, to provide a framework for the selection of sites for phase II of the study. Some 92 out of a total of 149 authorities responded to phase I of the study and these provided the basis for the analysis. As discussed in the first part of this chapter, the response rate varied by local authority type with a higher response amongst principal metropolitan cities compared to London boroughs (see Table 3.1). Table 3.54 indicates that the completion rate also varied by Association of Directors of Adult Social Services regional structure, with the highest response received from Eastern authorities (80%), and the lowest from the South West (40%).

Table 3.54: Response rate by ADASS region

Region*	Total authorities	No. distributed	No. responding	% completion rate
East Midlands	9	9	6	67
Eastern	10	10	8	80
Greater London	33	33	17	52
North East	12	12	9	75
North West	22	22	16	73
South East	19	19	13	68
South West	15	15	6	40
West Midlands	14	14	7	50
Yorkshire and Humber	15	15	9	60
All	149	149	91	61

*One response could not be classified by region.

The development of the typology of local authorities is discussed below. Firstly, the use of survey data to construct criteria by which to classify local authorities will be outlined, together with the resulting typology. Secondly, the basis for selection of sites for phase II of the study is presented. Finally, the measures used to verify the typology are described.

Cluster analysis: criteria and findings

Questions spanning both domiciliary care and care home provision and care management arrangements were selected from the national survey to create variables for the analysis. As well as consideration of their substantive importance, their capacity to discriminate between authorities was also important. Thus, only those which showed variation between authorities were included in the selection. A set of fourteen binary indicators was developed for the analysis. These were apportioned to the three domains of interest. Table 3.55 gives details of the domains of interest and their constituent variables, as well as the distribution of authorities across these indicators.

Table 3.55: Indicators of variation in commissioning and contracting arrangements (minimum n=82, maximum n=92)

		Selection criteria				
Domains of interest	Indicators (source question)	Present	%	Absent	%	No. of authorities
Commissioning and contracting arrangements	Number of stakeholder groups routinely involved in commissioning (12)	10 or more	56	Less than 10	44	90
	Pooling of ring fenced monies or total agency budgets for the joint commissioning of services (15a)	Yes	48	No	52	89
	Proportion of hours provided by independent providers that are block contracted (20d)	61% and over	38	60% or less	63	88
	Specify flexibility and around the clock services in tendering/contracting for domiciliary care (26)	Yes	64	No	36	87
	Standard price for domiciliary care within current contracts (27a)	Yes	36	No	64	90
	Requirement for providers to separate the wages element from other costs in tendering/contracting processes (28)	Yes	42	No	58	85
	Time frame typically specified in contracts with independent providers (29)	4 years and over	42	Less than four years	58	88
Employment practices	Form a training partnership with NHS (9b)	Yes	41	No	59	91
	Same training courses provided to both independent sector and in-house staff (10)	Yes	38	No	62	85
	Describe commissioning arrangements as 'A means of ensuring compliance with employment legislation' (11)	Yes	62	No	38	92
	Specify payment for travel time and/or mileage in tendering/contracting for domiciliary care (25)	Yes	41	No	59	86
	Specify payment for staff attending training in tendering/contracting for domiciliary care (25)	Yes	31	No	69	86
Flexibility in service provision at the level of the service user	Arrangement for outcome based commissioning of domiciliary care 'Assessor purchases required services from provider' (43)	Yes	52	No	48	82
	Presence of intensive care management service (45a)	Yes	34	No	66	88

A cluster analysis using the indicators described above identified seven clusters. Table 3.56 gives details of how the local authority types distributed across, as well as the resulting number of local authorities within, each cluster.

Table 3.56: Cluster membership by authority type (n=91)

	Cluster number						
Local authority type	1	2	3	4	5	6	7
Inner London	0	1	1	1	0	3	1
Other metropolitan districts	5	0	2	6	1	2	2
Outer London	3	3	1	0	0	1	2
Principal metropolitan cities	1	1	1	0	0	1	1
Shire counties	3	4	5	3	1	4	2
Shire unitary authorities	3	10	1	5	4	2	4
Total no. of authorities*	15	19	11	15	6	13	12

*One response could not be classified.

Table 3.57 details the mean score for each variable by cluster. This provides the details of the features of the 'prototypical' authority for each cluster (described in terms of scores for each of the indicators within each domain of interest) and these are used to determine how clusters differ from one another. The analysis demonstrates considerable variability in scores for indicators within clusters, with some variables scoring high or low scores relative to others. It is the presence or notable absence of these features that differentiates one cluster from another. For example for cluster 5 the mean score ranged from zero for 'time frame typically specified in contracts with independent providers,' to one for 'specify payment for travel time and/or mileage in tendering/contracting for domiciliary care,' suggesting the latter, but not the former, is a feature of its commissioning and contracting arrangements. There is also substantial variability between clusters. For example, scores for 'form a training partnership with the NHS,' range from zero for cluster 3, to one for cluster 7, indicating that is one particular feature by which these clusters vary.

Table 3.57: Mean score for each indicator by cluster (minimum n=82, maximum n=92)*

Domains of interest	Indicators (source question)	Cluster						
		1	2	3	4	5	6	7
Commissioning and contracting arrangements	Number of stakeholder groups routinely involved in commissioning (12)	0.3	0.8	0.8	0.2	0.5	0.6	0.8
	Pooling of ring fenced monies or total agency budgets for the joint commissioning of services (15a)	0.8	0.1	0.2	0.2	0.8	0.8	0.7
	Proportion of hours provided by independent providers that are block contracted (20d)	0.7	0.2	0.8	0.2	0.0	0.2	0.3
	Specify flexibility and around the clock services in tendering/contracting for domiciliary care (26)	0.9	0.7	0.9	0.4	0.3	0.2	1.0
	Standard price for domiciliary care within current contracts (27a)	0.1	0.1	0.4	0.7	0.5	0.3	0.7
	Requirement for providers to separate the wages element from other costs in tendering/contracting processes (28)	0.1	0.8	0.8	0.1	0.8	0.3	0.2
	Time frame typically specified in contracts with independent providers (29)	0.2	0.8	0.4	0.1	0.0	0.3	0.8
Employment practices	Form a training partnership with NHS (9b)	0.6	0.6	0.0	0.1	0.7	0.0	1.0
	Same training courses provided to both independent sector and in-house staff (10)	0.9	0.3	0.5	0.2	0.5	0.0	0.2
	Describe commissioning arrangements as 'A means of ensuring compliance with employment legislation' (11)	0.4	0.8	0.5	0.1	0.8	0.9	1.0
	Specify payment for travel time and/or mileage in tendering/contracting for domiciliary care (25)	0.1	0.3	0.9	0.1	1.0	0.3	0.6
	Specify payment for staff attending training in tendering/contracting for domiciliary care (25)	0.3	0.2	0.6	0.1	0.2	0.1	0.6
Flexibility in service provision at the level of the service user	Presence of intensive care management service (45a)	0.1	0.1	0.9	0.2	0.0	0.4	0.7
	Arrangement for outcome based commissioning of domiciliary care 'Assessor purchases required services from provider' (43)	0.7	0.2	0.7	0.5	0.8	0.2	0.7

*Missing data represented at indicator level.

Mean scores for each domain were calculated for each local authority and cluster. These were used to compare the level of activity in these domains, between authorities within clusters, and between the clusters. The latter are presented in Table 3.58 and were used to determine how active each cluster of authorities was in each domain of interest. Note that the discrepancy between Table 3.57 and Table 3.58 is due to missing data at authority level as noted in chapter 2.

Table 3.58: Average score for each domain of interest (minimum n=77, maximum n=80)*

		Domain of interest		
Cluster no.	No. of authorities	Commissioning and contracting	Employment practices	Flexibility in service provision at the level of the service user
1	15	0.5	0.5	0.4
2	19	0.5	0.5	0.2
3	11	0.6	0.5	0.8
4	15	0.3	0.1	0.3
5	6	0.5	0.7	0.4
6	13	0.4	0.3	0.4
7	13	0.7	0.7	0.7

*Missing data represented at domain level.

These scores were then categorised to provide a summary descriptive measure of activity in each cluster by domain of interest. The resulting categorisation is presented in Table 3.59 below. This indicates, for example, that cluster 7 scored high and cluster 4 low on all three domains.

Table 3.59: Characteristics of cluster types (minimum n=77, maximum n=80)*

		Domain of interest		
Cluster no.	No. of authorities	Commissioning and contracting arrangements	Employment practices	Flexibility in service provision at the level of the service user
1	15	Medium	Medium	Medium
2	19	Medium	Medium	Low
3	11	High	Medium	High
4	15	Low	Low	Low
5	6	Medium	High	Medium
6	13	Medium	Low	Medium
7	13	High	High	High

Note: High ≥0.6, Medium 0.4-0.5, Low ≤0.3. *Missing data represented at domain level.

Using the results from the cluster analysis based on the sample of authorities (n=92), it is possible to consider how the 149 local authorities in England would distribute across the seven clusters. It is based on the assumption that the obtained sample is representative. This is considered reasonable, as part one of the findings indicated that there was usually no appreciable difference by authority type. Where there were differences, they have been reported and, as indicated above, these were not major and were few in number. Table 3.60 demonstrates how all 149 local authorities might distribute across the seven clusters. It shows for example, that cluster 2 contained 21 per cent of the 92 local authorities in the initial analysis. Assuming the same proportionality for the total population of local authorities, 31 of these would fall into

this category. As only 6 local authorities (7%) are contained within cluster 5, only 10 would populate this group.

Table 3.60: All local authorities in England – cluster membership projection

	Sample		Population	
Cluster	No. of authorities	%	No. of authorities	%
1	15	16	24	16
2	19	21	31	21
3	11	12	18	12
4	15	16	24	16
5	6	7	10	7
6	13	14	21	14
7	13	14	21	14
Total no. of authorities	92		149	

Cluster analysis: selection of authorities for phase 2

The concept of 'prototypical authority' was used again to assess the extent to which the authority was representative of the cluster. A distance measure (SPSS, 2006) was used to identify local authorities that were more or less typical of each cluster, with values nearer zero indicating higher, and values further away from zero, lower, typicality. Authorities were listed in order of how closely they matched the characteristics of the 'prototypical authority' of each cluster (see Table A4.1). Table 3.61 explores these distance measures in more detail. An examination of this gives an indication on how authorities might differ on average from the 'prototypical' authority for each cluster. For example, the most typical authority of cluster 1 is that scoring 1.22, the minimum distance measure for that cluster. Furthermore, the authority scoring 1.71, the maximum distance measure, is considered least representative of it. This is informative as it allows the identification of those authorities most representative of the different types of levels of activity in domains of interest in each cluster. Further descriptors of the distance measures are listed in Appendix 4 (see Table A4.2). These tables together with other data in Tables A4.3-A4.4 form the basis of the selection of sites for phase II.

Table 3.61: Descriptors of distance measure (n=92)

	Cluster						
Descriptives	1	2	3	4	5	6	7
Mean distance	1.48	1.45	1.44	1.39	1.37	1.35	1.45
Minimum	1.22	0.76	0.70	1.02	1.20	1.17	1.20
Maximum	1.71	1.96	1.85	1.67	1.57	1.88	1.82
Range	0.48	1.19	1.15	0.64	0.38	0.70	0.62
No. of authorities	15	19	11	15	6	13	13

Verification

The results of the cluster analysis were verified in two ways: additional statistical calculations and an exploration of the extent to which the emergent typology constitutes an ideal type. In the first instance further analysis was undertaken. This explains why the description of the clusters in Tables A4.3-A4.4 differ from that in Tables 3.58-3.59. The former were constructed using the mean scores in Table 3.57. However the latter were based on a cluster average of local authority domain scores. Note the findings from both approaches would have been equivalent had there been no missing data. The implications of this change are small as this revision did not affect the logic of selection or the underlying construction of the typology. The value of this amendment is that Tables 3.58 and 3.59 more accurately reflect the differences between the clusters with respect to the domains of interest. As indicated in Table 3.62, an analysis of variance test confirmed that at least one of the clusters was significantly different to the others with respect to scores for the domains of interest.

Table 3.62: Analysis of variance test of the difference in domain scores by cluster

Commissioning and contracting					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.986	6	0.164	7.168	0.000
Within Groups	1.604	70	0.023		
Total	2.589	76			
Employment practices					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2.568	6	0.428	14.825	0.000
Within Groups	2.078	72	0.029		
Total	4.646	78			
Flexibility in service provision at the level of the service user					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	3.256	6	0.543	5.568	0.000
Within Groups	7.116	73	0.097		
Total	10.372	79			

Table 3.63 details further analysis involving comparisons between pairs of clusters. This indicated that there were significant differences between several of them in regard to the mean scores for each of the domains (Argyrous, 2002), suggesting that the domains of interest provided a useful means of describing the differences between clusters. For example, clusters 1 and 4; and clusters 5 and 6, had significantly different scores for 'employment practices.'

Table 3.63: Test of the difference in domain scores between cluster pairs (minimum n=77, maximum n=80)*

Domain of interest	Cluster (I)**	Cluster (J)	Domain score (I)	Domain score (J)	Mean Difference in domain score (I-J)	Sig.	95% confidence interval lower bound	95% confidence interval upper bound
Commissioning and contracting arrangements	3	4	0.6	0.3	0.321	.002	0.077	0.566
	4	7	0.3	0.7	-0.359	.000	-0.597	-0.122
	6	7	0.4	0.7	-0.268	.019	-0.510	-0.026
Employment practices	1	4	0.5	0.1	0.334	.001	0.095	0.573
	2	4	0.4	0.1	0.339	.000	0.108	0.571
	3	4	0.5	0.1	0.377	.000	0.116	0.638
	4	5	0.1	0.7	-0.597	.000	-0.924	-0.270
	4	7	0.1	0.7	-0.544	.000	-0.792	-0.295
	5	6	0.7	0.3	0.431	.005	0.085	0.778
	6	7	0.3	0.7	-0.378	.001	-0.652	-0.104
Flexibility in service provision	2	3	0.2	0.8	-0.601	.003	-1.072	-0.131
	2	7	0.2	0.7	-0.516	.006	-0.936	-0.096

*Missing data represented at domain level. **(I) and (J) together represent a cluster pair. Note that only those cluster pairs found significantly different at 0.05 level are represented in the table.

Box 3.1 shows how the construction of the emergent typology described above was further validated by confirming that it was underpinned by the characteristics of an 'ideal type' (Psathas, 2005). For example, survey questions were developed to measure those aspects of commissioning, contracting and care management arrangements believed to influence the recruitment and retention of the social care workforce. The aim was to include in the typology all the characteristics deemed necessary to understand variations between local authorities in these outcomes (characteristic 1). Domains of interest were constructed using the selected indicators to reflect existing areas of local authority activity. These were informed by a review of the literature and policy guidance and subsequently validated by stakeholders. This was done to ensure they provided a way of describing current arrangements derived from historical patterns and were *"adequate for the purpose intended"* (characteristic 2) (Psathas, 2005 p. 165).

Box 3.1: Characteristics of ideal type applied to emergent typology

Ideal type*	Practical application
• *"The types would include the necessary or essential characteristics which the analyst could best determine to be relevant for understanding the social phenomena" (p154).* Ideal type used to *"provide order…select the significant…to provide understanding" (p165).*	• Survey questions were constructed to measure factors believed to influence recruitment and retention of the social care workforce for older people. Data was analysed and a selection of indicators were created for the construction of the typology (see Appendix 1).
• A way of describing current arrangements which are derived from historical patterns…and *"adequate for the purpose intended" (p155)*	• Domains of interest were constructed using the selected indicators to reflect existing areas of local authority activity (see Table 3.55). These were derived from literature and policy guidance and validated by stakeholders.
• *"A comparison with an empirical instance could lead to reformulations of the type in order to make revisions which the analyst thought might be necessary for achieving better understanding" (p154-155)*	• Hierarchical cluster analysis was used to identify the number of clusters present in the data. A variety of different methods were compared before the final selection. Non-hierarchical cluster analysis was used to refine the results of this analysis (see Chapter 2).
	• The identification of clusters of local authorities confirmed the validity of the indicators (see Table 3.56).
• *"Conceptual tools …(used) to provide a possible interpretation, an interpretative scheme" (p155)*	• Seven clusters were identified and the characteristics of each were documented in terms of the mean score for each indicator (see Table 3.57).
• Provision of *"understandable, recognisable and acceptably valid interpretations" (p155)*	• Summary descriptive measures of the domains of interest were used to describe the characteristics of cluster types (see Table 3.58 and 3.59) and validated by the use of statistical tests (see Table 3.62 and 3.63).
• *"can serve an heuristic purpose in that it leads others, in examining instances, situations or historical periods other than those originally studied by the analyst, to discover the same phenomena" (p.165)*	• This framework can be used in a number of ways. Within the research it served as a sampling frame for fieldwork (see Tables A4.1-A4.4). It can also be applied to all English local authorities (see Table 3.60).

*Source: Psathas, 2005

In the next and final chapter, findings from both part one and two of this chapter are reviewed in the context of the relevant literature and current policy framework.

CHAPTER 4: SUMMARY AND CONCLUDING OBSERVATIONS

This report provides a description of local authority commissioning and contracting arrangements for domiciliary and residential care services. There is considerable variation between local authorities and, more generally, between types of authorities. To what extent does this pattern of development shed light on factors relating to the recruitment and retention of the social care workforce in older people's services? We explore this using the conceptual framework described in chapter 1. A final section draws together this discussion and identifies potential implications for the recruitment and retention of a social care workforce for older people. First, however, the findings are summarised.

Summary of findings

Background information

- At the time the questionnaire was completed, most local authorities negotiated with one Primary Care Trust, whilst a fifth negotiated with more than two.

- Only a minority of authorities had an integrated service provider for all provision. Where local authorities had an integrated provider for selected services this was most likely to be for intermediate care.

- Nearly all local authorities had a provider forum. The majority of local authorities reported these meetings were held three or four times a year. A considerable number were held six times a year or more.

- Most local authorities formed a training partnership with other agencies, typically independent providers, and to a lesser extent with local NHS organisations. Only a minority included the voluntary sector.

- A wide range of training courses were provided to care staff. However, these were more likely to be made available to in-house staff than to those in the independent sector.

Commissioning

- Of the statements used to describe arrangements for commissioning and contracting, most frequently selected was 'a means of specifying service arrangements with independent providers.' Furthermore, for the majority, they were viewed as 'a means of ensuring the views of older people and their carers are reflected in the design of services.' Less than half of local authorities viewed these as 'a range of tasks undertaken by member(s) of staff who also have operational responsibilities.'

- A wide range of stakeholders were routinely consulted in the commissioning of older people's services. However, whilst nearly all authorities consulted current service users and their carers, less than half consulted with next generation older people. Furthermore, whilst most consulted with the providers of social care services, only around a third consulted employee representatives.

- Several types of care home provision were commissioned by most authorities and nearly all authorities commissioned domiciliary care. Adult placement schemes and specialist domiciliary provision were commissioned to a lesser extent.

- Nearly three quarters of local authorities reported commissioning or providing specialist services dedicated to hospital discharge, outside of the intermediate care sector. Within these, short term residential or nursing home care, and adult placement schemes, were most likely to be provided by staff from the independent sector. Specialist domiciliary care services were most likely to be provided by staff employed directly by the local authority.

- In terms of joint commissioning, over three quarters of authorities had joint plans and planning processes. In contrast, only a minority pooled total agency budgets for older people's services, and less than a third had a single lead commissioner for health and social care.

- Almost all authorities jointly commissioned with the NHS for intermediate care, with local authority/NHS staff most likely to provide these services. Over half of local authorities jointly commissioned with the NHS for old age mental health services, with these most likely to be staffed by the independent sector.

Contracting arrangements

Domiciliary care

- Just over a quarter of local authorities had contracted out the majority of their domiciliary care services to the independent sector before 1999. Of the remaining authorities, most had done this between 2000 and 2004. Just under a quarter had contracted out domiciliary care services in 2005 or later. Whilst most authorities retained in-house provision, the majority of their expenditure was allocated to independent providers.

- Authorities were most likely to be contracting with providers who operated in areas both in and outside of their geographical boundary. A majority of local authorities used block contracting to purchase domiciliary care from the independent sector, although nearly two fifths had no block contracts for this provision. The number of independent providers contracting with local authorities varied considerably by local authority type reflecting differences in size.

- In-house domiciliary care services were typically located within the intermediate care sector, with independent sector services focussing predominantly on community based care and old age mental health provision. Local authorities were more likely to have multiple independent providers of old age mental health domiciliary care than within their intermediate care service. Irrespective of sector, domiciliary care providers were less likely to be available at night time than other times of the week.

- Nearly a third of local authorities had tendered for domiciliary care services in 2007 or later. The number of tenders received varied considerably between local

authorities, with London boroughs receiving the most. At the time of tendering, most authorities considered the supply of potential providers to be 'about right,' however a considerable number felt that there had been too many submitting tenders.

- A guide price was used in tendering documentation by nearly two fifths of authorities, who all included travel time within this. Most of these also included: weekend and bank holiday enhanced rates; sickness and training payments; and holiday entitlements.

- With regard to the deployment and training of staff, most authorities specified in tendering and contracting for domiciliary care: induction and training for new staff; and staff development and appraisal. However, less than a third specified the provision of sick pay and payment for staff attending training and less than half specified payment for mileage or travel time. In relation to the provision of services, the majority of local authorities specified in tendering or contracting for domiciliary care: equity of access to services for ethnic minorities; and a commitment to a monitoring system. Those aspects least likely to be specified in tendering and contracting documentation were crisis response and innovative ideas/cost savings.

- Over a third of authorities reported having a standard price for domiciliary care. Where the price varied it was most likely to do so by different types of provider or contract. Just over two fifths of local authorities required domiciliary care providers to separate the wages element from other costs in the tendering/contracting process.

- Typically domiciliary care contracts were two to three years in length, with most authorities using fixed term contracts. In designing contracting documents, the majority were created within individual authorities, though a considerable number used a combination of their own design and a model contract.

- In regard to the monitoring of services, for in-house domiciliary care this was most likely to be undertaken through a contractual framework or the use of quality assurance systems. For independent sector provided services this process utilised a greater variety of information sources, including human resource policies, for example staff development and training and recruitment procedures.

Residential care

- Just over a quarter of local authorities no longer provided in-house residential care. The majority had transferred most of their residential care services to the independent sector before 2001. Where in-house residential care was provided, it typically focused on short term/respite and dementia specific care.

- Block purchasing formed only a small part of contracting arrangements for residential care services, with the most common purpose for these being specialist dementia care and respite care.

- The price paid for independent sector residential/nursing care varied by authority type with inner London authorities paying the highest prices. Dementia nursing care was more expensive than nursing and residential care.

- Generally, homes were not personally owned and managed by single proprietors. This meant that they were more likely to be run by organisations owning and managing a number of homes usually spanning authority boundaries.

- With regard to the deployment and training of staff, most authorities specified in tendering and contracting for residential care induction and training for new staff and training achievement levels against national training standards. However, only around a quarter specified the provision of sick pay and payment for staff attending training.

- Factors most likely to be taken account of in the monitoring and review of the quality of care homes were Commission for Social Care Inspection (CSCI) reports and the number of complaints. The majority of local authorities monitored contracts with independent residential care providers in relation to staffing and human resource policies. Examples of areas of review included staff development and training and recruitment procedures. In the review of service level agreements for in-house provision, CSCI reports and the fabric of the building were most likely to be considered.

Care management arrangements

- A minority of local authorities had developed a system of self assessment in older people's services in respect of domiciliary care. This employed the use of both web and paper based tools.

- Nearly all local authorities reported having a direct payments support scheme at the time of the survey. This was most likely to be provided through a local authority scheme. In addition, almost a quarter of local authorities had other arrangements for flexible budgets to access care for older people.

- In addition to the provision of personal care, several services were purchased from the independent sector or directly provided by the local authority. Of these, help with meal preparation and shopping were most commonly provided.

- Authorities were most likely to have only one approach to micro commissioning by care managers. The most commonly reported description was that the 'assessor purchases required services from provider.' Other approaches described by authorities included ones in which the provider had greater responsibility. However, no authorities described their arrangements solely as one in which the 'assessor recommends, provider determines allocation.'

- Care managers were able to commit finance to and/or allocate any in-house services to implement a care packages, without consultation with a first line manager in one quarter of local authorities.

- Just over a third of local authorities reported having intensive care management arrangements. This was most likely to be provided in the form of long term, on going community support for older people with mental health problems, and short term, time limited intervention, for those with primarily physical and/or mental health problems.

- Admission to care homes was authorised in a number of ways. The most frequently reported was a panel of local authority and NHS staff, followed by a panel comprising solely local authority staff.

Typology of local authorities

- Fourteen questions describing variations in arrangements for both domiciliary care and care home provision and care management arrangements were selected from the national survey to create indicators to classify local authorities into different types.

- These were assigned to three domains of interest: commissioning and contracting arrangements; employment practices; and flexibility in service provision at the level of the service user.

- Seven types of local authority were identified and were found to vary in the level of activity in each domain of interest. This is summarised below.

Type (No. of authorities)	Commissioning and contracting arrangements	Employment practices	Flexibility in service provision at the level of the service user
1 (15)	Medium	Medium	Medium
2 (19)	Medium	Medium	Low
3 (11)	High	Medium	High
4 (15)	Low	Low	Low
5 (6)	Medium	High	Medium
6 (13)	Medium	Low	Medium
7 (13)	High	High	High

Concluding observations

Commissioning

Following the creation of an enabling role for local authorities, commissioning for social care services in order to promote the development of independent sector provision alongside in-house services, has assumed greater importance within policy guidance *(*Cm 4169, 1998; Cm 6499, 2005; Cm 6737, 2006). In this section four areas are discussed: joint commissioning;
the relationship between commissioners and providers; stakeholder consultation; and strategic planning. The concept of needs analysis is omitted as this was an issue about which it was deemed difficult to capture variation in a postal questionnaire.

Joint commissioning

Policy guidance emphasises joint commissioning across health and social care (Department of Health, 2007a). Evidence of joint commissioning for older people's services has been noted, together with a number of obstacles to joint working (Hudson, 1999b; Glendinning et al., 2001; 2002). Nevertheless, the removal or relaxation of structural, organisational, and financial boundaries through the new Health Act flexibilities is regarded as having assisted in the integration of services, and later work has demonstrated that the majority of Primary Care Trusts (PCTs) collaborate with social services partners in the commissioning of services for older people (Glendinning, 2003). A number of recent initiatives have been introduced to promote joint working in localities both within local authorities and in conjunction with the NHS (Department of Health, 2008a; b).

As would be expected, in the current study, the majority of local authorities had developed joint plans and planning processes with the appropriate health authorities. However, only a small minority reported pooling total agency budgets for older people's services. Additionally, it is relevant to note, that the majority of local authorities only commissioned a small proportion of their older people's services in conjunction with their PCT, although a few jointly commissioned all their older people's services. In terms of service provision, a high proportion of local authorities jointly commissioned with the NHS for intermediate care, however fewer jointly commissioned with the NHS for old age mental health services. This might be expected to be an area of development, as one of the most frequently mentioned changes in respect of commissioning was closer working arrangements with PCTs and housing departments.

Relationship between commissioners and providers

Discourse between commissioners and providers in order to prioritise issues for shaping the market in social care and to support local providers to reconfigure their services appropriately is an important feature of current policy guidance (Department of Health, 2007a). This relationship appears to have been affected in the past by an absence of the involvement of providers in the planning of community care services and a lack of information sharing between the two parties (Filinson, 1998; Wistow and Hardy, 1999; Ware et al., 2001). However, more recently it has been concluded that the relationship is improving and this is a focus of attention for commissioners (Andrews and Phillips, 2002; Matosevic et al., 2008).

In the present study, nearly all local authorities reported having a provider forum and the majority of these met three or more times a year, suggesting that local authorities sought to promote a dialogue with providers. Furthermore, most authorities reported that they routinely involved providers in the commissioning of new services and the redesign of existing ones, confirming the recent improvement noted above.

Stakeholder consultation

Stakeholder consultation, with regard to the commissioning of services, necessarily involves older people, their carers, and representative organisations together with organisations providing residential and domiciliary care within a locality. Recent

policy guidance has, however, required the involvement of local people in the commissioning process and placed a greater emphasis on outcomes in commissioning (Department of Health, 2006a; Cm 6737, 2006). However, less emphasis has been placed on the involvement of providers of social care services in this process, compared to other stakeholder groups (Cm 6737, 2006). The benefits of consulting with stakeholder groups in commissioning older peoples services have been demonstrated (Raynes et al., 1998; Barnes and Bennett, 1998; Abbey et al., 1999), together with the value of obtaining views of specific groups of service users (Temple et al., 2002; Bowes and Wilkinson, 2003; Bamford and Bruce, 2000) and the need to consult with a wide range of stakeholder groups (Tucker et al., 2007). The literature also has suggested positive gain from consulting with providers of residential and domiciliary care (Ware et al., 2001).

It is noteworthy in this context, that in terms of descriptions of commissioning arrangements for older peoples services, one of the key statements selected by respondents was 'a means of ensuring that ensuring the views of older people and their carers are reflected in the design of services.' More generally, data from the current study indicated that most authorities consulted with a wide range of stakeholder groups. In addition, the majority of authorities obtained the views of older people from minority ethnic or religious groups. This suggests that local authorities are responding to the current policy agenda in this respect and recognising the value of consulting with a range of groups in the commissioning of older people's services. There is also some evidence to suggest a commitment to consulting with providers through, for example, provider forums but less evidence of the involvement of employee representatives such as trade unions in this process.

Strategic planning

Following the introduction of the community care reforms, local authorities have been required to develop services to allow people to live in their own homes wherever possible and more recently, in determining the type of service provision, there has been a duty of Best Value. This requires that in terms of choice of service provider, judgements are made in respect of optimum outcomes for service users together with the development of a range of services, including those which are predominantly preventative in focus (Cm 849, 1989; Cm 4169, 1998; Cm 6499, 2005; Department of Health, 2008a).

The findings from this study indicated that almost all authorities commissioned domiciliary care and all types of care home including specialist provision, for example for older people with dementia. Around half of respondents to the questionnaire stated their local authority commissioned specialist domiciliary care services. These included old age mental health services, intermediate care, and assistance to those living in supported housing. Irrespective of the source of provision, domiciliary care was less likely to be available at night time compared with daytime, evenings and weekends. In terms of preventative services, this study provided data relating to alternatives to hospital admission. It revealed that independent sector providers were most likely to provide this in a residential/nursing home setting, with public sector services more likely to undertake this role with older people in their own homes. With regard to the range of service provision, it is

noteworthy that only two thirds of authorities commissioned adult placement schemes.

Contracting

In this section four areas are discussed: market management; extent and uptake of training; contract setting; and contract monitoring. Market management and contract setting are further subdivided for clarity.

Market management

Local authority influence on the social care market

Policy guidance has sought to improve the quality of care services through better contracting and market management (Cm 6499, 2005; Cm 6737, 2006). Evidence from the literature has suggested that local authorities are able to influence the market through the contracting process by means of price and type of contract (Forder and Netten, 2000; Netten et al., 2003; Ware et al., 2001). There is also some evidence to suggest that local authorities have actively sought to manage the market in order to ensure the survival of smaller providers and to regain control over the price of domiciliary care (Drake and Davies, 2006).

In respect of domiciliary care providers and the tendering process, this study provides some information on supply. Generally most local authorities considered the supply of potential providers to be 'about right,' with oversupply rather a lack of it most likely to be reported. The information from the questionnaire in respect of tendering for domiciliary care is more difficult to place in context. In terms of the tenders/expressions of interest received by local authorities, analysis by authority type (a possible proxy for size and rurality) reveals that on average shire unitary authorities had the lowest and inner London authorities most. Around two fifths of local authorities had a guide price in tendering for domiciliary care. Whilst block contracting was a common feature of domiciliary care provision, it was used less in respect of residential and nursing care. In this context, it is reasonable to assume that in respect of the latter, as noted above, this was mainly used as a mechanism to secure the supply of specialist provision for older people with dementia.

Balance of local authority and independent sector provision

In terms of strategic planning within older people's services, the most important areas to address are the balance between care provided at home and that within residential and nursing care settings, together with the balance between independent and public sector provision incorporating the principle of Best Value (DETR, 1998b; Cm 6737, 2006). In this study this is reflected in data relating to the transfer of local authority provision to the independent sector and the balance of expenditure between the two sectors in respect of domiciliary care.

Overall this study demonstrates that most authorities have contracted out the majority of their residential and domiciliary care services, with the earlier transfer of residential compared to domiciliary care, reflecting the development of their enabling role and the financial imperative (Cm 849, 1989; Cm 4169, 1998). A considerable proportion of authorities had transferred their in-house residential provision to the independent sector before 2001 with just over a quarter reporting having no care

homes. This is consistent with other studies which have reported that the independent sector is increasingly providing residential/nursing care, with it now providing the majority of all care home provision (Andrews and Phillips, 2000; Forder and Netten et al., 2000). With regard to domiciliary care, most local authorities had contracted out the majority of their domiciliary care services to the independent sector between before 2005. Other research reports considerable differences between local authorities in the split between in-house and independent domiciliary care services, together with an increase in the independent sector share of the market (Ware et al., 2001).

In terms of domiciliary care expenditure, most local authorities reported they allocated over 60 per cent of this to independent providers, with a third allocating more than four fifths. This is an issue that was not addressed in the literature review. However, other evidence from this study suggests that local authority domiciliary care is increasingly focussing on reablement reflecting the principle of Best Value and a more recent policy focus on timely discharge from hospital (Cm 4169, 1998; Department of Health, 2001d). These may be construed as implicit factors influencing the balance of domiciliary care provision between the two sectors.

Focus of provision

At the heart of the community care reforms was the development of the enabling role of the authority with a focus on commissioning rather than providing services. In this context, local authorities were required to become a residual service provider with responsibility for commissioning cost effective services from the independent sector, both not-for-profit and voluntary organisations (Cm 849, 1989). Subsequently, policy guidance has emphasised the importance of service commissioners developing capacity in the third sector (Cm 6737, 2006). Also important in this context, is the duty of Best Value which requires services to be commissioned in ways which encompass economy and efficiency and also effectiveness and quality of local services together with optimum outcomes for service users (DETR, 1998b; Cm 4169, 1998).

In the current study, as noted above, in-house domiciliary care services focused mainly on intermediate care, with independent sector services predominantly focusing on community based care. This is consistent with previous work which has suggested that the majority of independent providers offer a broad range of community based care services and evidence that suggests some local authorities have retained reablement services in-house (Ware et al., 2001; Drake and Davies, 2006). Our data suggested that in-house residential care typically focused on short term/respite intermediate care and dementia specific care. The finding that the majority of local authorities have transferred the majority of their residential care services to the independent sector suggests, along with previous research, that independent sector homes cater for a wide variety of clients (Andrews and Phillips, 2000).

Characteristics of independent sector providers

The policy guidance underpinning this section relates to the requirement to develop markets to ensure that individual budget holders have a range of innovative services of high quality to choose from (Cm 6737, 2006). More specifically, commissioners are expected to develop the market in social care in a way which facilitates a range

of provision through different service providers thereby maximising choice for service users (Department of Health, 2007a).

In this study, the data suggested limited progress towards the twin goals of diversity in both the range of services and the organisations providing them. For example, local authorities, particularly those in London, were more likely to be contracting with independent providers that operated across their local authority boundary. This is consistent with research that has suggested an increase in the number of agencies operating in more than one authority due to consolidation of providers into larger organisations (Ware et al., 2001). With regard to the ownership of care homes, research has also suggested that a growing number are owned by major providers and that smaller homes are more likely to facing closure (Darton et al., 2003; Netten et al., 2000; Andrews and Phillips., 2002). This is reflected in the current study, with the data suggesting that local authorities are less likely to be contracting with care homes owned by single proprietors.

Extent and uptake of training

Government has established training targets and funding mechanisms to support the establishment of appropriate arrangements for meeting the training needs of the social care workforce (Department of Health, 2003a; b; c). In terms of uptake, cost and cover for staff attending training are cited as inhibiting factors (Francis and Netten, 2004). Research has also indicated that domiciliary care workers have lower expectations in terms of access to training than their counterparts in care homes (Fleming and Taylor, 2006).

Findings from this study suggest that local authorities are taking responsibility for the training needs of the care staff in their locality. A high proportion of local authorities formed part of a training partnership with other agencies and most of these included independent providers. However, it was noteworthy that whilst nearly all local authorities provided training, this was most likely to be received by in-house staff than those employed by the independent sector. Nevertheless, a considerable number of local authorities provided the same training to all care workers regardless of sector. Two other findings from the research are relevant in this context. Firstly, most authorities specified in their tendering and contracting for domiciliary and residential care services induction and training for new staff and staff development and appraisal. Secondly, a substantial number of local authorities did monitor contracts with independent providers of these services with respect to staff development and training.

In terms of specialist dementia care, government guidance urges service providers to induct, retain and develop staff by commissioning suitable training and providing regular supervision and support to all staff (Department of Health, 2003g; Department of Health/CSIP, 2005). This study indicated that most authorities provided dementia care training to in-house care workers and around three fifths provided this to independent sector providers in their locality. Perhaps more significantly, just under half of respondents specified dementia training in contracting/tendering for domiciliary care, and around three fifths for residential care.

Contract setting

Type of contract

Recent policy initiatives mean this is a particularly important area for strategic service commissioners. Service commissioners are required to both promote flexibility in service delivery arrangements, and to ensure continuity of provision. Concurrently, guidance anticipates that the introduction of the personalisation agenda will result in a greater number of older people and carers assuming responsibility for care arrangements. More detailed policy guidance advises against too many short term contracts and for the support of the voluntary sector so as to compete with other providers (Cm 6499, 2005; Cm 6737, 2006; Department of Health, 2007a). These factors and a history of different patterns in service provision between authorities suggest substantial variation in current arrangements across the country and it is implicitly anticipated that contracting arrangements will be subject to change and development in the near future.

Data from this study suggested that although the majority of local authorities had block purchase contracts for residential/nursing home services for older people, this approach formed only a small part of contracting arrangements. This finding confirms that from previous research (Filinson, 1998; Forder and Netten, 2000; Matosevic et al., 2008). In the present study, block contracts were typically used for dementia and respite care, confirming an earlier observation that they are mainly used for purchasing specialised services (Matosevic et al., 2008).

The majority of local authorities also reported having block contracts with domiciliary care providers, with a small number reporting that all their domiciliary care hours were provided through this process. This also confirms earlier research which suggested a move towards a greater use of block purchasing arrangements (Ware et al., 2001; Drake and Davies, 2006). The current study also found variations in the extent of block contracting with independent domiciliary care providers by local authority type, with shire counties most likely to block contract with these agencies. Longer length contracts were found to be most popular, with contracts of one year or less being rare. However, marked variation in contract length was found by local authority type, with London boroughs most likely to have contracts of four years or longer with their independent providers.

These findings have implications for providers of residential and domiciliary care. However, the popularity of different contract types amongst providers, an issue addressed in previous research (Kendall, 2001; Ware et al., 2001; Drake and Davies (2006), is not in the remit of this study.

Price

Issues in respect of price are dealt with largely by implication within the policy guidance. This is most clearly seen in the principle of Best Value which suggests that issues of effectiveness and quality should be within the price as well as those relating to economy and efficiency (DETR, 1998b). This suggests that price setting is more than ascribing a monetary value, incorporating a quality dimension and, by implication, wages and conditions of service for staff.

The latter is most clearly illustrated in this study in respect of domiciliary care. Almost two fifths of authorities had a guide price in their tendering documentation for block

contracts. Of these, all included travel time in the guide price and most included: weekend and bank holiday enhanced rates; mileage costs; sickness and training payments; and holiday entitlements. A similar proportion of authorities required domiciliary care providers to separately identify staff remuneration costs within the envelope of funding submitted as part of the tendering process.

Wage levels within the local labour market have been found by one study to have the most significant effect on residential care prices (Darton et al., 2003). More generally, a higher price is associated with nursing compared to residential care (Forder and Netten, 2000). This has been confirmed by this study with specialist dementia nursing care as the most expensive form of provision. Marked variation by authority type was also noted. For example, with regard to independent sector residential and nursing care, prices were highest in inner London.

Contract monitoring

It is notable that oversight of human resource policies within the contract monitoring process is not addressed in the principal policy guidance documents. By contrast, in terms of policy guidance, monitoring of user and carer experience and satisfaction with services (Cm 4169, 1998) can be extended into the contract monitoring process. Additionally, there were found to be no articles relating to this subject that met the inclusion criteria for the literature review. It was, however, an issue which the postal questionnaire sought to address. This revealed that contract monitoring whilst encompassing user and carer experience, also included other determinants of quality, with Commission for Social Care Inspection (CSCI) reports being part of this process with regard to independent domiciliary care, in-house residential provision and, more generally, care home provision.

Just over half reported that their authority contracting/commissioning sections monitored their in-house domiciliary care service. Approaches included: monitoring through the use of a contractual framework and the use of quality assurance systems. Information most likely taken into consideration in the monitoring and review of contracts with independent domiciliary care providers included CSCI reports and the number of complaints. Understandably, a higher proportion of local authorities monitored contracts with independent domiciliary care providers in relation to staffing and human resource policies. Examples of areas of review were: staff development and training; recruitment procedures; retention of staff; and conditions of service.

Factors most likely to be taken account of in the monitoring and review of the quality of care in homes for older people were once again CSCI reports and the number of complaints. In their periodic reviews of in-house residential provision, authorities were also most likely to consider CSCI reports together with the fabric of the building. Just under three quarters of local authorities reported that they monitored contracts with independent providers of residential/nursing home care with respect to staffing and human resources policies. Examples of areas of review included: staff development and training; recruitment procedures; and conditions of service.

Care management arrangements

Personalisation of care

As part of the development of the concept of the personalisation of care, policy has reaffirmed the government's commitment to increasing the uptake of direct payments amongst older people and the take-up of direct payments is now a performance indicator (Cm 6737, 2006; Leece, 2007). In addition, recent guidance has outlined proposals to introduce individual budgets and a pilot scheme has demonstrated the benefits and barriers to implementing them (Cm 6499, 2005; HM Government, 2008a; Glendinning et al, 2008b) particularly for older people. With regard to the uptake of direct payments, recent evidence suggested intra and inter variation in local authorities with a tendency for this method of resource allocation to be used less in older peoples services (Fernández et al., 2007).

Evidence from the current study indicated that nearly all local authorities had begun to respond to this agenda and had a direct payments support scheme for older people within the local authority. A relatively small proportion of authorities had other arrangements for flexible budgets to access care for older people such as individual budgets. Overall, it would seem therefore that there is considerable scope for development in this area. For example, one of the changes that could be anticipated would be a move to a more flexible approach to contracting arrangements with less emphasis on block contracts in domiciliary care, in order to respond to the personalisation agenda.

Devolved budgets

As noted in Chapter 1, at the outset of the community care reforms government acknowledged the importance of devolved budgets in care management arrangements (Cm 849, 1989). However, findings from the current study indicated that the majority of local authorities did not have devolved budgetary arrangements. This is consistent with those from previous research (Lewis et al., 1996; 1997; Challis et al., 2001a). The implications of this are twofold. Firstly, care managers have little capacity to develop flexible care packages in response to individual circumstances and secondly, that this arrangement has promoted stability in respect of service provision which has enhanced the sustainability of services particularly domiciliary care. From this it might be concluded that greater flexibility in service response will only be achieved by resultant fragmentation of service response which will inevitably impact on working conditions, particularly for domiciliary care staff.

Care planning

Policy guidance indicates that support should be available to both older people and their carers (Department of Health, 2008a; HM Government, 2008b). Other aspects of the government's transformation agenda relate to the increasing use of self assessment and the support of individuals with lower level need through services designed to support and prevent increased dependency (Department of Health, 2008a). As part of the personalisation of social care described above, it is intended that all individuals eligible for publicly funded adult social care will have a personal budget. This is described as a transparent allocation of resources to enable the

deployment of resources flexibly in order to meet their needs rather than being offered a choice of services (Department of Health, 2008a).

Only a small number of local authorities had a system of self assessment for older people in respect of domiciliary care. More typically, local authorities had an arrangement for outcome-based domiciliary care whereby the 'assessor purchases required services from the provider.' Furthermore, local authorities appear to be responding to the current policy emphasis on outcomes with one of the most frequently mentioned changes to contracting arrangements being a move to outcome based commissioning for older people's services.

In the majority of local authorities, the domiciliary care component of a package was costed for both local authority and independent sector provided services. This study also provides data relating to older people and their carers with substantial levels of need. An interesting finding was that in addition to personal care, the principal services offered were meal preparation, shopping and housework. These services were much more likely to be offered to older people than to their carers. This finding is in contrast to earlier work that suggested the range of services care managers were able to offer was more restricted (Ware et al., 2003).

Intensive care management

Within the context of community care, care managers were identified as key players in the process of ensuring that resources were targeted effectively and that services were planned to meet specific needs of individuals (Cm 489, 1989). More recently, it has been recognised people with complex needs will need a care manager to work alongside them to undertake an assessment of need and devise a package of care (Cm 6499, 2005; House of Commons, 2008). Such people, including those with dementia, often require intensive care management in order to live at home (Challis and Davies, 1986; Challis et al., 1995; 2002).

The study has shown that around a third of local authorities reported having intensive care management arrangements with the majority providing this service in both long term community support services and the intermediate care sector. This suggests an increase from an earlier postal survey when few social services departments reported specialist care management services for older people (Challis et al., 2001b). However in contrast to the earlier survey, this one included both short term and long term service provision.

Implications for the social care workforce - emergent themes

In the light of recently established targets for the transformation of social care, the present study suggests that there is considerable capacity for development with regard to commissioning arrangements, contracting processes, and care management arrangements, with consequent implications for the workforce. Moreover, further changes can be anticipated consequent on the government's agenda to modernise social care.

With regard to commissioning, this study demonstrated considerable investment by local authorities in the process and workforce issues were encapsulated within this.

There was evidence of provider involvement in the formal processes of commissioning through the stakeholder consultation process. Additional channels of communication were through provider forums and training partnerships which included local NHS organisations. These developments may help to ensure that workforce issues are taken into account in service commissioning particularly in relation to the availability of training. Increased emphasis on joint commissioning with health colleagues was another noticeable feature and it could be surmised that if this led to jointly provided services there would be implications for the workforce in terms of conditions of service.

In terms of contracting, with regard to the independent sector in particular, the data suggested that this was an important area of activity, both in terms of content and monitoring, the latter representing a departure from the existing literature. Human resource policies were an important component of this and therefore provide a means of monitoring the impact on the workforce of changes in the content and range of services consequent on the requirement for greater flexibility in provision.

The future of care management arrangements is dominated by the development of the current personalisation agenda. Within social care services for older people this potentially creates a tension between the demand for flexible patterns of care and the requirement to have such services available on demand. Whilst block contracted services, particularly with regard to domiciliary care provide stability for the agency with obvious implications for conditions of staff service, the new vision for social care requires greater flexibility and therefore potentially less stability in provider organisations which will impact on conditions of service. Changes are also anticipated in the manner in which arrangements for care are made with this task undertaken by service users and their families as well as by care managers. The implication of these changes for both agencies and their staff in terms of service expectations is as yet unknown.

Finally, it is relevant to note, that these data provide opportunities for further enquiry and analysis. As with other studies, there is the opportunity to explore the relationship between price and supply in both the care home and domiciliary care sectors. Of particular interest might be the influence of local authority provision in this context. More generally, the possibility of linking this data with more detailed findings relating to the provision of long term coordinated care for older people in the community could be investigated. Notwithstanding these possibilities, this present study as reported provides a baseline, or template, against which the achievements of the personalisation agenda in terms of commissioning and contracting arrangements and the consequent implications for the workforce may be measured.

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APPENDIX ONE

Postal questionnaire

PERSONAL SOCIAL SERVICES RESEARCH UNIT

Recruitment and Retention of a Care Workforce for Older People

Questionnaire

In this questionnaire we use the term "commissioning" to describe the process of needs analysis and strategic planning. We use the term "contracting" to describe the process of contract setting (procurement), market management and contract monitoring.

Respondent's name _____

Job title _____

Telephone number _____

Authority name _____

BACKGROUND INFORMATION

1. What was the political control of your authority at 31/5/2007?

Conservative	
Labour	
Liberal Democrats	
No overall Control	

2. Does the social services department form a single department or part of a combined organisation e.g. housing/social services, PCT/Social Services?

Single	
Combined	

If combined, please specify the name of the organisation

_____

3. How many primary care trusts does your authority **routinely** negotiate with? (please state number)

4. At what level in the local authority is responsibility for **commissioning** and **contracting** combined in a single manager?

2nd tier (e.g. service manager)	
3rd tier	
4th tier	
5th tier or above	
Not applicable	

Please specify the job title of this single manager

_____

5. At what level in the local authority is responsibility for **assessment of need**, **purchasing of services** and **managing of in-house services** combined in a single manager?

1st tier (e.g. team leader)	
2nd tier (e.g. service manager)	
3rd tier	
4th tier or above	
Not applicable	

Please specify the job title of this single manager _____

6. Does your authority have an integrated health and social care provider for older people for:

a. All provision

Yes ☐

No ☐

b. Selected services

Yes ☐

No ☐

If yes, please specify which services _____

7. Is your contracting unit located in:

Adult social care services ☐ Legal services ☐

Chief executives department ☐ Other ☐

If other, please specify _____

8a. Do you have a provider forum?

Yes ☐

No ☐

8b. If yes, how frequently does it meet?

Once a year ☐ 6 times a year ☐

3 times a year ☐ More than 6 times a year ☐

9a. Does your local authority form part of a training partnership with other agencies?

Yes ☐

No ☐

9b. If yes, is this a partnership with

Independent providers	☐	NHS	☐
Other local authorities	☐	Other	☐

If other, please specify _____

10. What type of training do you provide to domiciliary/care home staff and is it available to in-house staff and independent sector staff? **TICK ALL THAT APPLY**

	In-house staff	Independent sector staff
Client handling		
Carer awareness		
Safeguarding adults		
Falls prevention		
First aid		
Medication management		
Health and safety		
Food hygiene		
Infection control		
Dementia care		
Diabetes care		
Loss and depression in elders		
Palliative care/end of life		
Parkinson's care		
Stroke care		

COMMISSIONING

11. Which of these statements describe your department's commissioning arrangements for older people? **TICK ALL THAT APPLY**

A **range of tasks** undertaken by member(s) of staff **who also have operational responsibilities**	
A means of **specifying service arrangements** with independent providers	
A means of **specifying service arrangements** with in-house services	
A means of promoting the development of **new forms and styles of service** response	
A means of promoting the **redesign of existing services**	
A means of providing information to allow **care managers to make informed choices** about individual services	
A method of **promoting quality assurance** of service provision	
A means of **specifying a framework** for care managers to negotiate services for individual users	
A mechanism for **the implementation of local strategic planning decisions**	
A means of ensuring the **views of older people and their carers** are reflected in the design of services	
A means of ensuring **providers comply with employment legislation**	
A means of ensuring the **principles of best value** influence future service provision	

12. Which of the following groups do you routinely involve in the commissioning of new older people's services and the redesign of existing ones? **TICK ALL THAT APPLY**

Current service users	
Potential or former users of services	
Older people from minority ethnic or religious groups	
Next generation older people i.e. people less than 65 years of age	
Carers	
Primary care trusts	
Care managers	
Scrutiny groups	
Providers of social care services	
Older people's champions	
CSCI	
Local Implementation Teams (LIT's)	
Employee representatives	
Housing department	

13. Which of these older people's social services does your local authority commission? **TICK ALL THAT APPLY**

Domiciliary care	
Specialist domiciliary provision (please specify):	
Care homes	
Care homes with nursing	
Care homes dementia	
Care homes with dementia nursing	
Adult placement	
Respite care	
Other (please specify):	

14a. Do you commission or provide any special services dedicated to hospital discharge (including early discharge) outside of the intermediate care sector? Please include jointly provided schemes.

Yes ☐

No ☐

14b. If yes, please specify the services and the type of staff who provide these services. **TICK ALL THAT APPLY**

	LA staff only	LA/NHS staff	Independent sector staff
Short term residential or nursing home care			
Adult placement scheme			
Special domiciliary care service			
Other (please specify):			

15a. Which of these arrangements does your authority have for the joint commissioning of older people's services? **TICK ALL THAT APPLY**

Joint plans and planning processes	
Joint specification and overseeing of contracts	
Pooling of ring-fenced monies	
Pooling of total agency budgets for older people's services	
Single lead commissioner for health and social care	

15b. What proportion of your local authority's commissioning for older people's services is done in conjunction with your PCT (i.e. jointly commissioned)?

- 0-20% ☐
- 21-40% ☐
- 41-60% ☐
- 61-80% ☐
- 81-99% ☐
- 100% ☐

16a. Do you jointly commission with the NHS for intermediate care services?

- Yes ☐
- No ☐

16b. If yes, please specify the type of services and the staff that provide them. **TICK ALL THAT APPLY**

	LA staff only	LA/NHS staff	Independent sector staff
Prevention of hospital admission - care at home			
Prevention of hospital admission - residential/nursing home			
Early/supported hospital discharge - care at home			
Early/supported hospital discharge - residential/nursing home			
Rehabilitation scheme - care at home			
Rehabilitation scheme - residential/nursing home			

17a. Do you jointly commission with the NHS for old age mental health services?

- Yes ☐
- No ☐

17b. If yes, please specify the type of services and staff that provide them? **TICK ALL THAT APPLY**

	LA staff only	LA/NHS staff	Independent sector staff
Care homes dementia			
Nursing homes dementia			
Specialist home care worker			
Other (please specify):			

CONTRACTING

DOMICILIARY CARE SERVICES

18. When did you contract out the majority (51%+) of your domiciliary care services to the independent sector?

Before 1999	☐
Between 2000-2004	☐
2005 or later	☐

19a. Is your authority still a **provider** of in-house domiciliary care for older people?

Yes	☐
No	☐

If no, please proceed to question 20a

19b. If yes, what proportion of the expenditure on domiciliary care is contracted to **independent** providers?

0-20%	☐
21-40%	☐
41-60%	☐
61-80%	☐
81% or more	☐

19c. If yes, what approaches to monitoring **in-house** provision does the contracting/ commissioning section of your authority employ?

_____

_____

_____

_____

_____

20a. How many **independent** providers of domiciliary care do you currently contract with? (please state number)

☐

20b. How many of these operate solely within your authority? (please state number)

☐

20c. Of the number of providers listed in 20a how many have **block** contracts with your local authority? (please state number)

☐

20d. Of the domiciliary care hours provided by **independent** providers, estimate the proportion provided through block contracting?

0-20%	☐
21-40%	☐
41-60%	☐
61-80%	☐
81-99%	☐
100%	☐

21a. Please indicate what are the foci of your domiciliary services for older people **TICK ALL THAT APPLY**

	In house (if applicable)	Independent
Intermediate care		
Old age mental health care		
Community based care		
Other (please specify):		

21b. For the **independent sector** please state the **number** of providers who provide each of these services

Intermediate care	
Old age mental health care	
Other (please specify):	

22. What is the availability of your domiciliary care providers during the working week? **TICK ALL THAT APPLY**

	In house providers	**All** independent providers	**Some** independent providers
Day time Monday-Friday			
Evenings Monday-Friday			
Night time			
Weekends			

23a. When did you last put out a tender for domiciliary care services? (please state the year)

☐

23b. On this occasion, how many tenders/expressions of interest did you have? (please state number)

☐

23c. On this occasion, was the supply of potential providers:

About right ☐
Too many ☐
Too few ☐

24a. Did you have a **guide price** in your tendering document for **block** contracts?

Yes ☐
No ☐

24b. If yes, was it inclusive of: **TICK ALL THAT APPLY**

Weekend enhanced rates ☐
Bank holiday enhanced rates ☐
Travel time ☐
Mileage cost ☐
Sickness payment ☐
Training payments ☐
Holiday entitlements ☐

25. With regard to the **deployment and training of staff** do you specify in your tendering and contracting with **independent** providers of domiciliary care the following: **TICK ALL THAT APPLY SEPARATELY FOR TENDERING AND CONTRACTING**

	Tendering	Contracting
Staff development and appraisal		
Induction/training for new staff		
Provision of management training		
Specialist dementia training		
Training achievement levels against national training standards		
Payment for staff attending training		
Provision of sick pay		
Supervision of staff		
Payment of travel time		
Payment of mileage		

26. With regard to the **provision of services** do you specify in your tendering and contracting with independent providers of domiciliary care the following: **TICK ALL THAT APPLY SEPARATELY FOR TENDERING AND CONTRACTING**

	Tendering	Contracting
Commitment to monitoring system		
Innovative ideas/cost savings		
Medication policy		
Equity of access to services for ethnic minorities		
Flexibility and around the clock services		
Crisis response		

27a. Within your current contracts do you have a standard price for domiciliary care?

Yes ☐
No ☐

27b. If **no**, does it vary by: **TICK ALL THAT APPLY**

Type of contract ☐
By different providers ☐
Local labour markets within the authority ☐
Ease of travel to area (i.e. payment of a travel premium) ☐
Time of day ☐
Day of week ☐
By individual user ☐
Additional hours over and above contracted hours ☐

28. Do you require providers to separate the wages element from other costs in your tendering/contracting process?

Yes ☐
No ☐

29. What time frame is **typically** specified in your contracts with **independent** providers? **TICK ONE ONLY**

1 year ☐
2-3 years ☐
4 years and over ☐

30. What type of contract do you **typically** use in contracting for care with **independent** providers of domiciliary care? **TICK ONE ONLY**

Fixed term ☐
Roll on ☐
Other ☐

If other, please specify _____

31a. When contracting for domiciliary care services do you use documents which are:

Created within your own authority ☐
A standard model contract designed elsewhere ☐
A combination of own design and model contract ☐

31b. If you use a model contract please specify which organisation this was obtained from? (e.g. Department of Health, CSIP, other local authority)

_____

32a. Does your contracting section monitor **independent sector** domiciliary care services?

Yes ☐
No ☐

32b. If yes, when do you monitor domiciliary care services provided by the **independent** sector?

Prior to renewal of contract ☐
Throughout the contract period ☐
In response to complaint ☐

33. What information do you take into account in **the monitoring and review of contracts** with **independent** domiciliary care providers? **TICK ALL THAT APPLY**

Number of complaints ☐
Interviews with care managers ☐
Level of service use ☐
User satisfaction surveys ☐
Returns from providers e.g. activity data ☐
CSCI reports ☐
Other ☐

If other, please specify _____

34. If you monitor contracts with **independent** domiciliary care providers please specify areas of review in relation to **staffing and human resource policies**

_____

_____

_____

_____

RESIDENTIAL/NURSING HOME CARE

35a. Is your authority a **provider** of residential home care?

Yes ☐

No ☐

If no, please go to question 36

35b. If yes, please indicate the focus of your **in-house** residential care for older people **TICK ALL THAT APPLY**

	Long term	Short term/respite
Intermediate care		
Dementia specific		
Resource centre		
Other (please specify)		

35c. What information do you take into account in the review of service level agreements or their equivalent for **in-house** residential provision? **TICK ALL THAT APPLY**

Political mandate ☐

Cost of service ☐

Needs analysis ☐

Views of residents ☐

Views of staff ☐

CSCI reports ☐

Fabric of building/building standard ☐

Other ☐

If other, please specify _____

36. When did you transfer the majority of local authority residential provision into the independent sector (or make other arrangements)?

Before 1993 ☐

Between 1994 - 2000 ☐

2001 or later ☐

37a. Do you have any block purchase contracts for **independent** residential/nursing home services for older people?

Yes ☐

No ☐

If no, please go to question 38

37b. If yes, for what purpose? **TICK ALL THAT APPLY**

Dementia care ☐

Intermediate care ☐

Respite ☐

Other ☐

If other, please specify _____

37c. If yes, of the number of beds provided by **independent** providers, estimate the proportion provided through block contracting?

1-9% ☐

10-19% ☐

20-29% ☐

30-39% ☐

40-49% ☐

50% or more ☐

38. What is the price you pay for **independent sector care** in the current financial year (07/08)?

	Price per bed per week
Long term residential care	£
Long term nursing care	£
Long term nursing care for older people with dementia	£

39. What proportion do you estimate of the **independent sector care homes** you currently contract with are **personally** owned and managed by single proprietors?

0-19% ☐

20-39% ☐

40-59% ☐

60% or more ☐

40. With regard to the **deployment and training of staff** do you specify in your tendering and contracting with external providers of residential/nursing home care the following: **TICK ALL THAT APPLY SEPARATELY FOR TENDERING AND BLOCK CONTRACTING**

	Tendering	Block Contracting
Staff development and appraisal		
Induction/training for new staff		
Provision of management training		
Specialist dementia training		
Training achievement levels against national training standards		
Payment for staff attending training		
Provision of sick pay		
Supervision of staff		
Other (please specify)		

41. In the monitoring and review of the quality of care in homes in which you place older people, what information do you take into account? **TICK ALL THAT APPLY**

Coroners reports ☐
Number of complaints ☐
Information from care managers ☐
User satisfaction surveys ☐
Levels of service use ☐
Information from friends and family ☐
CSCI reports ☐
Home star ratings ☐
Other ☐

If other, please specify _____

42. If you monitor contracts with **independent sector** providers of residential/nursing home care, please specify areas of review in relation to **staffing and human resource policies**

_____

_____

_____

_____

_____

_____

COMMISSIONING WITHIN CARE MANAGEMENT ARRANGEMENTS

43. What arrangements do you have for outcome-based commissioning of domiciliary care as part of a package of care from specific providers? **TICK ALL THAT APPLY**

- Assessor purchases required services from provider ☐
- Assessor prescribes and determines allocation provided ☐
- Assessor prescribes and negotiates content with provider ☐
- Assessor prescribes and commissioner negotiates content from specific external providers ☐
- Assessor recommends, provider determines allocation ☐
- Provider assesses and provider allocates ☐

44. Do you have a system of self assessment for older people in respect of domiciliary care? ☐

Yes

No ☐

If yes, please describe

_____

_____

_____

45a. Does your department have a specialist care management service working exclusively with people with high needs/at high risk carried out by staff carrying **small caseloads**?

Yes ☐

No ☐

45b. If yes, please tick box(es) which best describe service(s) offered:

	Older people with primarily mental health problems	Older people with primarily physical health problems	Older people with either physical or mental health problems
Short term/time limited intervention (e.g. intermediate care)			
Long term, ongoing community support			

46. Is the domiciliary care component of a package costed?

	Yes	No
Local authority domiciliary care services (if applicable)		
Independent domiciliary care services		

47. Are care managers/care manager assistants, or those undertaking the equivalent role, able to commit finance to and/or allocate **externally provided domiciliary care services** to implement a community based care package without consultation with a first line manager or member of their commissioning team?

Yes ☐
No ☐

48. In addition to personal care, which of the following services are purchased or directly provided by the local authority for older people receiving long term community support or their carers? **TICK ALL THAT APPLY**

	Older person	Carer
Housework		
Teleshopping		
Shopping		
Help with meal preparation		
Other, please specify		

49. Is there a recognised direct payments support scheme in your authority for older people?

Yes ☐
No ☐

If yes, what type of scheme is it? **TICK ALL THAT APPLY**

Centre for Independent Living ☐
User led ☐
Local authority ☐
Disability organisation ☐
Older people's organisation ☐
Charity ☐
Voluntary ☐

50. Apart from direct payments, do you routinely use any other arrangements for flexible budgets to access care for older people?

Yes ☐
No ☐

If yes, please describe

_____

_____

_____

51. How are care decisions for the entry of older people into residential and nursing home care authorised? **TICK ALL THAT APPLY**

First line manager budget ☐
Team quota ☐
Panel – LA staff only ☐
Panel – LA and NHS staff ☐
Senior manager ☐
Other ☐

If other, please specify _____

52. What do you think are the strengths of your current commissioning processes?

_____

_____

_____

_____

_____

53. What changes (if any) is your local authority planning to make to its existing contracting arrangements for older peoples services?

_____

_____

_____

_____

_____

Please return the completed form in the envelope provided to:

Professor David Challis, Personal Social Services Research Unit
Dover Street Building, University of Manchester, Oxford Road, Manchester, M13 9PL

Thank you for your assistance in completing this form

APPENDIX TWO

Contract setting and market management – national guidance

Box A2.1: Intermediate care services – guidance for domiciliary care contracts

- Define intermediate care, state service objectives and define population served.
- Make clear the responsibilities of the commissioner and provider.
- Type of contract required for crisis intervention and rapid response may be different in its nature to a planned domiciliary care contract.
- A rolling contract with annual review of both commissioner and provider performance.
- Likely to be a cost and volume contract to give commissioner flexibility to budget to meet an initially, relatively unknown need and at the same time give a prospective provider a guaranteed volume of contract.
- May be set within the context of Long Term Service Agreements (related to care pathways) which might be of three years duration.
- Contain an estimate of the number of hours to be purchased initially.
- Contract for the number of hours clinical/therapy input separately from personal and home care, where the entire service is provided by a single provider.
- Requirement for provider to carry out employment checks on all staff and to ensure that agreed adequate levels of appropriately qualified staff are maintained at all times, and that staff competencies are maintained through regular training. Part time staff to be subject to the same standards and requirements as full time staff.
- Assessment process agreed and understood by all parties.
- Review of outcomes of care against pre-agreed care standards.
- Ensure adequate insurance.

Source: Department of Health, 2001e

Box A2.2: Intermediate care services – guidance for residential care contracts

- Define intermediate care, state service objectives, and define population served.
- Make clear the responsibilities of the commissioner and provider.
- A rolling contract with annual review of both commissioner and provider performance.
- Assessment process agreed and understood by all parties.
- Likely to be a block contract and it is important that bed use is maximised.
- May be set within the context of Long Term Service Agreements (related to care pathways) which might be of three years duration.
- Requirement of provider to carry out employment checks on all staff and to ensure that agreed, adequate levels of appropriately qualified staff are maintained at all times, and that staff competencies are maintained through regular training.
- Providers should ensure that all qualified staff have extant registration with the relevant professional registration bodies.
- Review of outcomes of care against pre-agreed care standards.
- The commissioner should be familiar with the requirements of the registered homes act and ensure that any additional requirements are written into the contract.
- Ensure adequate insurance.

Source: Department of Health, 2001e

Box A2.3: Principles of contracting with the third sector

- Efficiency: contracts should enable the purchasers to achieve quality services at value for money.
- Sustainability: contracts need to embody a general approach to a proper working relationship which fosters sustainable, long term provision (where appropriate) in the interests of service users.
- Proportionately: contracts should aim to achieve what is necessary or highly desirable in the simplest possible way. Document length should be reduced as much as possible and the "kitchen sink" approach abandoned.
- Suitability: contracts should reflect the service that is required and the actual agreement between the parties.
- Simplicity: departures from plain English need plain English explanations.
- Fairness: contracts should reflect a fair and proper balance between purchaser and provider. Risk should be properly allocated.
- Equality: contracts should be the same for every sector.

Source: Department of Health, 2006b

Box A2.4: Guide to fairer contracting - care placements and domiciliary care services

- Providers need to be involved at the earliest possible stage so their input can help shape contract clauses and/or specifications.
- Commissioners should develop with providers a rolling programme of drafting and reviewing contracts in a similar way to their programme for commissioning strategies.
- Users views should be sought on all aspects of service delivery and they should be consulted before any major change is made to contract arrangements that directly affect them.
- Commissioners need to ensure that potential and existing providers are not discouraged by having to face a bureaucratic and expensive contracting process.
- Fair contracts seek to ensure that each signatory to the contract bears some of the risk and acknowledge and protect the interest of both.
- Commissioners to offer incentives to providers to encourage them to adopt new approaches to providing services.
- Open book accounting can assist commissioners and providers in reaching a transparent partnership arrangement particularly when purchasers wish to develop a new service to avoid the price being set too high or too low.
- Contracts need to be clear about the price agreed as a part of the tender process, by whom it is to be paid, when and in what circumstances.
- Price of the contract will be formed in recognition of the actual cost of providing the service which will include staffing costs (national minimum wage, local market conditions, pension, holiday entitlement, travel costs) and the costs of managing and training of staff (supervision, induction, specialist training). Training costs may be excluded from the overall price if purchasers pay for training via some other local consortium available to a range of providers.
- Clear duration to any block or cost and volume contract.

Source: CSIP, 2005

Box A2.5: Guide to fairer service specifications - domiciliary care

- Purpose of the service and required service outcomes.
- Details of service user groups.
- Values or principles that apply to all contact with service users and their carers.
- Type of tasks expected to be undertaken (personal care, cleaning and house care) which may be broad or specific if specialist service being commissioned.
- Where specification relates to a block contract, it may set out the number of hours being purchased.
- Expectations regarding hours of service availability.
- Geographical area to be covered should be made clear to the provider.
- Clear details of where referrals will come from.
- Requirement that providers will be registered with the CSCI.
- Service standards that providers are expected to meet.
- Details about monitoring and reviewing procedures.

Source: CSIP, 2007

Box A2.6 Guide to fairer service specifications - care homes

- Purpose of the service and required service outcomes.
- Details of the type of service being commissioned including details of service user groups.
- Values or principles that apply to all contact with service users and their carers types of tasks expected to be undertaken (including personal care, assistance with social/spiritual/emotional needs).
- Where the specification relates to a block contract, set out the number of care home places being purchased.
- Details regarding the admission process.
- Requirement that providers will be registered with CSCI.
- Service standards that providers are expected to meet.
- Details about monitoring and reviewing procedures.

Source: CSIP, 2007

APPENDIX THREE

Supplementary tables from chapter 3

Table A3.1: Political control at 31st May 2007, by authority type (n=91)

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
Conservative	6	35	2	9	17	77	14	48	39	43
Labour	3	18	10	44	3	14	8	28	24	26
Liberal Democrats	3	18	4	17	1	5	1	3	9	10
No overall control	5	29	7	30	1	5	6	21	19	21
No. of authorities	17		23		22		29		91	

*One response could not be classified. Source: Question 1 – What was the political control of your authority at 31/5/2007?

Table A3.2: Structure of social services department, by authority type (n=90)

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
Combined	13	81	14	61	7	32	21	72	55	61
Single	3	19	9	39	15	68	8	28	35	39
No. of authorities	16		23		22		29		90	

*One response could not be classified. Source: Question 2 – Does the social services department form a single department or part of a combined organisation e.g. housing/social services, PCT/Social Services?

Table A3.3: Workforce training – in-house and independent sector

	In-house		Independent sector	
	No.	%	No.	%
Safeguarding adults	80	94	72	84
Health and safety	77	91	53	62
Client handling	76	89	53	62
Food hygiene	75	88	53	62
Medication management	75	88	54	63
Dementia care	73	86	52	61
Infection control	73	86	51	59
First aid	72	85	47	55
Falls prevention	62	73	47	55
Palliative care	56	66	36	42
Carer awareness	54	64	32	37
Stroke care	51	60	29	34
Loss and depression in elders	45	53	33	38
Diabetes care	39	46	28	33
Parkinson's disease	37	44	22	26
No. of authorities	85		86	

Source: Question Q10 – What type of training do you provide to domiciliary/care home staff and is it available to in-house staff and independent sector staff? Tick all that apply.

Table A3.4: Local authority commissioning arrangements (n=92)

	No.	%
A means of specifying service arrangements with independent providers	87	95
A means of ensuring the views of older people and their carers are reflected in the design of services	85	92
A means of ensuring the principles of best value influence future service provision	83	90
A means of promoting the redesign of existing services	82	89
A means of promoting the development of new forms and styles of service response	82	89
A method of promoting quality assurance of service provision	78	85
A mechanism for the implementation of local strategic planning decisions	76	83
A means of specifying service arrangements with in-house services	58	63
A means of ensuring providers comply with employment legislation	57	62
A means of providing information to allow care managers to make informed choices about individual services	55	60
A means of specifying a framework for care managers to negotiate services for individual users	50	54
A range of tasks undertaken by member(s) of staff who also have operational responsibilities	40	43

Source: Q11 – Which of these statements describe your department's commissioning arrangements for older people?

Table A3.5: Local authority commissioning arrangements, by authority type (n=91)

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
A means of specifying service arrangements with independent providers	17	100	20	87	22	100	27	93	86	95
A means of ensuring the views of older people and their carers are reflected in the design of services	17	100	22	96	20	91	25	86	84	92
A means of ensuring the principles of best value influence future service provision	16	94	22	96	19	86	25	86	82	90
A means of promoting the redesign of existing services	17	100	19	83	20	91	26	90	82	90
A means of promoting the development of new forms and styles of service response	14	82	20	87	21	95	26	90	81	89
A method of promoting quality assurance of service provision	16	94	21	91	16	73	24	83	77	85
A mechanism for the implementation of local strategic planning decisions	16	94	18	78	21	95	21	72	76	84
A means of specifying service arrangements with in-house services	9	53	16	70	14	64	19	66	58	64
A means of ensuring providers comply with employment legislation	12	71	13	57	13	59	18	62	56	62
A means of providing information to allow care managers to make informed choices about individual services	12	71	14	61	10	45	19	66	55	60
A means of specifying a framework for care managers to negotiate services for individual users	8	47	14	61	10	45	18	62	50	55
A range of tasks undertaken by member(s) of staff who also have operational responsibilities	7	41	8	35	10	45	15	52	40	44
No. of authorities	17		23		22		29		91	

*One response could not be classified. Source: Q11 – Which of these statements describe your department's commissioning arrangements for older people?

Table A3.6: Number of stakeholder groups consulted (n=90)

No. of groups consulted	No.	%
Two	1	1
Three	2	2
Four	3	3
Five	2	2
Six	4	4
Seven	10	11
Eight	9	10
Nine	9	10
Ten	11	12
Eleven	10	11
Twelve	9	10
Thirteen	10	11
All	10	11

Source: Q12 – Which of the following groups do you routinely involve in the commissioning of new older people's services and the redesign of existing ones? Tick all that apply.

Table A3.7: Type of specialist domiciliary provision (n=47)

	No.	%
Old age mental health service	24	51
Intermediate care	13	28
Services for specialist groups	11	23
Learning disabilities	7	15
Physical disabilities	6	13
Supported housing	5	11
Complex needs	2	4

Source: Q13 – Which of these older people's social services does your local authority commission?

Table A3.8: Range of services commissioned, by authority type (n=90)

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
Care homes dementia	17	100	23	100	21	95	28	100	89	99
Care home	17	100	22	96	21	95	28	100	88	98
Care home with nursing	17	100	23	100	20	91	28	100	88	98
Respite care	17	100	23	100	21	95	27	96	88	98
Domiciliary care	16	94	21	91	20	91	25	89	82	91
Care homes with dementia nursing	16	94	23	100	18	82	28	100	85	94
Adult placement	7	41	17	74	18	82	18	64	60	67
Specialist domiciliary	12	71	9	39	15	68	10	36	46	51
Other	9	53	6	26	8	36	11	39	34	38
No. of authorities	17		23		22		28		90	

*One response could not be classified. Source: Q13 – Which of these older people's social services does your local authority commission?

Table A3.9: Hospital discharge services by service sector (n=66)

	LA staff only		LA/NHS staff		Independent sector	
	No.	%	No.	%	No.	%
Short term residential or nursing home care	28	42	19	29	45	68
Specialist domiciliary care service	40	61	14	21	25	38
Adult placement scheme	12	18	3	5	15	23
Other services	4	6	0	0	4	6

Source: Q14b – If yes, please specify the services and the type of staff who provide these services. Tick all that apply.

Table A3.10: Intermediate care services by service sector (n=81)

	LA staff only		LA/NHS staff		Independent sector	
	No.	%	No.	%	No.	%
Prevention of hospital admission - care at home	21	26	61	75	30	37
Rehabilitation scheme - care at home	25	31	53	65	11	14
Early supported hospital discharge - care at home	27	33	50	62	27	33
Early supported hospital discharge – care home	20	25	48	59	38	47
Rehabilitation scheme - care home	19	24	42	52	27	33
Prevention of hospital admission – care home	24	30	42	52	37	46

Source: Q16b – If yes, please specify the type of services and staff that provide them.

Table A3.11: Old age mental health services by service sector (n=52)

	LA staff only		LA/NHS staff		Independent sector	
	No.	%	No.	%	No.	%
Nursing home dementia	7	13	12	23	40	76
Care home dementia	17	32	14	26	35	66
Specialist home care worker	14	26	11	21	13	25
Other	3	6	8	15	7	14

Source: Q17b – If yes, please specify the type of services and staff that provide them. Tick all that apply.

Table A3.12: Date domiciliary care services contracted to the independent sector, by authority type (n=89)

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
1999 or before	4	24	4	17	6	30	8	28	22	25
Between 2000 and 2004	8	47	12	52	11	55	15	52	46	52
2005 or later	5	29	7	30	3	15	6	21	21	24
No. of authorities	17		23		20		29		89	

*One response could not be classified. Source: Q18 – When did you contract out the majority of your domiciliary care services to the independent sector?

Table A3.13: Number of independent providers of domiciliary care, by authority type (n=87)

	Local authority type*						All
	Inner London	Other metropolitan districts	Outer London	Principal metropolitan cities	Shire counties	Shire unitary authorities	
Minimum	2	5	4	5	7	3	2
Maximum	28	31	26	17	150	33	150
Percentile 25	5	10	7	5	29	6	8
Percentile 75	26	17	20	16	73	12	27
Median	15	14	14	9	40	9	13
No. of authorities	7	17	10	4	21	28	87

Source: Q20a - How many independent providers of domiciliary care do you currently contract with?

Table A3.14: Independent domiciliary care providers – proportion operating solely within the authority, by authority type

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
None	8	50	5	25	2	13	8	30	23	29
1 to 24.99%	6	38	8	40	3	19	8	30	25	32
25 to 49.99%	1	6	4	20	4	25	5	19	14	18
50% or more	1	6	3	15	7	44	6	22	17	22
No. of authorities	16		20		16		27		79	

*One response could not be classified. Source: Q20b – How many of these operate solely within your authority?

Table A3.15: Block contracts – proportion of independent sector domiciliary care hours, by authority type

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
Block contracts	11	65	13	57	14	74	16	57	54	62
No block contracts	6	35	10	44	5	26	12	43	33	38
No. of authorities	17		23		19		28		87	

*One response could not be classified. Source: Q20d - Of the domiciliary care hours provided by independent providers estimate the proportion provided through block contracting.

Table A3.16: Foci of domiciliary care services (minimum n=84, maximum n=88)

	In-house		Independent sector	
	No.	%	No.	%
Intermediate care	65	77	30	34
Old age mental health	48	57	70	80
Community based care	46	55	84	96
Other	8	10	14	16
No. of authorities	84		88	

Source: Q21a – Please indicate what are the foci of your domiciliary services for older people. Tick all that apply.

Table A3.17: Tenders received for domiciliary care services, by authority type (n=78)

	Local authority type						All
	Inner London	Other metropolitan districts	Outer London	Principal metropolitan cities	Shire counties	Shire unitary authorities	
Minimum	16	1	4	15	3	3	1
Maximum	60	44	127	43	130	92	130
Percentile 25	33	11	21	16	15	9	11
Percentile 75	55	31	71	39	56	21	40
Median	50	17	40	27	28	15	19
No. of authorities	5	18	9	5	16	25	78

Source: Q23b – On this occasion, how many tenders/expressions of interest did you have?

Table A3.18: Specifications for staff deployment and training in tendering and contracting for domiciliary care (minimum n=82, maximum n=86)

	Tendering		Contracting		Either	
	No.	%	No.	%	No.	%
Induction and training for new staff	67	82	77	90	78	91
Staff development and appraisal	69	84	74	86	76	88
Supervision of staff	64	78	70	81	73	85
Training achievement levels against national training standards	63	77	68	79	72	84
Provision of management training	52	63	54	63	57	66
Specialist dementia training	30	37	39	45	41	48
Payment of travel time	30	37	28	33	34	40
Payment of mileage	27	33	23	27	29	34
Payment for staff attending training	23	28	24	28	27	31
Provision of sick pay	21	26	21	24	23	27
No. of authorities	82		86		86	

Source: Q25 – with regard to the deployment and training of staff do you specify in your tendering and contracting with independent providers of domiciliary care the following. Tick all that apply separately for tendering and contracting.

Table A3.19: Specifications for service provision in tendering and contracting for domiciliary care (minimum n=84, Maximum n=88)

	Tendering		Contracting		Either		
	No.	%	No.	%	No.	%	N=
Equity of access to services for ethnic minorities	68	81	77	88	80	91	87
Commitment to monitoring system	67	80	74	84	78	89	88
Medication policy	64	76	71	81	75	85	88
Flexibility and around the clock services	49	58	52	59	56	64	87
Innovative ideas/cost savings	40	48	31	35	44	51	87
Crisis response	37	44	41	47	43	49	87
No. of authorities	84		88				

Source: Q26 – with regard to the provision of services do you specify in your tendering and contracting with independent providers of domiciliary care the following. Tick all that apply separately for tendering and contracting.

Table A3.20: Length of domiciliary care contracts, by authority type (n=87)

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
Less than 4 years	7	44	17	74	13	68	14	48	51	59
4 years and over	9	56	6	26	6	32	15	52	36	41
No. of authorities	16		23		19		29		87	

*One response could not be classified. Source: Q29 – What time frame is typically specified in your contracts with independent providers? Tick one only.

Table A3.21: Type of contract used in purchasing independent sector domiciliary care, by authority type (n=87)

	Authority type								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
Fixed term	14	88	15	65	13	65	21	75	63	72
Roll on	1	6	6	26	4	20	4	14	15	17
Other	1	6	2	9	3	15	3	11	9	10
No. of authorities	16		23		20		28		87	

Source: Q30 – What type of contract do you typically use in contracting for care with independent providers of domiciliary care? Tick one only.

Box A3.1: Domiciliary care contracts – staffing and human resource policies

Conditions of service
- Absence and sickness arrangements
- Appraisal system
- Confidentiality/data protection
- Disciplinary and grievance procedures
- Equality and diversity policy
- Health and safety policy
- Insurance
- Rates of pay
- Whistle blowing policy

Management structure
- Management and leadership skills
- Management of agency
- Management or organisation structure

Policies and procedures of providers
- Application
- Monitoring
- Review

Recruitment procedures
- Adequate recruitment to staff the contract
- Advertising
- CRB checks
- Equal opportunities policy
- Recruitment and selection: processes and practice.
- References

Retention of staff
- Staff turnover and reason.

Staffing levels/numbers
- Monitor number of staff as ratio of provision
- Staffing rotas, timesheets

Staff development and training
- Additional cost implications of training detailed
- Induction programme
- NVQ records
- Promotions procedures
- Qualifications of staff
- Skills mix
- Staff supervision
- Training and development programme
- Training needs analysis and database for mandatory training
- Training: policies and procedures
- Training: support and personal care delivery

Source: Q34 – If you monitor contracts with independent domiciliary care providers please specify areas of review in relation to staffing and human resource policies.

Table A3.22: Year of transfer of residential care services to the independent sector, by authority type (n=90)

	Authority type*								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
Before 1993	4	24	1	4	4	19	6	21	15	17
Between 1994 and 2000	8	47	12	52	8	38	11	38	39	43
2001 or later	4	24	7	30	5	17	5	17	21	23
Not applicable	1	6	3	13	4	24	7	24	15	17
No. of authorities	17		23		21		29		90	

*One response could not be classified. Source: Q36 - When did you transfer the majority of local authority provision into the independent sector?

Table A3.23: Price - independent sector residential care, by authority type (n=75)

	Local authority type						All
	Inner London	Other metropolitan districts	Outer London	Principal metropolitan cities	Shire counties	Shire unitary authorities	
Minimum	396.32	317.45	398.63	318.00	300.58	285.00	285.00
Maximum	560.00	394.00	535.00	388.50	450.00	450.00	560.00
Percentile 25	428.16	338.81	416.50	318.00	331.38	332.14	338.81
Percentile 75	531.92	359.00	496.25	-	381.78	393.57	406.00
Median	472.00	346.92	460.00	378.63	350.63	353.19	358.50
No. of authorities	5	15	10	3	18	24	75

Source: Q38 – What is the price you pay for independent sector care in the current financial year (07/08)? Price per bed per week.

Table A3.24: Price - independent sector nursing care, by authority type (n=62)

	Local authority type						All
	Inner London	Other metropolitan districts	Outer London	Principal metropolitan cities	Shire counties	Shire unitary authorities	
Minimum	522.00	330.47	531.69	362.00	339.00	224.50	224.50
Maximum	662.00	495.00	620.00	404.40	499.67	575.00	662.00
Percentile 25	546.63	365.88	545.00	362.00	370.00	390.25	387.53
Percentile 75	653.11	467.50	617.25	-	470.00	497.07	533.77
Median	600.00	390.97	575.00	388.50	434.80	440.00	462.45
No. of authorities	5	12	9	3	15	18	62

Source: Q38 – What is the price you pay for independent sector care in the current financial year (07/08)?

Table A3.25: Price - independent sector dementia nursing care, by authority type (n=64)

	Local authority type						All
	Inner London	Other metropolitan districts	Outer London	Principal metropolitan cities	Shire counties	Shire unitary authorities	
Minimum	535.00	330.47	574.00	367.00	339.00	285.00	285.00
Maximum	700.00	511.00	750.00	419.40	528.50	630.00	750.00
Percentile 25	555.91	386.21	576.36	367.00	394.00	383.65	395.50
Percentile 75	676.12	465.00	651.75	-	470.00	504.50	529.63
Median	610.00	418.50	602.50	399.50	420.91	443.00	452.16
No. of authorities	5	13	8	3	15	20	64

Source: Q38 – What is the price you pay for independent sector care in the current financial year (07/08)

Table A3.26: Independent sector residential care homes – ownership and management, by authority type (n=82)

	Authority type								All	
	London boroughs		Metropolitan cities/ districts		Shire counties		Shire unitaries			
	No.	%	No.	%	No.	%	No.	%	No.	%
40% or more	2	13	11	48	7	44	8	30	28	34
Less than 40%	14	88	12	52	9	56	19	70	54	66
No. of authorities	16		23		16		27		82	

Source: Q39 – What proportion to do you estimate of the independent sector care homes you currently contract with are personally owned and managed by single proprietors?

Table A3.27: Specifications for staff deployment and training in tendering and contracting for residential care (minimum n=61, maximum n=77)

	Tendering		Contracting		Either	
	No.	%	No.	%	No.	%
Staff development and appraisal	53	74	46	75	62	81
Induction and training for new staff	56	78	50	82	67	87
Provision of management training	40	56	33	54	48	62
Specialist dementia training	36	50	34	56	46	60
Training achievement levels	53	74	49	80	65	84
Payment for staff attending training	18	25	15	25	20	26
Provision of sick pay	18	25	14	23	19	25
Supervision of staff	49	68	47	77	61	79
Other	0	0	1	2	1	2
No. of authorities	72		61		77	

Source: Q40 – with regard to the deployment and training of staff do you specify in your tendering and contracting with external providers of residential/nursing home care the following. Tick all that apply separately for tendering and block contracting.

Box A3.2: Residential care contracts – staffing and human resource policies

Conditions of service
- Annual leave
- Absence and sickness arrangements
- Appraisal system
- Contact of employment
- Disciplinary and grievance procedures
- Equalities and diversity policy
- Health and safety policy
- Rates of pay
- Whistle blowing policy

Retention of staff
- Exit interviews
- Rates of sickness and absence
- Staff turnover and reason
- Turnover of management

Recruitment procedures
- Ability of staff to work
- Composition of staff group
- CRB checks
- Equal opportunities policy
- Recruitment and selection: processes and practice
- References

Staff development and training
- Customer care
- English as a second language (ESOL)
- Food hygiene
- Induction programme
- Investors in People
- Minimum standards on training
- NVQ records
- Promotions procedures
- Qualifications of staff
- Staff supervision
- Team meetings
- Training and development programme
- Training: files/records
- Training plans
- Record of training offered and completed
- Registration of nursing staff

Staff/resident interface
- Confidentiality/privacy/dignity
- Culture specific, specialist care
- Customer satisfaction with staff
- Observe interaction with users
- Ratio of staff to residents

Source: Q42 – If you monitor contracts with independent sector providers of residential/nursing home care, please specify areas of review in relation to staffing and human resource policies.

Table A3.28: Intensive care management arrangements - location

	No.	%
Intermediate care only	6	20
Long term support only	4	13
Long term support and intermediate care	20	67

Source: Q45b – If yes, please tick box(es) which best describe service(s) offered.

Box A3.3: Strengths of current commissioning processes

- (1) Based on building capacity needs analysis. (2) Staffed by commissioning specialists. (3) Quality assured and performance managed. (4) Engaged and involving providers, users and carers. (5) Reported through scrutiny process.
- A good mix of block and spot commissioning. Effective brokerage arrangement for domiciliary care. Flexibility built into current arrangements. Good relationships with local suppliers/providers. Established tendering processes etc.
- A range of block and spot arrangements to ensure capacity in all service areas.
- Ability to manage the market and provide improved outcomes for service users.
- An intention to procure innovative services.
- Assessed as 'excellent' by CSCI, Nov 07. Robust operational commissioning model linked to strategic priorities and planning process. Strong user and carer involvement, involving lay assessor teams. Outcome based service specifications linked to the 7 outcomes of the White Paper.
- Balanced across need, so good preventative focus. Joint manager. Pooled fund for modernisation.
- Based within the older peoples unit, which allows for closer liaison with care staff knowledge and experience of the market.
- Being developed currently so are able to reflect personalisation. Long standing contracting arrangements in place so good relationships with providers.
- Clarity of processes and evidence based assessment. This has been developed through the Joint Strategic Needs Assessment for Older People.
- Clarity of roles and a separation of the grind of finding placements from the assessments task. Our care purchasing team know the current availability of provision and being co-located with care management teams are both independent and accessible.
- Clear model differentiates between commissioning and procurement. Clear sense of direction around developing enablement and personal care agenda.
- Clear procedure *[for]* tendering/contracting. Strong partnership arrangements and monitoring arrangements.
- Close liaison *[between]* health and social care staff. Flexible response to individual needs.
- Commissioning is based on a sound analysis of the health and social care needs of the population, and *[we are]* now working on producing a joint strategy needs analysis. Commissioning is informed by service users. Collecting data on low level need through monitoring to inform the preventative agenda.
- Commissioning processes aligns to corporate objectives. Direct payments and individual budgets. Support for carers and developing a carer's network. Equality and diversity, social inclusion. Independent workforce strategy - working with the sector to develop the workforce.
- Commissioning/care management/PCT joint working/user choice - block/spot contracts; regional working/contracts; strong relationship with providers; strong local domiciliary care market; management provisions/activity system.
- Contract monitoring. Value for money via block contracting.
- Controls and challenges decisions to make permanent placements, ensuring that every option for home based support is explored.
- Decision making is clear - delegated powers. Speedy process. Budget management. Individual focus. Reliability - people needing services get them.
- Dedicated commissioner, contract officer and monitoring staff to older people across all services.
- Dedicated commissioning division within adult social care; joint health and social care posts.
- Difficult question! Eligibility criteria which has its faults is important as is the assessment and care plan.
- Effective communication with providers. A strong brokerage arrangement in domiciliary care purchasing. High proportion of owner providers in both sectors.
- Establishes pattern of accredited and contracted services for care manager to call off against.
- Flexibility and person centredness.
- Flexible and responsive to local needs - working with the market.
- Focus on quality and value for money. Using band and guide prices to manage market and robust monitoring to ensure quality.
- Good balance between professionals experienced in care services, contracting practice and procurement procedures. Good links with PCT commissioning colleagues. All staff in *[name of authority]* and *[name]* PCT have recently trained together on the 'Oxford Brookes' 'certificate in

commissioning and purchasing in public care' course.

- Good on-going engagement with older people, including representatives of BME *[British ethnic minority]* communities. Strong joint working, within a single directorate, with housing colleagues, successful in bidding for extra care housing grants to reduce reliance on residential care.
- Good positive relationships with providers, healthy local market with capacity. Strong emphasis on protection of vulnerable adults.
- Good relationships with providers. Well developed communication systems. Very detailed specifications in contracts.
- High quality service at reasonable cost.
- History of spot purchasing has been local/responsive/flexible and cost effective but no capacity for accreditation/QA *[quality assurance]* or strategic procurement has meant quality control left entirely to CSCI *[Commission for Social Care Inspection]*.
- Integrated commissioning across health and social care. Pooled budget arrangements. Well developed contestability framework.
- Involvement of service users/carers in tendering process. Good contracting and procurement support. Relationships with local providers. Engagement with self directed support agenda. Cross county joint working and procurement. Needs analysis work with PCT and JSNA *[Joint Strategic Needs Assessment]*.
- It seems to give us good results in terms of outcomes and price.
- Joint decision making forums for CHC *[care home commissioning]*, Nursing and Joint funded packages LA/PCT. Joint commissioning for intermediate care LA/PCT. Joint approach to work started re: MHSOP *[mental health services for older people]*/LTC
- JSNA is probably one of our greatest strengths. Successfully worked with partners including joint strategic needs assessment (JSNA) and mapping *[name]* for funding with the aid of partners. The direction is building relations with the partner organisation and beginning to start joint commissioning process. PCT's and borough councils have good data around demographic population needs.
- Linking price to quality.
- Local needs analysis. Knowledge of demand and local provision. Quality monitoring. Engagement of users and carers
- Long established experienced contracts and commissioning team in place. No block contracts which gives flexibility and greater personalisation in packages and placements. Good understanding of the market.
- Moving towards long term commissioning arrangements with health. Have been able to move from institutionalised/residential agenda to personalisation agenda very quickly - reduced number of admissions.
- Multi agency decision making.
- Now backed by joint commissioning strategies and implementation plans. Stronger service user/carer/potential service user influence.
- Person centred, care planning, needs based analysis, whole systems planning.
- Positive working relationships with providers based on principled outcomes. Older people's services management structure (commissioning arrangements and relationship with assessment and care management).
- Project management approach - developed over time. Body of experience and skills in staff group. Conscious efforts to involve service users at different stages of the process. Understanding of need to develop skills/sharing experience. Good understanding of the commissioning cycle.
- Provides a quality check for standardisation ensuring equity of provision in partnership with health.
- Provides services within budget. Is adaptable to new initiatives - "in control", self directed care, outcome based. Varied and responsive provider base. Good use of web and 'e' commissioning.
- Quick turnaround for service provision. Monitoring process including quality and performance. Trouble shooting to support service users' relationship with providers. Development work - sharing learning across providers.
- Range of provision of services available. Good commissioner/contract department links. Direct payments available - good user involvement. Good partnership working with NHS colleagues.
- Recognised as leaders in country, work with CSIP CSED frequently undertaken to assist other councils.
- Regulation of quality.
- Robust costing of services and care packages. Vetting of providers prior and post contract award, VFM *[value for money]*. Monitoring of providers.

- Robust monitoring of independent sector providers which highlight standards of poor provision and a contract framework that prevents placements being made with providers that do not meet commissioning standards.
- Scrutinising social work spending and reducing risk in social work practice
- Separating commissioning from procurement. Meetings with provider forums.
- Sound strategies. Joint with PCT. Lead commissioning and pooled budgets. Good levels of user satisfaction.
- Stability of local markets. Capacity in local markets. Market intelligence to inform and maximise service user choice.
- Stability of the market. Quality Premium Awards recognising level of quality provided.
- Strong financial control. Early signals via commissioning strategies, in terms of direction of travel and action to consider impact of individual budgets and self directed care there are projects established.
- Strong panel process where alternatives can be discussed. Also close co-operation between contracts and care management.
- Strong partnerships, robust monitoring including older people themselves.
- Strong procurement team. Panel arrangements prior to placing clients. Strong review function both with care managers and contacts team.
- Tend to be concentrated on macro and micro commissioning. As yet, little by way of strategic commissioning, but about to reorganise to include a strategic commissioning section to work fully with PCT.
- The ability to look at things in a joined up way having the opportunity to use an integrated approach through Social Services and Community Health coupled with excellent working relationships with the Acute Trust and GP's.
- The adult social care and health department has restructured from 1.4.08 which establishes lead commissioning allied to adult partnerships across health and social care. Adult social care and health will lead older people's commissioning which will build on the previous multi-agency approach.
- The partnership with the PCT has strengthened considerably over the past 12 months, moving towards lead commissioning and pooled budgets in LD *[learning disabilities]*. This model, once tested is likely to impact significantly on the approach to commissioning older people's services.
- The strengths of the process lie in the logistical arrangements that are in place to undertake the process. There are clear teams/people responsible for the different elements of the process, enabling each step to be delivered with a 'pass the baton' approach to ensure nothing is missed. This approach has strengthened how we engage individuals, carers and staff within the commissioning process, alongside how we develop the market to meet future needs and expectations.
- Tight controls on quality assurance. Tight budgetary management. Ability to work closely with providers to develop services to meet local needs.
- Under pinned by long term (15 yr) strategy. Good relationships with providers. Good engagement from older people and voluntary sector.
- Understanding of the market. Relationship with providers. Domiciliary cost and volume contracts. Management of residential/nursing home market.
- VFM *[value for money]*, strengthening approach to quality improvement.
- We are currently finalising a commissioning strategy. This is linked to a council wide efficiency review led by KPMG and this will help redefine assessment, commissioning and brokerage functions. A new social care panel was established 6 months ago.
- We are embracing personalisation and flexible care; we are using individual budgets and working closely with *[name]* PCT to work towards common aims.
- We are moving to a more outcome focussed monitoring format. Close links with local community.
- We have a strategic commissioning plan and a 15 year long term plan. There is local flexibility in the local care markets in a large authority.
- We undertake detailed qualitative and quantitative needs analysis of all our population in conjunction with the PCT. We also have detailed purchasing plans for all client groups aimed at providers.

Source: Q52 – What do you think are the strengths of your current commissioning processes?

Box A3.4: Planned changes to existing contracting arrangements

- 2008/9 moving to outcome based commissioning and contracting. Moving away from block contracts to preferred providers
- About to carry out competitive tender for supply of homecare from independent sector into geographical zone contracts. In-house will become more integrated with PCT as main provider of rehabilitation/rapid response/intermediate care.
- Above inflation fee uplift planned for 2008/9 to introduce a quality development scheme. Outcome monitoring will be reflected in contracts from April 2008.
- Adopting national fair pricing tool, outcome based commissioning, externalising in-house home care service, extending extra care sheltered housing, roll-out of new client database to include financial and workflow management.
- Any changes in the short term will be determined as a result of a growth in demand for self directed support.
- As part of government transformation agenda, we are looking to roll out individual budgets for older people over the next three years. Also, wish to offer more universal and community preventative schemes.
- Both the local authority and its partner PCT are keen to extend the currently limited joint commissioning and contracting services for older people. Within the next three years, the models of care and the contracting arrangements will need to be fundamentally reviewed as self directed care arrangements are rolled out to older people.
- Changes brought about by individualised budgets which will see more user led contracting arrangements.
- Commission some local specialist EMI *[elderly mentally ill]* residential places possibly block. Contract EMI *[elderly mentally ill]* specialist domiciliary care.
- Creation of a contract commissioning and brokerage unit.
- Current scoping work on new domiciliary care contracts to be outcome-based, rehabilitation focused and able to respond to individualised care and personalised budgets. Increase in block extra care provision. Increase in block nursing care home provision.
- Currently developing approved list for residential and nursing care placements. Reconfiguration and retendering domiciliary care contracts. Changing all contract terms and conditions to allow price negotiation/bench marking costs on some services. Retendering day care services. Developing new contract for residential and nursing care framework. Developing new quality assurance framework across all service areas and much more.
- Developing more integrated preventative services. A more integrated approach for services for people with mental health needs. Introduction of a range of self-directed support models.
- Developing new contracts - pre placement agreement and individual placement agreements - outcome based service specification. Quality risk based matrix to monitor providers.
- Development of individualised budgets.
- Engaging with the market in advance of any changes that are going to be made to ensure that they are consulted; provide useful feedback; have enough information to decide if they need to change/diversify in order to meet the changes.
- Establishment of single commissioning agency. Joint contract with NHS for nursing homes/new contract with homeowners.
- Further development of commissioning for quality in 2009/10 using CSCI data and monitoring information. Further developments in relation to how to support the market with the individualised budget agenda and flexible options for people. Further consideration of 'make or buy' decisions in relation to in-house services and development of monitoring of those services.
- Impact assess individual budgets. Joint planning, strategy, commissioning with PCT. New commissioning unit dedicated to quality, monitoring and market management.
- Improved purchasing/care brokerage arrangements.
- In-house reablement service under development. Introduction of individualised budgets. Separation of assessment and procurement of services.
- Increased choice and control, individual budgets, self assessment.
- Increasing the focus upon outcomes.
- Increasing use of extra care housing, short term intensive home care *[and]* joint intermediate care services.
- Introducing framework agreement for home care and care homes.

- Introducing Q.P.A. for domiciliary care.
- Introduction of locally designed quality frameworks, fair price for care, preferred/block contracting (extension of use).
- Introduction of residential and nursing home revised contracts (December 2007) focusing on individual client outcomes.
- Introduction of self directed support. Flexible, non-block contracts, outcome-based contracting, greater joint commissioning with PCT and housing.
- It is intended to outsource 3 out of 5 residential homes and all of in-house domiciliary care services. The existing homes will have specialist units e.g. dementia to create market forces.
- Joint commissioning arrangement with the PCT. Extending to brokerage role to include care home sector. Brokerage arrangements will include purchasing on behalf of PCT. Creation of a care navigator role to assist self funders. Electronic monitoring. Pilot outcome based commissioning.
- Joint commissioning arrangements.
- Joint commissioning of HRS/SP and domiciliary care on approved provider basis-no block or PI contracts from mid 2009. Introduce enhanced workers community wide. Emphasis on extra care with enhanced level of service. Develop NFP *[not for profit]* sector to link in effectively with domiciliary care and housing support and capture preventive agenda.
- Lead commissioning arrangements with PCT. Personalisation agenda.
- Market management and development re: preventative services and a realignment of block contracts to inform individual budgets and support brokerage.
- Modernising assessment and procurement systems in accordance with social care reform
- More integrated approach to contract monitoring through balanced scorecard (see Q19c), including improvements to contract specifications to make them smarter. Considering 'light touch' contract-like arrangements for grants to Third Sector moving from 'gift' to expectations of delivery. Exploring variable fees linked to quality of services for residential/nursing care and home support in the independent sector. Considering developing 'individual contracts' for customers explaining what they can expect from council and providers (based on care plan) and for how long.
- More outcome based. Planning for individualised budgets. LA lead commissioning.
- Move outcome focused: increase the size of DLA block allocation
- Move towards flexible framework contracts determined by individual service user demand.
- Moving towards closer cooperation with PCT commissioners and contracting staff. Working together to prepare for the contracting implications of self directed support. Identifying an outcomes based approach.
- New commissioning and brokerage service has just been developed and implemented.
- New contracts will need to reflect direct payments and individual budgets - there may need to be 'call off' arrangements for block contract arrangements. Flexibility from providers will be the key.
- New joint commissioning and contracting structure being put in place currently. Development of new arrangements such as frameworks replacing blocks to respond to personalisation.
- Not much on the agenda for change but only to improve as and when we can e.g. supporting more housing, and improving day care for older people. Looking at void management in homes but its not definite yet that anything about this will change in contracting. The changes before SDS - review of contracting arrangements and reviewing funding to be released for individual budgets. Voluntary sector - working with PCT's and district councils to jointly commission services - range of prep? Grant pilot across *[name]* - *R*eablement pilot - jointly commissioned with PCTs.
- Ongoing review of mix of block and spot contracting - trying to ensure best value and effectiveness. Ongoing partnership with NHS to obtain best value in contracting for social and health care funded beds in nursing homes.
- Outcome-focussed approach. More personalised service.
- Outcome focussed contracts by April 2009. Strengthen quality monitoring and contract monitoring. Implement a quality assurance system - 'bespoke' by and from April 2009 phasing in.
- Outcome focussed home care. Self directed support.
- Outcome measures. Reduction in block contracts to accommodate personalisation. Self directed services. Raising awareness of different types of funding. Developing new systems and procedures and through discussion reducing impact of change on the workforce.
- Re-commissioning to ECH *[extra care housing]* and support.
- Re-negotiating all contracts.
- Re-tender for domiciliary care to reflect personalisation agenda and outcomes based contracting. Exploration of joint contracting/commissioning with PCT.

- Re-tendering of Community Support Services. Electronic authorisation, data capture and payment to providers. Re-modelling of brokerage in light of above and O.H.O.C.O.S.
- Re tender home care, outcomes based contracting, preferred provider list - residential, fairer contracting.
- Reducing reliance on residential care. Retendering some blocks. Reducing prices in in-house provision.
- Reduction in number of small contracts and looking at brokerage arrangements for residential care services.
- Review of current provision/contracting arrangements.
- Self directed care will lend to less "cost and volume" contracting. Preferred lists will be used for service users to access choice. Outcome based initiatives will be used more.
- The authority is looking at how to model future contracts to meet changes individual budgets will bring.
- The biggest change we are about to move onto is the transformational change through the personalisation of services to vulnerable people - individual budgets. This will mean dissolving block contracting arrangements over a period of time and a new style of marketplace management.
- The new circular Transforming Social Care will result in major challenges and will impact on contracting arrangements particularly around domiciliary care.
- To jointly commission with NHS partners across the spectrum of continuing, intermediate and social care.
- Total transformation to self directed support by 2012.
- Under review - domiciliary/day services. Contract due for renewal.
- We are just embarking on a joint venture with the two PCT's to set up our Joint Commissioning Unit. This will include a strategic housing staffing group and separation of commissioning and procurement. We have a substantial change programme in place which involves closure of in-house services.
- We are looking to develop the market in line with the personalisation agenda.
- We are planning to incorporate individual budgets/direct payments into new services i.e. integrated community equipment service. Making providers more accountable through improved contract monitoring.
- We plan some block contracts to secure supply in rural areas. All our in house provision of residential care will become extra care in 2012.
- Working with providers to develop more flexible services to respond to personalised agenda. Commissioning for outcomes rather than outputs. More focus on quality monitoring
- Yes, changes will be informed by the above in addition to a new independent living scheme, reprovision of residential care by resource centres and a new outcome based tendered home care service.

Source: Q53 – What changes (if any) is your local authority planning to make to its existing contracting arrangements for older peoples services?

APPENDIX FOUR

Data for the selection of sites for phase II

Table A4.1: Local authorities ordered according to typicality of cluster

Cluster No.	Local authority*	Distance
1	130	1.22
	34	1.23
	3	1.28
	35	1.30
	125	1.36
	37	1.38
	5	1.46
	121	1.50
	13	1.58
	110	1.59
	74	1.61
	64	1.62
	142	1.68
	62	1.69
	60	1.71
2	78	0.76
	124	1.13
	87	1.17
	73	1.21
	81	1.29
	56	1.35
	67	1.36
	115	1.36
	84	1.37
	96	1.40
	99	1.43
	4	1.51
	50	1.55
	141	1.65
	41	1.72
	46	1.74
	89	1.75
	98	1.82
	137	1.96
3	118	0.70
	68	1.30
	132	1.35
	39	1.40
	21	1.41
	79	1.43
	36	1.44
	14	1.60
	104	1.61
	47	1.78
	69	1.85

Cluster No.	Local authority*	Distance
4	138	1.02
	131	1.14
	42	1.22
	77	1.22
	83	1.25
	122	1.25
	71	1.32
	123	1.41
	103	1.42
	119	1.48
	106	1.53
	85	1.61
	149	1.61
	144	1.65
	91	1.67
5	128	1.20
	12	1.32
	139	1.32
	114	1.34
	92	1.45
	8	1.57
6	25	1.17
	24	1.19
	108	1.22
	17	1.22
	86	1.22
	145	1.22
	101	1.25
	58	1.27
	15	1.32
	140	1.41
	65	1.56
	143	1.62
	61	1.88
7	93	1.20
	72	1.28
	10	1.31
	38	1.37
	29	1.38
	107	1.38
	66	1.40
	135	1.40
	109	1.55
	**	1.56
	129	1.60
	49	1.65
	22	1.82

*Local authority identification number in the database. **One response could not be identified.

Table A4.2: Further descriptors of distance measure (n=92)

	Cluster						
Descriptives	1	2	3	4	5	6	7
Median	1.50	1.40	1.43	1.41	1.33	1.25	1.40
St. dev	0.17	0.28	0.30	0.20	0.13	0.21	0.17
Lower CI*	1.15	0.89	0.84	0.99	1.11	0.93	1.11
Upper CI*	1.81	2.01	2.04	1.79	1.63	1.77	1.79
No. of authorities	15	19	11	15	6	13	13

*95% confidence intervals.

Table A4.3: Average score for each domain of interest – initial classification (minimum n=82, maximum n=92)*

		Domain of interest		
Cluster no.	No. of authorities	Commissioning and contracting	Employment practices	Flexibility in service provision at the level of the service user
1	15	0.4	0.5	0.4
2	19	0.5	0.4	0.2
3	11	0.6	0.5	0.8
4	15	0.3	0.1	0.4
5	6	0.4	0.6	0.4
6	13	0.4	0.3	0.3
7	13	0.6	0.7	0.7

*Missing data represented at indicator level.

Table A4.4: Characteristics of cluster types – initial classification (minimum n=82, maximum n=92)*

		Domain of interest		
Cluster no.	No. of authorities	Commissioning and contracting arrangements	Employment practices	Flexibility in service provision at the level of the service user
1	15	Medium	Medium	Medium
2	19	Medium	Medium	Low
3	11	High	Medium	High
4	15	Low	Low	Medium
5	6	Medium	High	Medium
6	13	Medium	Low	Low
7	13	High	High	High

Note: High ≥0.6, Medium 0.4-0.5, Low ≤0.3. *Missing data represented at indicator level.