



Commissioning services for adults with learning disabilities or autism: the views and experiences of commissioners

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Acknowledgements

This research was funded by the Department of Health and undertaken by researchers at the Quality and Outcomes of Person-centred Care Research Unit (QORU). The views expressed here are those of the authors and are not necessarily shared by any individual, government department or agency.

Thanks to commissioners and two anonymous ADASS reviewers who piloted and commented on draft versions of the survey. We are also very grateful to commissioners who gave their time and responded to the survey.

Executive summary

In a time of significant change in the way that services are commissioned in the UK, little is known about commissioning practices and the challenges faced by commissioners. Following a series of scandals in health and social care services, including the revelations of abuse at Winterbourne View, significant attention has been given to the quality of services for people with intellectual disabilities. Although there is a move to many people managing their own support through personal budgets, Commissioners still play an important role in purchasing services to meet people's needs. They also play a role in ensuring that high quality services are available locally including for those with personal budgets.

There is limited research into the role and experiences of commissioners, how they make decisions and the challenges they encounter in their role. This is particularly important at a time of austerity and change (e.g. the implementation of the Transforming Care agenda).

Aims and objectives

The study aimed to explore commissioning practices related to people with learning disabilities and autism in England, with a particular focus on the information used to help make decisions about services to commission as well as the challenges to commissioning effective services. In particular, the study has set out to explore the following questions:

- Is quality or outcomes of services part of the commissioning process?
- What sources of quality information are used in the commissioning process?
- What are the barriers and facilitators of using quality information in commissioning?
- What are the main challenges to commissioning high quality services?

Methodology and participants

All directors of adult services for local authorities in England (N=153) and chief operating officers (or equivalent role) of clinical commissioning groups (CCGs) (N=209) were invited to take part in an on-line survey in November 2015.

Local authorities returned 45 questionnaires, a response rate of 29.4 per cent. Twenty-five responses were returned by CCGs - including 15 joint responses – covering a total of 55 clinical commissioning groups (a response rate of 26%). Respondents came from a variety of geographical areas and represented a range of local government structures (e.g. unitary authorities, county councils etc.). Returns were analysed using a combination of descriptive statistics and thematic analysis.

Main findings

Three categories of services were explored: residential care, supported living, and day services. The majority of local authorities commission services from fewer than 20 services in each category. All but two CCGs were commissioning specialist hospital services. Direct (local authority) provision was more common in day services than residential care or supported living.

There is large variation in the level of out-of-area provision, although most local authorities and all CCGs reported moving people back into area.

All LAs and around three quarters of CCGs were using direct payments or personal budgets, including personal health budgets. Managed personal budgets are most often used when people cannot or do not want to manage their own personal budget. Support to budget holders, including brokerage, was provided by most local authorities and around half of CCGs.

Quality was reported to be the most common selection criterion for providers, with open tendering being the next most common basis for residential care, supported living, and day services, while approved lists based on business checks was the second most common method for specialist hospitals.

The top three factors considered by LA and CCGs commissioners to support their purchasing decisions were quality, safety, and suitability to the needs of the individual. Two thirds of respondents said that cost was a very important consideration in their decisions.

Most respondents reported using quality assessment frameworks and monitoring checklists of some type with information drawn from a range of sources. The frequency of quality assessment ranged from quarterly to yearly, or focusing on those identified as higher risk services.

Many respondents recognised the limitations and challenges of measuring, monitoring, and comparing service user outcomes. Service user outcomes were conceptualised in two key ways: user satisfaction and progress on goals in individual plans or improvements in the quality of life domains, such as health. Only a minority of commissioning bodies involved service users and carers in monitoring the quality of services.

Respondents identified a number of challenges – restructuring, spending cuts, skills shortages, demographic changes – and some opportunities associated with these, including potential ways of dealing with these, such as more collaboration and partnership working, integrated/joint commissioning with pooled budgets, prime funding to support market and capital development, greater flexibility and innovation in procurement and contracting, evidence-based commissioning and a good understanding by commissioners of how services deliver the right outcomes for people.

There are various limitations to consider. Due to the relatively low response rate and the fact that responses are not based on a full sample of geographical areas or commissioners, it is not possible to ascertain whether responses are entirely representative. However responses were received from across a wide range of geographical areas and from both a range of different types of commissioning bodies and including different commissioning arrangements, affording greater confidence in the relevance of the findings. It is not possible to be certain whether social desirability may have influenced answers to certain questions or whether the online format may have affected response rates.

Implications for policy and practice

The elements of how commissioners check quality are similar among and across local authorities and CCGs but also with many differences. This is likely to result in a lack of consistency in how quality is measured and judged. It also means that, especially in times of austerity, there remain inefficiencies

in the systems through doubling up of activities. A consensus on what good services for people with intellectual disabilities and autism look like, with valid and reliable data provided by CQC, would potentially make decisions about services easier, based on one primary source of information.

The acknowledgement of these issues and the need for CQC processes and reports to be more useful for commissioners has been raised as part of the Transforming Care agenda and has led to the development of a guide and checklist for inspectors on “What does good look like” . This guide is based on both research evidence and good practice. It provides an opportunity to explore whether it is possible to achieve some of the consensus and streamlining outlined above. If these were also endorsed by the Department of Health this may also provide the positive motivational context for the development of high quality services that will not only ensure the success of Transforming Care for those who display behaviour that is viewed as challenging, but to improve outcomes for people with disabilities in general.

1. Introduction

In a time of significant change in the way that services are commissioned in the UK, little is known about commissioning practices and the challenges faced by commissioners. Following a series of scandals in health and social care services, including the revelations of abuse at Winterbourne View, significant attention has been given to the quality of services (or lack thereof) for people with intellectual disabilities. Although there is a move to many people managing their own support through personal budgets, the majority of these are still provided as council managed budgets (ADASS, 2014)¹, meaning that Commissioners still play an important role in commissioning services to meet people's needs. They also play a role in ensuring that high quality services are available locally for those with personal budgets to purchase. However, there is very little research into the role and experiences of commissioners, how they make decisions and the challenges they encounter in their role. This is particularly important at a time of austerity and change (e.g. the implementation of the *Transforming Care* agenda).

1.1 Aims and objectives

The study has aimed to explore commissioning practices related to people with learning disabilities and autism in England, with a particular focus on the information used to help make decisions about services to commission as well as the challenges to commissioning effective services. In particular, the study has set out to explore the following questions:

- Is quality or outcomes of services part of the commissioning process?
- What sources of quality information are used in the commissioning process?
- What are the barriers and facilitators of using quality information in commissioning?
- What are the main challenges to commissioning high quality services?

Findings from this study will also hopefully give a useful snapshot of commissioning practices before full implementation of the Care Act (2014).

1.2 Methodology

All directors of adult services for local authorities in England (N=153) and chief operating officers (or equivalent role) of clinical commissioning groups (N=209) were contacted by email between September and November 2015 and invited to take part in a survey on commissioning services² for people with learning disabilities and autism, with a link to the on-line questionnaire in the email.

¹ ADASS (2014). *ADASS Personalisation Survey 2014. National Overview Report*. Table 6, p. 15. Available: <https://www.adass.org.uk/media/4692/adasspersonalisationsurveyreport03102014.pdf>

² The questionnaires can be obtained via email from: A.V.Turnpenny@kent.ac.uk

Local authorities and CCGs received slightly different versions of the same questionnaire (the CCG questionnaire had additional questions on commissioning specialist hospital services).

Submitted questionnaires were downloaded into a database (SPSS) for analysis. Local authority and CCG returns were not merged but they were analysed separately using the same queries and methods. Results were then compared or merged where appropriate for reporting. Descriptive statistics was used to analyse responses to close-ended questions, while answers to open ended questions were analysed thematically.

2 Findings from the survey

This chapter presents the findings from the survey and it is structured as follows. The [first section](#) presents the main characteristics – regional distribution, type, multiple deprivation, commissioning arrangements – of local authorities and CCGs that responded to the survey. The [second section](#) provides information about the nature of commissioned services, including the types and number of providers, the use of direct payments and brokerage, as well as information provided to service users and family carers. The [third section](#) how services are commissioned: how providers are selected and the types of contract used. The [fourth section](#) is on factors considered and information used in commissioning decisions, including on information on how quality and outcomes are conceptualised. The [fifth and final section](#) looks at the challenges and opportunities, in particular the impact of restructuring and spending cuts, as well as the changing demand for social care.

2.1 Characteristics of responding local authorities and CCGs

Local authorities returned a total of 45 questionnaires – excluding duplicate and blank responses – that represents a **response rate of 29.4 per cent**. Twenty-five responses were returned by CCGs, 15 of these were joint responses: four joint LA-CCG and 11 joint CCG responses (the number of CCGs per joint response ranged from two to seven).³ Responses covered a total of 55 clinical commissioning groups (**a response rate of 26%**). This analysis uses unweighted responses (N=25).

The distribution of responses across regions is shown in Table 1. Among LA returns, the East Midlands, Yorkshire and the Humber and East of England were somewhat underrepresented, meanwhile the majority of CCG responses were from the South East, London, and the North West.

³ Approximately 40% of individuals completing the LA questionnaire and half of those returning the CCG questionnaire had learning disability-specific commissioning roles.

Table 1: Distribution of responses by region

	Local authority		CCG	
	N	Percent	N	Percent
South West	5	11.1	1	4.0
South East	6	13.3	7	28.0
London	9	20.0	3	12.0
East of England	3	6.7	1	4.0
West Midlands	7*	15.6*	3	12.0
East Midlands	1	2.2	2	8.0
Yorkshire and the Humber	3	6.7	1	4.0
North East	5	11.1	1	4.0
North West	6	13.3	6	24.0
Total	45	100.0	25	100.0

*One local authority returned two questionnaires that could not be merged and were treated as separate responses.

The number of adults with learning disabilities and autism local authorities commission services for ranged from 280 to 5,183 in the survey, with a median of 850. It is not possible to provide this information for CCGs. This is because some CCGs recorded total populations with LD/autism and others also included the number of children or people already counted under the local authority commissioners, and we could therefore not be sure of the accuracy of this data.

There was a relatively even distribution of responses by type of local authority as shown in Table 2.

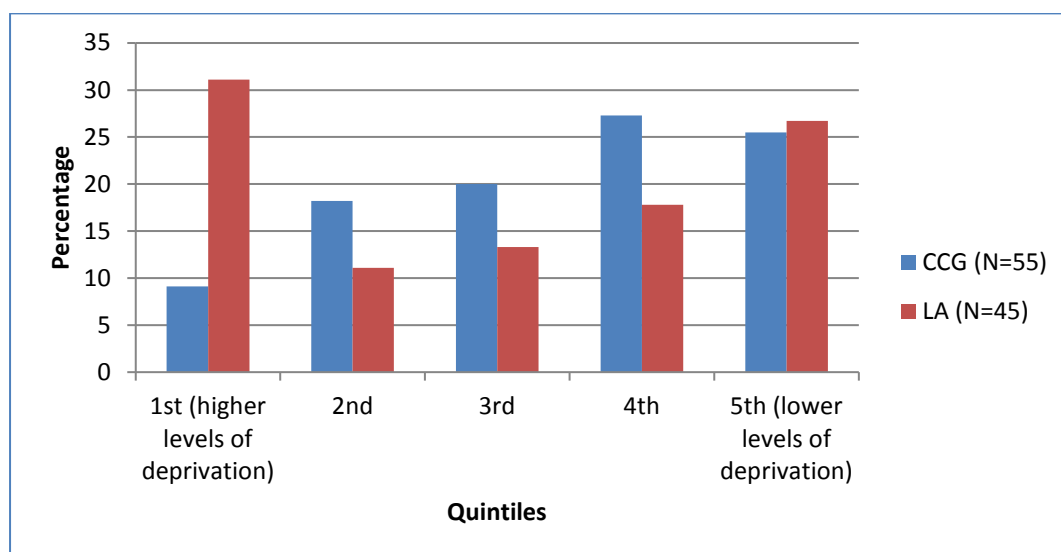
Table 2: Distribution of responses by type of local authority

	N	Percent
county council	12	26.7
unitary authority	14	31.1
metropolitan borough	10	22.2
London borough	9	20.0
Total	45	100.0

The socio-economic composition of responding LAs and CCGs – based on their average score on the Index of Multiple Deprivation⁴ – is summarised in Table 3. Nearly a third of LAs ranked in the top 20% – indicating higher levels of deprivation – and one in four were in the bottom quintile – suggesting less deprivation. Meanwhile – taking into account all CCGs for which we received information (N=55), just one in 10 CCGs were in the top quintile and over half (52.8%) were in the bottom two quintiles.

⁴ Smith, T., Noble, M., Noble, S., Wright, G., McLennan, D., & Plunkett, E. (2015). *The English indices of deprivation 2015*. Department for Communities and Local Government. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464597/English_Indices_of_Deprivation_2015_-_Research_Report.pdf

Figure 1: Distribution of respondents according to their rank on the average Index of Multiple Deprivation* (percentage)



* Data retrieved from File 11 upper-tier local authority summaries and File 13 clinical commissioning group summaries (<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>)

The majority of local authorities and just over a quarter of CCGs had joint commissioning functions across all adult groups (LA: 64.4%; CCG: 28%), while over a third (35.6%) of LAs and nearly half (48%) of CCG respondents reported commissioning functions exclusively for people with ID or autism. One in four (24%) CCGs had joint commissioning functions for people with ID and mental health. One LA were in the process of merging strategic commissioning functions for Adult Social Care and Children's Services.

Local authorities reported a variety of commissioning arrangements such as a single (strategic) commissioning team, a series of local commissioning teams, or a combination of these.

All CCGs who answered this question (n=21) and all but two LAs (out of N=45; 4.4%) had some form of joint commissioning arrangement; most commonly with other CCGs or local authorities (see Table 4). Some local authorities and CCGs had integrated local commissioning arrangements.

Figure 2: Joint commissioning arrangements of local authorities

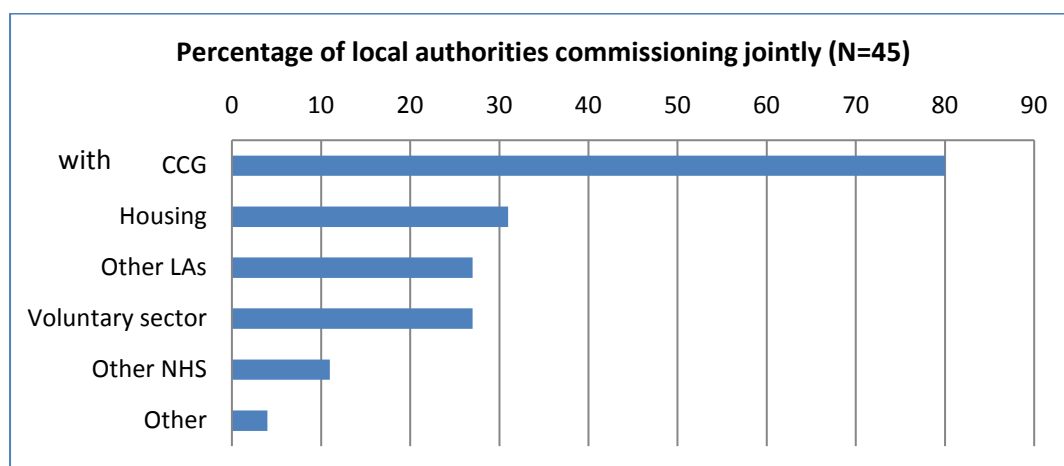
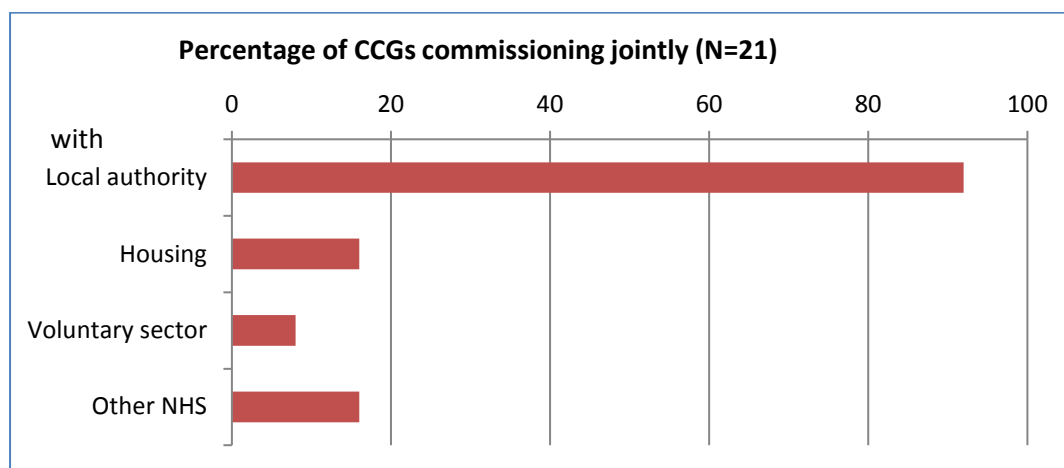


Figure 3: Joint commissioning arrangements of CCGs



2.2 Nature of commissioned services

2.2.1 Types of services commissioned and number of providers used

The number of service providers from which local authorities commission residential care ranged from two to 282. For supported living the same figures were two to 659, and for day care two to 429 (see Table 4). However, the majority of local authorities commissioned services from fewer than 20 providers in each category.

Table 3: Number of providers the LA commissions services from, by type

	Residential care	Supported living	Day services
Mean	55	48	29
Median	26.5	18	10
Minimum	2	2	2
Maximum*	282	659	429
N	34	35	34

* Individually-commissioned packages

Only a minority of CCG respondents indicated that they commission residential care (n=7), supported living (n=8), or day care (n=7) directly; therefore these are not reported here. Meanwhile, all but two CCGs (n=23) commission specialist hospital services: the number of providers ranged from one to 12 (median=3.5; mean=4.5).

Direct (in-house) provision was more common in day services than in residential care or supported living (see Table 5). Over 90% of CCGs commissioned at least some specialist hospital services from the NHS.

Table 4: Percentage of local authorities reporting direct provision of services

	Residential care	Supported living	Day services
Percentage	31.7	25.0	83.3
Total N	41	40	42

2.2.2 Use of out-of-area providers

There were large variations in the level of out-of-area provision; some local authorities and CCGs used no out-of-area providers at all, while elsewhere all providers were from out of area. Overall, the percentage of out-of-area providers was under 20% in residential care, 10% in specialist hospital provision and under 5% in day services and supported living in the majority of localities we had information about. The relatively high number of missing answers should be noted here.

Table 5: Percentage of out-of-area providers by type of service (percentage)

	Residential care (LA)	Supported living (LA)	Day services (LA)	Specialist hospital (CCG)
Mean	35	15	17	27
Median	17.5	3	4.50	10
Min.	0	0	0	0
Max.	100	100	90	100
Total N	32	33	32	13

Respondents were asked to describe the circumstances under which out-of-area placements are used. The thematic analysis of these responses highlighted three main sets of circumstances. Firstly,

out-of-area placements are used, as a 'last resort', when no adequate support or services are available locally and it is not possible to develop them in the required timescale. This is because of a shortage or lack of accessible housing or specialist services (e.g. autism, challenging behaviour, complex needs, forensic, assessment etc.). Secondly, out-of-area placements are also used in a planned way, when individuals want to be closer to family who had moved away or they had moved out-of-area to attend school and no longer wish to return, or it is the expressed choice of individuals or family members. Finally, out-of-area placements are sometimes used when local placements would not be appropriate due to forensic risks or previous victimisation.

Out of area placements are generally used when we have tried to find or develop local support, but this is not possible in the required location or timescale. This is often because of a shortage of accessible housing. We also occasionally use out of county placements in a planned way when an individual wants to move away, e.g. to be near supportive family members. (LA Commissioner)

They are generally historical and we intend to not make placements outside of the borough. The exception to this is where a user/family may wish to live closer to each other. (LA Commissioner)

Most local authorities and all CCGs also reported that they are moving people back into area, most commonly:

- after completing out-of-area educational placement or assessment and treatment;
- when the individual is ready to "step down" to local/community-based services, and needs can be met within the local area;
- if there are any concerns about the quality of out-of-area placement or it is not progressing as expected or the placement breaks down;
- if it is requested by the individual or family;
- cost saving on the basis of best interest decision and if it is appropriate and safe to do so.

Transforming Care was mentioned by various respondents – CCGs and local authorities – as an important policy driving forward the repatriation of people. However, some local authorities also noted programmes to review historic out-of-area placements and return people if possible. These local authorities are actively developing local capacity and services to facilitate this.

2.2.3 Use of direct payments

All LAs (N=41) and around three out of four CCGs (72.7%, N=22) use direct payments or personal budgets (including individual health budgets). The use of managed personal (health) budgets was more common among LAs (90%) than CCGs (61.9%). Some local authorities were taking part in Individual Service Fund pilots and one CCG was piloting *Individual Personalised Commissioning (IPC) – My Life, My Way*.

Respondents were asked to provide a brief description of the circumstances under which each arrangement was used. The analysis of these highlighted that the use of direct payments is "actively encouraged and facilitated" and routinely offered to people who meet the eligibility criteria in many

local authorities and CCGs. Direct payments are often used for “non-traditional services” or where service delivery requires “hybrid staff skills sets”, personal assistance, and providers that are not on the framework agreement or approved list.

We have instilled self-directed support within our care management process since 2006/7 and this is the default process for all people not in crisis. Everyone eligible for services is aware of their indicative resource allocation and offered a Direct Payment. (LA Commissioner)

Managed personal budgets are used for all types of support and for a variety of reasons; most often for people, who cannot manage a personal budget/direct payments (e.g. they lack capacity, they do not wish to manage their own personal budget, they do not have a family member or carer who could do this for them, it would be too complex to manage, particularly the case for larger personal budgets, or it would be deemed too risky financially). In some local authorities managed personal budgets are provided as Individual Service Funds. Managed arrangements are also available via third party organisations or care managers. Some CCGs noted that Personal Health Budget pilots were underway. The majority of local authorities and CCGs (of those that use direct payments/personal budgets) provide some form of support to budget holders (Table 6). The small number of responses should be noted.

Table 6: Types of support offered to direct payments or personal budget holders (percentage)

	LA	CCG
Financial support (e.g. broker)	32.4	68.8
In-house support officer / NHS team	54.1	43.8
List of providers	56.8	37.5
Total N	37	16

Some local authorities also reported providing commissioned personal budget/direct payments services and other forms of support for budget holders such as written information (guidance, fact sheets), workshops, direct payment help-line, card for transactions, website etc.

2.2.4 Use of brokerage

Three quarters (75%) of LAs and half of CCGs (N=40 and N=20 respectively) use brokerage. Some local authorities use it routinely for residential care, supported living, and domiciliary care packages, as well as commissioned day services. Brokerage is also used to support people with direct payments or personal budgets, including those managed by the council. In some local authorities, brokerage is available on demand, for those who require support to source options to meet their needs. Brokerage is often provided in-house, for example within the local authority’s social work team or as a dedicated brokerage team. In some LAs brokerage is offered via a third party, or a combination of both.

We routinely use a brokerage system. Social workers assess and write a care plan or Self-directed Support (SDS) plan with a service user and the Brokerage team are then tasked with finding the services that can fulfil the care plan that will meet their needs. (LA commissioner)

2.2.5 Information provided to service users and carers

Nearly all local authorities and CCGs provided information and support for service users and family carers to identify the most appropriate type of service. Four out of five local authorities and half of CCGs provided help to identify the most appropriate service provider to meet their needs. Support included advice from care managers, written information and signposting to information sources (e.g. care directory, CQC), commissioned information and advice services, and brokerage. In some CCGs this is managed via the local authority. Some local authority respondents highlighted the provision of Easy Read literature and advocacy support, as well as peer support groups.

2.3 How services are commissioned

2.3.1 How providers are selected

The majority of local authorities and CCGs reported that providers were selected either on the basis of quality or via an open tendering method. Day services and specialist hospitals were more likely than residential care or supported living to be selected from an approved list based on business checks (See Table 7). The list of approved providers was publicly available in 77 per cent of LAs where there was an approved list (N=31).

Table 7: How providers are selected (percentage)

	Local authority			CCG
	Residential care	Supported living	Day services	Specialist hospital
Approved list based on quality	57.9	50.0	44.4	45.5
Approved list based on business checks	15.8	15.0	25.0	22.7
Open tendering	26.3	35.0	30.6	13.6
Other	-	-	-	18.2
N	38	40	36	22

2.3.2. Types of contract used

The dominant contract types for each type of service are summarised in Table 8. For residential care the dominant contract type was spot contracts – a contract set up to purchase a particular service for an individual either at a negotiated price or a list price. Supported living was most often purchased using framework agreements. The use of mixed arrangements was also highlighted, for

example spot contracts that incorporate a cost and volume element – that allow commissioners to purchase additional services at a set price – with strategic suppliers or the use of different types of contracts with different providers.

For day services, spot and block contracts were similarly common, however nearly one in five respondents indicated “other” types of contract, particularly direct payments/personal budgets and also the use of in-house/direct provision (often via block arrangements). Block contracts are set up to purchase an agreed volume of services for a fixed price for a period of time. The transition from block to spot or framework contracts was also mentioned by a number of respondents as currently happening in relation to residential care and day activities.

For specialist hospital provision spot contracts were the most common arrangement; however block contracts were still relatively widespread, too. Some CCG respondents noted that they were moving from block to spot contracting or a framework for specialist hospital provision. Others noted that assessment and treatment units were commissioned on a spot basis “according to the needs of the patient and the specialist skills of the service”. Two respondents highlighted that a block contract was used for forensic beds while assessment and treatment unit beds were commissioned on a spot basis.

Table 8: Dominant contract by type of service (percentage)

	Local authority			CCG
	Residential care	Supported living	Day services	Specialist hospital
Spot	70.5	34.1	29.5	40.0
Cost & volume	-	6.8	4.5	4.0
Block	6.8	9.1	25.0	28.0
Framework agreement	18.2	43.2	18.2	8.0
Other	4.5	6.8	18.2	12.0
Not commissioned	-	-	4.5	8.0
Total N	44	44	44	25

The majority of respondents –LAs and CCGs – indicated that contracts had quality specifications on both process and outcomes (see Table 9).

Table 9: Quality specifications for services in contract (percentage)

	Local authority			CCG
	Residential care	Supported living	Day services	Specialist hospital
General statement	10.0	7.5	15.4	14.3
Process	5.0	2.5	5.1	4.8
Outcome	10.0	7.5	12.8	9.5
Process & outcome	72.5	82.5	64.1	61.9

None	2.5	-	2.6	4.8
N	40	40	39	21

2.4 Factors considered and information used to support commissioning decisions

2.4.1 Factors considered in commissioning decisions

The top three factors considered by local authority and CCG commissioners to support commissioning decisions were quality, safety, and suitability (i.e. whether the service meets the individual’s needs). The least important factors were size, existing contracts, and pressure/demand from the public. Cost was an important consideration; around two thirds of commissioners said it was “very important”. Fewer local authority than CCG commissioners thought that size and location were “very important” factors (Table 10).

Table 10: Percentage of commissioners reporting each factor as either ‘very important’, ‘somewhat important’, or ‘not important’ in supporting commissioning decisions – Local authority (n=44) or CCG (n=24). Ranked importance is the rank of the percentage reporting very important

	Very important		Somewhat important		Not important		Ranked importance	
	LA	CCG	LA	CCG	LA	CCG	LA	CCG
Quality	95.5	95.7	4.5	4.3	-	-	1	2
Safety	93.2	91.7	6.8	8.3	-	-	2	3
Suitability	93.2	95.8	6.8	4.2	-	-	2	1
Availability	63.6	75.0	36.4	20.8	-	4.2	4	4
Cost	61.4	66.7	38.6	33.3	-	-	5	5
Location	38.6	62.5	61.4	33.3	-	4.2	6	6
Size	27.9	50.0	55.8	45.8	16.3	4.2	7	7
Existing contracts / tenders	23.3	37.5	58.1	50.0	18.6	12.5	8	8
Pressure / demand from public	9.1	37.5	72.7	37.5	18.2	20.8	9	8

Various respondents mentioned other factors that played an important role in their commissioning decisions, such as:

- Access (to accommodation, activities etc.);
- Carers;
- Diversity and sustainability of the service;
- Resources;
- Capital availability;
- Working relationships with providers;
- Co-production with service users;
- Whether a service can anticipate and respond to emerging needs.

When asked about the ideal factors the same three factors – quality, suitability and safety – topped the list among both LA and CCG commissioners (Table 11). No commissioners put either size or pressure/demand from public in the top three. Some commented that cost/budget should not be an

issue under ideal circumstances, while others suggested that ideally the long term outcomes and working practices should be among the most important factors considered in commissioning decisions.

Table 11: Top three factors that should be considered in commissioning decisions

	Percentage putting it in top three	
	LA	CCG
Quality	93.3	80.0
Suitability	82.2	76.0
Safety	57.8	60.0
N	44	24

2.4.2 What information is used to inform commissioning decisions

The most important information sources to support commissioning decisions were broadly similar among LAs and CCGs (Table 12); however there were some notable differences (highlighted in the table): consultation and feedback from users and carers as well as frontline staff (e.g. care managers) were seen as more important by LA commissioners than their CCG counterparts. At the same time, CCG commissioners were more likely to rate CQC reports and safeguarding information as very important compared to those working for local authorities. In general, strategies and data/research were seen as less important for decision-making. The limited use of research evidence is especially noteworthy.

Table 12: Percentage of commissioners reporting each source of information as either very important or not important/not used to inform commissioning decisions by type of commissioning body

	Very important		Not important/not used		Total N	
	LA	CCG	LA	CCG	LA	CCG
Consultation and feedback from users and carers	84.1	43.5	-	21.7	44	23
Joint Strategic Needs Assessment	68.2	62.5	2.3	-	44	24
Safeguarding information	63.6	91.7	2.3	-	44	24
Feedback from frontline staff	61.4	54.2	2.3	16.6	44	24
Joint Health and Social Care Self-Assessment Framework	56.8	70.8	13.7	4.2	44	24
Care Quality Commission reports	50.0	79.2	2.3		44	24
Socio-demographic data	48.8	43.5	2.4	17.3	41	23
Market position statement	47.6	58.3	7.2	8.3	42	24
Academic research/reports	4.5	13.0	38.6	26.1	43	23
Making It Real statement	37.2	31.8	16.3	31.8	43	22
CCG Commissioning plan	34.9	87.5	9.3	-	43	24
Adult Social Care Outcomes Framework	32.6	47.8	11.7	17.3	43	23

Health and Wellbeing Board strategy	27.9	62.5	11.6	8.3	43	24
Driving up Quality Framework	27.3	75.0	29.5	4.2	44	24

Some local authorities and CCGs mentioned further sources of information, such as the *Transforming Care* agenda – which was especially influential and highlighted by many – co-produced strategies with local partnership boards (learning disability and autism), *Working Together for Change* (CBF), the *Public Value Review* process, and *Autism Self-Assessment*.

2.4.3 How the quality of commissioned services is checked

Table 13 shows the sources of information used to check the quality of commissioned services. Safeguarding information and information from service visits were the most important information sources, while business checks and ASCOF returns were seen as less important. CCGs were more likely to consider CQC reports “very important” than local authorities. Additional responses highlighted the use of feedback from carers and users, quality checks by self-advocates, as well as information from other commissioners and relationship meetings with providers.

Table 13: Percentage of commissioners reporting each type of information as either ‘very important’ or not important/not used to check quality by type of commissioning body - Local authority (n=44) or CCG (n=24). Ranked importance is the rank of the percentage reporting very important.

Information used to check quality	Very important		Not important or not used		Ranked importance	
	LA	CCG	LA	CCG	LA	CCG
Feedback from service visits	88	88	0	0	1	2
Safeguarding information	86	96	0	0	2	1
Service user outcomes information	77	71	2	4	3	4
Internal quality assessment	48	46	7	4	4	5
CQC reports	61	75	2.3	0	5	3
ASCOF	26	17	19	22	6	7
Business checks	26	38	2.3	14	6	6

Thirty-three local authority and 22 CCG respondents provided information on how quality is assessed. These were analysed thematically focusing on four main aspects: a) what aspects of quality are assessed; b) who is responsible for quality assessment; c) what are the mechanisms/methods used; and d) how often/when quality is assessed. The main findings are summarised below.

a) What aspects of quality are assessed?

Only a few respondents commented on how quality was operationalised. ASCOF and CQC were mentioned as informing local quality assessments as well as quality of life standards. The following aspects of quality were highlighted: safeguarding, medication, activity, resident finances, management and leadership, staff competence, complaints, care planning and person-centred planning, safeguarding, service user experience, and quality of the environment.

b) Who is responsible for quality assessments?

Most local authorities have in-house teams responsible for quality assurance. These are typically the contract monitoring or compliance team or a dedicated quality assurance team. One LA respondents noted “a deliberate organisational structure to bind both commissioning and reviewers to working alongside one another”. In some local authorities quality assurance teams are also tasked to work with failing providers. Respondents noted that inter-agency cooperation and information sharing are very common. Internal teams liaise with a range of external professionals and organisations, such as Healthwatch, CQC, advocacy organisations, CCGs, partnership boards etc. A number of CCGs reported devolved responsibilities for contract and quality monitoring functions to NHS bodies (e.g. the local foundation trust etc.) or local authorities.

c) What mechanisms and methods are used?

Most local authorities and CCGs use quality assessment frameworks (e.g. *Supporting People QAF*, *Making it Real Outcomes framework*, *Self-Assessment Framework* etc.) and monitoring checklists, and some use or are introducing dashboards. Information is gathered from a range of sources and in a variety a ways:

- Service visits – either announced or unannounced, carried out by monitoring officers, external professionals, peer reviewers, or experts by experience.
- Self-assessments submitted by providers, audits of paperwork, and contract review meetings;
- Information from other sources including complaints and feedback from carers and users as well as care managers, intelligence from Healthwatch, Safeguarding teams, placement reviews or care and treatment reviews, financial information, CQC reports etc.

d) How often is quality assessed?

There is variation in the frequency of quality assessments and checks on providers. In some local authorities said this happens quarterly, elsewhere six-monthly or yearly. Some respondents assess only a sample of providers selected randomly or those identified as “higher risk”.

2.4.4 How commissioners conceptualise and measure service user outcomes

Although service user outcomes are seen as important information in commissioning decisions, the limitations and challenges in relation to measurement, monitoring and comparability are also recognised by many.

“Service user outcome information clearly reflects the point of what we are trying to do. [...] it is difficult to get reliable, objective, information that is comparable across services. Different services are delivering very different kinds of support, and different providers have different levels of resource to monitor and report outcomes. Large national providers can often produce much more impressive reports, but these do not always reflect better outcomes.” (LA commissioner)

Thirty-four local authorities and 21 CCGs provided information on service user outcome data. These were analysed thematically concentrating on two issues: a) how service user outcome is conceptualised; b) how it is measured.

a) How are outcomes conceptualised?

There were two main conceptualisations of service user outcomes: the most commonly discussed user outcome was satisfaction; a smaller number of responses identified outcomes as progress on goals set out in individual plans (e.g. support plan, person-centred plan, care and treatment plan etc.) or quality of life domains (e.g. health etc.).

b) How outcomes are measured?

Most respondents reported the use of direct feedback from users and carers via surveys – satisfaction surveys, structured feedback, ASCOF – the use of PROMs and PREMs, and consultations to collect information on outcomes. Another common method of measuring outcomes is the audit and review of support/care plans. Some commissioners noted that outcomes are part of service specifications or contracts.

“Ensure meeting client needs and having a good quality of life and achieving their goals.”

“Quality of life questionnaires are used at point of assessment which feed into support plans. Providers are checked to ensure the support plan is being delivered against the outcomes”

“Outcome data ranges from personal stories, concerns, compliments and complaints, case studies and quantitative data from providers.”

2.4.5 The involvement of service users and carers in monitoring services

Over a third of local authorities (35.6%) and 30.4% of CCGs involve service users and carers in monitoring the quality of services in general (i.e. as Experts by Experience, partnership boards, self-advocacy services etc.), while around sixty per cent of local authorities (62.5%, N=45) and CCGs

(60.9%, N=21) get feedback from them on the quality of services they use. One in five LAs and over a third of CCGs (34.8%) are planning to introduce this in the future.

“Service user and family/carer feedback is requested in terms of how well a provider is meeting a person's individual needs and that services wrap around the person rather than the individual having to fit into services. This tends to be on an individual basis however we are looking to have 'quality checkers' who will peer review services. Peer reviewers are used for the local inpatient services and the reviewers (people with a learning disability) are supported to feedback to the local Clinical Quality Review Meetings and patient councils are attended by commissioners to gather further feedback.” (CCG Commissioner)

Where service users and carers are involved in monitoring the quality of services, this is most often by providing feedback (see Table 14), while their involvement in monitoring visits is still relatively uncommon. The low number of cases should be noted here.

Table 14: How service users and carers are involved in monitoring the quality of services (percentage)*

	LA	CCG
Deciding what outcomes to monitor	44.4	38.5
Carrying out monitoring visits	26.7	61.5
Providing information and feedback	71.1	92.3
Total N	28	13

** percentages do not add up to 100 as some respondents reported more than one type of involvement.*

One local authority noted that they had worked with service users, including care home residents to develop a local quality charter for domiciliary care, nursing and residential care.

2.5 Challenges and opportunities

2.5.1 Restructuring of commissioning

The survey asked about future plans for commissioning. Over half of LA respondents (N=40) and one in four CCGs indicated that a re-structuring was taking place in 2015/16 or was planned for 2016/17. Four local authorities commented that re-structuring had already happened in 2014/15, and two respondents – one local authority and one CCG – indicated that re-structuring was a long-term plan with no clear timeline yet. Two respondents noted that commissioning was subject to frequent reviews and on-going re-structuring.

Table 15: Plans to re-structure commissioning (percentage)

	LA	CCG
Yes, happening in 2015/16	32.5	8.0
Yes, planned for 2016/17	20.5	16.0
No	10.5	24.0
I don't know	15.0	32.0
Other	22.5	20.0
Total N	40	25

The majority of LAs (70%) indicated that this was not the first time they were undergoing re-structuring: most of them had been restructured once in the previous five years and some had been restructured three or more times.

Responses describing plans and reasons for present or past re-structuring were analysed thematically and four main drivers of reorganisation were identified (these are not mutually exclusive):

- Improving partnership working with CCGs and/or local authorities as well as other bodies (e.g. Public Health, local NHS trusts etc.). This can involve the geographical realignment or co-location of existing teams or full integration of commissioning functions with pooled budgets.
- Integration of commissioning functions within the organisation, centralisation and the creation of all-age commissioning functions/commissioning hub to enhance efficiency.
- As part of a wider restructuring to make cost savings, streamline, improve efficiency and/or quality of commissioning.
- To ensure the implementation of the Care Act or other local strategies.

2.5.2 Spending cuts, their impact and opportunities for better services

Nearly 85% of LAs (out of N=38) and 20% of those responding to the CCG questionnaire (N=25) indicated that they were required to make savings on social care spending. The extent of these varied widely from around 3% to 30%. Twelve local authorities (but no CCG) reported a reduction of 10% or more. One local authority noted that after taking account of pressures (including inflation, demographics, and legislative changes) their social care budget will have reduced by over 40% by 2017/18. In a number of cases the extent of reduction was not yet known.

Nearly all of those affected by spending cuts (93.5% out of N=31) said that it was likely to have an impact on intellectual disability services. Respondents highlighted potential ways of dealing with cuts:

- The use of innovative and creative commissioning practices, as well as new ways of working together, such as pooling budgets, using shared premises etc.;
- Contracting with fewer providers;
- Focusing on enablement and the use of assistive technology;
- Greater emphasis on supported living arrangements and promoting independence as opposed to residential care;
- Reviewing care packages and reducing services, particularly day and social inclusion services;
- Promoting innovation in high-cost care packages;

- Shifting resources to focus on prevention, early intervention and the provision of more personalised services in order to reduce the demand for crisis and intensive support services.

Some of these were seen as opportunities to improve the effectiveness and quality of services and focus on independence; however negative implications were also highlighted such as reduced choice, reduced day occupation, more social isolation, or more generally the long-term sustainability of social care services. Some respondents questioned whether the environment characterised by funding cuts can provide the right context and incentives for service innovation and reforms (i.e. shifting the emphasis from crisis intervention to prevention and early intervention).

The hope is that increased preventative services and better, more personalised support will reduce the need for intensive support and crisis responses, which have led to some of the most expensive support packages. We have had some success in making this kind of shift. There still appears to be plenty of institutional care out there which could be changed, possibly leading to savings. However, the amount of scope left for savings in the system is very difficult to quantify. Steep funding cuts do not seem the most useful way to incentivise this kind of change. (LA Commissioner)

I am concerned that financial constraints may lead to an increase in residential care placements, as they are seen to be a more cost effective service, however do not afford the same rights, choice and control to people and not always the least restrictive option. (LA Commissioner)

2.5.3 Changing demand for social care

The vast majority of respondents (35 out of 38 LA and 22 out of 25 CCG respondents) expect the demand for social care to go up, primarily due to changes in the composition of the population of people with intellectual and developmental disabilities. In particular three main trends were highlighted by the majority of respondents:

- The population of people with intellectual disabilities is getting older: people live longer and as a result additional needs associated with aging are also on the increase;
- More younger people with complex (health) needs are making the transition to adult services; and related to this,
- The number of young people with Autism and complex behaviours is increasing.

A few respondents quantified the expected increase, which typically ranged from 1.5 to 5.0% over the next one to three years; however one CCG predicted an increase of 18% in demand over the next five years.

Demand for health and social care services increased year upon year. It will continue to rise - this is not in doubt. When set against a backdrop of shrinking resource the demands placed upon local government appear less and less deliverable in my opinion. (LA Commissioner)

2.5.4 Availability and accuracy of data

Overall, respondents thought that the availability and accuracy of data to predict changes in demand is improving, with intelligence coming from national prevalence estimates, data from children's services and schools and widely used in local documents (i.e. JSNA). Although, as pointed out by one respondent, there are some gaps.

There is a lack of demographic data with regards to people with LD and people with Autism. Most data sources are either performance data or forecast data but little data exists with regards to clients and housing, employment or other areas that can be used to develop not just services by pathways to outcomes. (LA Commissioner)

2.5.5 Challenges to commissioning high quality services and how they can be overcome

When asked about the challenges to commissioning high quality services, responses concentrated on the following key areas:

- Developing skilled services able to support people with complex needs and behaviours that challenge.
- Recruiting, developing and retaining a workforce with the right values and skills.
- Developing creative support and resilient communities in times of increased pressures on resources.
- Finding/developing affordable and appropriate housing and accommodation in the "right" locations.
- Partnership and joint working (i.e. integrated health and social care commissioning, improved access to mainstream services, including health checks etc.).
- Financial pressures, particularly the decrease in local authority funding/budgets and the rise of the national minimum wage; ensuring provider sustainability.
- Changing demand for social care services – as described above.
- The characteristics of the local providers' market; this can be on the one hand the shortage of providers locally and excess capacity and unplanned developments locally that attract out-of-area placements and make it more difficult to influence the market, on the other.
- The implementation of national policies, particularly *Transforming Care*, with reduced resources.
- The need for culture shift in services and commissioning, and the resistance to and fear of change.

High quality is generally, but not always, associated with high cost. When resources first began to shrink, we tried to get more for less – now we have to acknowledge that you actually get less for less. As we become less and less able to pay reasonable rates to providers for their services, they find staff retention, training and professionalism more challenging – quality suffers. We have been forced to squeeze the market continually for a number of years now – this has resulted in services being far more stretched, having less time/less staff to deal with people and much of the intangible, softer quality measures have become less important. (LA Commissioner)

In the face of Transforming Care and an imperative to provide care for people (who have historically been admitted to hospital) in the community, it is imperative that we are able to appropriately resource such services to enable good staff retention, high levels of skill and resilience and a realistic career pathway. This work is not easy, good staff members who care about the people they support - even when their day at work has been intensely difficult - can be driven away by poor wages and poor support. We cannot strip all the resource out of the system and at the same time build services capable of safely and sensitively managing people with very complex needs better than we ever have been able to - this is common sense. (LA Commissioner)

Local authority and CCG respondents identified a number of areas that could help to overcome these challenges. These were thematically analysed and grouped into the following main categories:

- Prime funding to support market and capital development, revenue funding for voluntary sector providers.
- Increased funding (less cuts) for social care to meet changing demand.
- Evidence-based commissioning and a good understanding by commissioners of how services deliver the right outcomes for individuals; robust quality management procedures.
- Innovation, greater flexibility in procurement and contracting.
- More partnership working, integrated/joint commissioning and services across health, social care (adults and children), housing, and the criminal justice system, as well as across local authorities/CCGs, with pooled budgets.
- Focused dialogue and positive, collaborative relationships between stakeholders, particularly with service users, carers, providers, and specialists.
- Greater focus on workforce development/issues nationally.
- Better market regulation to prevent providers from developing capacities in areas with no identified need.
- Community acceptance and awareness of people with intellectual disabilities, better access to mainstream facilities and services.

Better government financial settlement, a slower pace of austerity measures being applied, realisation by the government of the pressures adult social care face (LA Commissioner)

Integrated strategies, plans, approaches and budgets across health and social care (LA Commissioner)

Increase in workforce willing to work within the care/support sector and for training to commence for people when they are in education and NOT when they first enter the workforce. The interface needs to be developed between education and the market sector to see caring as a profession with as much value as working for the NHS. (CCG Commissioner)

This is such a niche area, my view is that we have to look outside of our own areas and get better at working in partnership across wider areas. We are all faced with the same challenges and could achieve economies of scale by working better together. (LA Commissioner)

3 Discussion

3.1 Summary of key findings

Nature of commissioned services

Three categories of services were explored: residential care, supported living, and day services. The majority of local authorities commission services from fewer than 20 services in each category. All but two CCGs were commissioning specialist hospital services. Direct (local authority) provision was more common in day services than residential care or supported living.

Out-of-area placements

There is large variation in the level of out-of-area provision, from none to all providers being out-of-area. It was most common in residential care, but with an average of under 20 per cent. Reasons for out-of-area placements included:

- “Last resort” – no immediately available support or services of adequate quality available locally;
- By choice, when individuals want to be close to their family or stay in the area where they attended school;
- When local placements would not be appropriate due to forensic risks or previous victimisation.

Most local authorities and all CCGs reported moving people back into area.

Use of direct payments

All LAs and around three quarters of CCGs were using direct payments or personal budgets, including personal health budgets. Managed personal budgets are most often used when people cannot or do not want to manage their own personal budget, do not have a family member or carer to help them with this, or when the care package is complex and difficult to manage. The majority of commissioners reported that support was provided to budget holders to help them manage their budget. Brokerage was used by three quarters of local authorities and half of CCGs; brokerage is often provided in-house but in some local authorities it is offered via a third party. Almost all local authorities provided information and support for service users and family carers to identify the most appropriate type of service.

How services are commissioned

Providers were most commonly selected on the basis of quality, with open tendering being the next most common basis for residential care, supported living, and day services, while approved lists based on business checks was the second most common method for specialist hospitals.

A variety of contract types were used for all service types across local authorities and CCGs. Spot contract was the dominant type of residential care and framework agreements were most common

for supported living arrangements. Day services and specialist hospitals were typically commissioned using block contracts.

The majority of respondents in both LAs and CCGs indicated that contracts had quality specifications on both process and outcome.

Decision making by commissioners

The top three factors considered by LA and CCG commissioners to support their decisions were quality, safety, and suitability to the needs of the individual. The least important factors were size, existing contracts, and pressure / demand from the public. Two thirds of respondents said that cost was a very important consideration in their decisions.

Information used to inform decisions

The information used to support commissioning decisions was broadly similar between local authorities and CCGs. However, consultation and feedback from users, carers, and frontline staff were seen as more important by LA commissioners; while CQC reports and safeguarding information were more important to CCGs commissioners.

Although commissioners reported using a range of strategy documents and other resources, research is seen as less important.

The *Transforming Care* agenda was highlighted as particularly influential by some respondents.

How quality is checked

Safeguarding information and information from service visits were the most important sources used by commissioners, followed by service user outcome information. CCGs were more likely to consider CQC reports “very important” than local authority commissioners.

Very few commissioners commented on how quality was operationalised. For those that did there was a range of aspects mentioned, highlighting difficulties in defining and capturing the relevant information.

Most local authorities have in-house teams for quality assurance; these are typically contract monitoring or compliance teams, or a dedicated quality assurance team. A number of CCGs reported devolved responsibilities for contract and quality monitoring functions to NHS bodies or local authorities.

Most respondents reported using quality assessment frameworks and monitoring checklists of some type. Information to complete these was drawn from a range of sources and collected in a variety of ways across LAs and CCGs, including service visits, self-assessments by providers, as well as complaints and feedback procedures.

There was no consistent pattern across commissioning bodies as to the frequency of quality assessment, ranging from quarterly to yearly, or focusing on those identified as higher risk services.

How do commissioners conceptualise and measure service user outcomes

Many commissioners recognise the limitations and challenges of measuring, monitoring, and comparing service user outcomes. Service user outcomes were conceptualised in two key ways: user satisfaction and progress on goals in individual plans or improvements in the quality of life domains, such as health. Outcomes were primarily measured through direct feedback from users and carers via surveys and consultations. Audit or review of support and care plans was also mentioned as a method of measuring outcomes.

Involvement of service users and carers in monitoring

Approximately one third of commissioning bodies currently involve service users and carers in monitoring the quality of services, and others were planning to introduce this in the future. Although involvement is often limited to providing feedback, and monitoring visits are relatively uncommon.

Challenges and opportunities

Restructuring: Over half of local authority respondents and a quarter of CCGs indicated that a restructuring of commissioning was currently happening or planned for 2016-17. Frequent restructuring was identified by some respondents as a challenge. Four main drivers of reorganisation were: improving partnership working, enhancing efficiency of commissioning functions, as part of a wider restructuring to make cost savings and improve quality, to ensure the implementation of the Care Act or other local strategies.

Spending cuts: The majority of local authorities and 20 per cent of CCGs indicated that they were required to make savings on social care spending, varying from three to 30 per cent savings. Cuts were seen as both an opportunity and as a threat impacting the individual experiences of people with learning disability and the long-term sustainability of the social care system.

However, commissioners were able to identify potential ways of dealing with the cuts, for example the use of more innovative and creative commissioning practices, shifting resources to focus on prevention, early intervention, and the provision of more personalised services to reduce the demand for crisis and intensive support services.

Increasing demand for social care: The majority of commissioners expected the demand for social care to rise due to the population of people with learning disabilities getting older and living longer, and an increasing number of younger people, in particular those with autism and complex behaviours are making the transition to adult services.

Commissioners felt that availability and accuracy of data to predict changes in demand is improving, although there are still gaps in the information available.

Developing skilled services: Perceived challenges to commissioning high quality services included developing skilled services able to support people with complex needs, including:

- developing and maintaining local skilled services,
- developing creative support and resilient communities,
- finding affordable and appropriate housing and accommodation,
- partnership and joint working,

- implementation of national policies, in particular *Transforming Care*, with reduced resources, and finally
- bringing about a culture shift in services and commissioning.

However, commissioners were able to come up with solutions to these challenges, such as more collaboration and partnership working, integrated/joint commissioning with pooled budgets, prime funding to support market and capital development, greater flexibility and innovation in procurement and contracting, evidence-based commissioning and a good understanding by commissioners of how services deliver the right outcomes for people.

3.2 Limitations of the study

There are various limitations to consider. Firstly, the relatively low response rate and the fact that responses are not based on a full sample of geographical areas or commissioners. It is not possible to ascertain whether responses are representative as no research has ever explored these issues before, although there is no evidence either that they are not. Moreover, responses represent a diverse group of local authorities and clinical commissioning groups from across the country.

Secondly, there is a possibility of social desirability effect for some questions, particularly those asking about commissioning decisions: respondents might have selected answers based on what might be considered acceptable and desirable based on government policy. However, the risk is minimal because respondents could remain anonymous and in the free text questions people gave considered responses with both challenges and solutions.

Thirdly, the use of online questionnaire format might also be associated with some bias in responding. Alongside some advantages (e.g. fewer omissions and longer responses for open-ended questions), the design of web surveys – question format and visual elements – may affect how participants interpret and answer questions.⁵ It is not known whether mode effects have had an impact on responses.

3.3 Implications for future research

It was clear from the responses that research reports or papers were not a source of information for commissioners in making decisions, although of course for some commissioners may have had an impact on how they think about what they do at a general level. Future research could usefully work collaboratively with commissioners to identify research that would help them in their job and identify what questions they need answered.

Part 2 of this study will explore the views and experiences of a sample of commissioners through a series of in-depth interviews but it would also be useful to explore with commissioners what type of data on service quality would be most useful to them.

⁵ Dillman, D.A. and Smyth, J.D., 2007. Design effects in the transition to web-based surveys. *American Journal of Preventive Medicine*, 32(5), pp.S90-S96.

3.4 Implications for policy and practice.

Following on from the previous point, commissioners said they used a wide variety of sources of information and frameworks to help them in their decisions about services and to monitor quality over time. Some of these were more important than others and there were some differences between LA and CCG commissioners at time. But there was also lots of overlap between different sources used. So for example, as noted above, almost 80% of CCG and 50% of LA commissioners rated CQC reports as very important in informing commissioning decisions and 75% of CCG and 61% of LA commissioners rated CQC reports as very important for checking the quality of services. However, most local authorities and CCGs said that they used some form of framework for quality assessment or a monitoring checklist and these were completed through service visits by a range of people (monitoring officers, external professions, peer reviewers/experts by experience), self-assessment submitted by providers and paperwork audits, information from other sources such as complaints, feedback from carers and users, information gained from other sources such as Healthwatch, safeguarding, financial information, and CQC.

The elements of how commissioners check quality are almost exactly the same as to how CQC checks quality but using a variety of different frameworks, some of which overlap but also with many differences. This is likely to result in a lack of consistency in how quality is measured and judged. It also means that, especially in times of austerity, there remain inefficiencies in the systems through doubling up of activities. If there was a consensus on what good services for people with intellectual disabilities and autism should look like and if CQC measured quality in a way that commissioners agreed on as meeting their needs then that would potentially make decisions about services much easier – with one primary source of reliable information.

The acknowledgement of these issues and the need for CQC processes and reports to be more useful for commissioners has been raised as part of the *Transforming Care* agenda and has led to the development of a guide and checklist for inspectors on “What does good look like”⁶. This guide is based on both research evidence and good practice. A version of this checklist focusing specifically on positive behaviour support has also been made available on the PBS academy website⁷. These tools provide an opportunity to explore whether it is possible to achieve some of the consensus and streamlining outlined above. If these were also endorsed by the Department of Health this may also provide the positive motivational context for the development of high quality services that will not only ensure the success of *Transforming Care* for those who display behaviour that is viewed as challenging, but to improve outcomes for people with disabilities in general.

⁶ See <https://www.unitedresponse.org.uk/what-does-good-look-like>

⁷ <http://pbsacademy.org.uk/wp-content/uploads/2016/11/Observational-resource-final-1-11-16.pdf>