PSSRU

Personal Social Services Research Unit

National Survey of Local Authority Arrangements for Commissioning Services for Older People

Summary Report

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Introduction

The National Survey of Local Authority Arrangements for Commissioning Services for Older People aimed to collect information from all English councils with social services responsibilities (CASSRs) about their local commissioning arrangements for services for older people with a particular focus on the implications of the on-going personalisation agenda. The study follows a similar survey implemented by PSSRU in 2001 and also funded by the Department of Health[1] . Since then, significant changes have taken place in the way local authorities commission services in terms of the types of contracts used and, in particular, in response to the increased personalisation of social care and the increased control by users over key commissioning responsibilities. The evidence collected from the survey provides a national benchmark from which to assess changes in commissioning processes in England over the last 10 years and differences in arrangements between local authorities. This report presents a descriptive summary of the contents of the survey.

Overview

In this study, we investigate the main aspects of commissioning social care from the perspective of local authorities. We explore both demand and supply factors in order to understand how the commissioning process has changed and where it stands at the moment. The transition to the current system started two decades ago when the central government endorsed policies that allowed the independent sector to supply social care services commissioned by local authorities and thereby creating the foundation of a social care market.

The idea was that competition among providers would increase choice and quality of service by allowing new incumbents to operate in the market and take advantage of their experience. For instance, it was crystal clear that some services, such as meals on wheels, would have been provided more effectively by a specialised agent rather than a local authority.

Initially, many local authorities were perplexed about opening the market to voluntary and private providers. In particular, some of them felt that the private sector did not share the same ideals and scope of local authorities, as this introduced a market incentive driven by profit. The involvement of the voluntary sector, in this respect, was considered more acceptable.

Several changes have occurred since those preliminary steps. Currently, independent providers provide the majority of services for several care-types. Moreover, choice has been increased further by providing users with individualised funds (Personal Budgets) and cash allowances (Direct Payments) that enable individuals to make their own choices in a wide market of services.

In terms of the services directly commissioned by councils, decisions and responsibilities have shifted from centralised managerial levels to operating levels, such as care managers.

[1] A brief report illustrating the summary results from this survey is available at http://www.pssru.ac.uk/pdf/rs024.pdf.

This study aims to explore the evolution of these processes by directly seeking the opinion of local authorities' purchasing team managers and commissioning managers involved in the implementation of the current policy changes.

The study obtained ethical clearance from SCREC and received ADASS support.

Participation rates

The questionnaire was sent to all authorities that had agreed to take part in the study in November 2011. At the time of the final analysis, 78 local authorities provided their responses to the questionnaire, which is equivalent to a participation rate of about 52%[2]. Some authorities were given an extension to the deadline for completing the survey, which was initially set in January 2012.

This section of the report describes the characteristics of the local authorities that agreed to participate in the study, focusing on local authority type, geographical location, deprivation level, population size, and per capita social care expenditure.

Table 1: Response rate by local authority type

Authority type	Invited to participate	Participated (N)	Participated (%)
Shire County	29	17	59%
Metropolitan District	36	21	58%
Inner London	13	7	54%
Outer London	19	10	53%
Unitary Authority	52	23	44%
Total	149	78	52%

Table 1 suggests relatively homogeneous participation rates across authority types. Shire counties and unitary authorities appear somewhat over and underrepresented relative to other authority types with 59% and 44% participation rates respectively.

[2] Due to their uncharacteristic nature, we did not include City of London, Guernsey, Isle of Man, Isles of Scilly and Isle of Wight in the study.

Table 2: Response rate by geographical area

Region	Invited to participate	Participated (N)	Participated (%)
North East	12	8	67%
South West	15	10	67%
East	11	6	55%
Yorkshire and the Humber	15	8	53%
London	32	17	53%
North West	23	12	52%
South East	18	8	44%
West Midlands	14	6	43%
East Midlands	9	3	33%
Total	149	78	52%

Table 2 suggests some differences in participation rates across local authorities from different geographical locations. Local authorities from the northeast and the south west show particularly high participation rates (67%); authorities from the East Midlands (33%) and West Midlands (43%) show low participation rates in comparison.

Table 3: Response rate by deprivation quintile

Deprivation quintile	Invited to participate	Participated (N)	Participated (%)
1 (least deprived)	30	17	57%
2	30	20	67%
3	30	14	47%
4	30	15	50%
5 (most deprived)	29	12	41%
Total	149	78	52%

Table 3 shows participation rates by deprivation quintiles using average rankings from the 2010 Index of Multiple Deprivation developed by the Department for Communities and Local Government. Table 3 suggests lower participation rates among more deprived areas (although with a deviation from the trend in the 4th quintile).

Table 4: Response rate by local authority population quintile

Total population quintile	Invited to participate	Participated (N)	Participated (%)
1 (smallest)	30	14	47%
2	30	15	50%
3	30	16	53%
4	30	16	53%
5 (largest)	29	17	59%
Total	149	78	52%

Table 4 shows a definite trend, indicating higher participation rates amongst larger local authorities.

Table 5: Response rate by total gross social care expenditure per capita quintile

Expenditure per capita quintile	Invited to participate	Participated (N)	Participated (%)
1 (lowest)	30	14	47%
2	30	22	73%
3	30	15	50%
4	30	12	40%
5 (highest)	29	15	52%
Total	149	78	52%

Table 5 shows no discernible pattern of response rates by levels of per capita expenditure. The table shows, however, uneven response rates across local authority groups. Local authorities in the second expenditure quintile showed a participation rate of 73% while only 40% of those in the fourth quintile took part in the study.

The results of the survey reported below were reweighted in order to take into account the imbalances in response rates indicated in tables 1 to 5.

Survey findings

This section provides a description of the survey responses provided by local authorities. As indicated above, responses are weighted on the base of local characteristics such as type of local authority, geographical location, deprivation level, population and social care expenditure. When the information was deemed relevant and not too demanding for local authorities, we repeated our question for seven different service types: residential care, supported living, intermediate care, home care, day care, meals and equipment and adaptations.

Characteristics of commissioning

Commissioning responsibilities

In this section, we aimed to understand the level of centralization of budget decisions and the degree to which budget responsibility was held centrally (at the council or SSD level) by the manager of a purchasing team, or whether it was delegated to care managers.

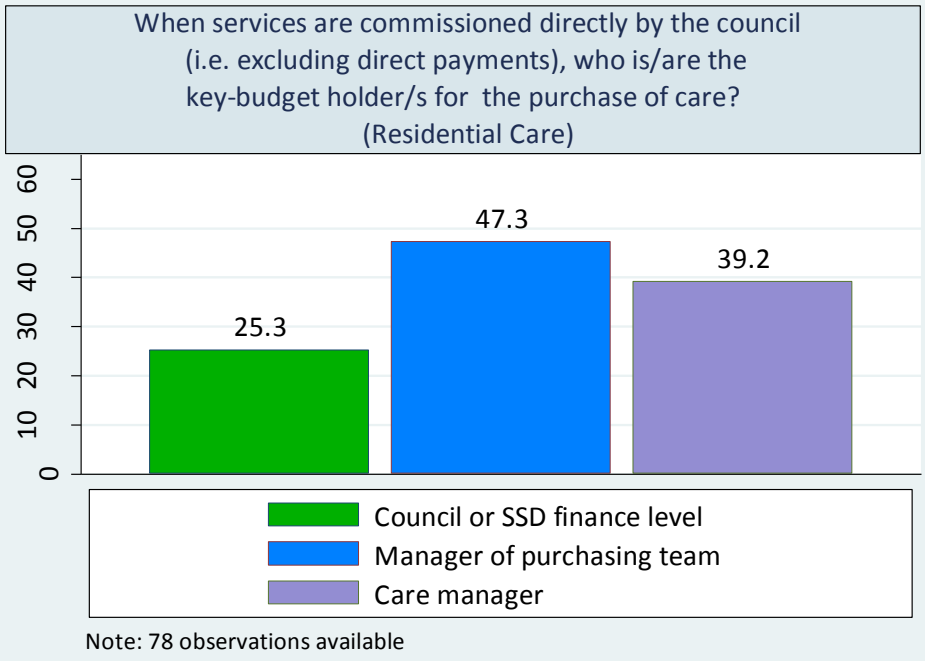
When responding to this question, local authorities were allowed to select more than one option to reflect the fact that they could have several key budget holders.

Approximately half of local authority respondents stated that the managers of purchasing teams were the key budget holders for the purchase of residential care services; approximately two in five selected care managers, and one in four selected the council or SSD finance level.

A similar trend was found with respect to the commissioning responsibilities for home-care and day-care services. Almost half of local authority respondents indicated that budget responsibility was held at the purchasing team level while care managers held budget responsibility in two out of five authorities and professionals at council/SSD level in one out of four authorities.

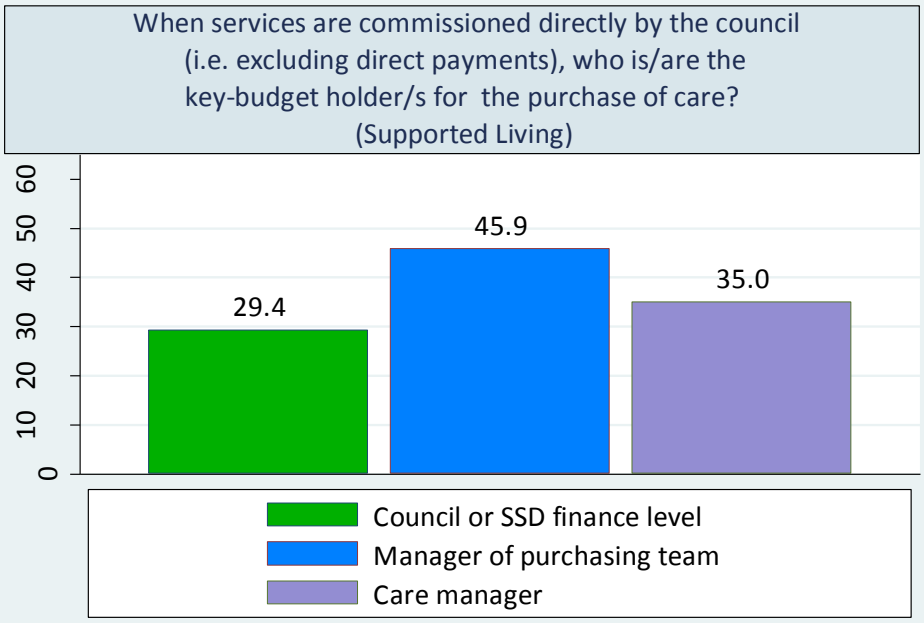
In particular, Figures 1 to 7 suggest that council/SSD finance level hold greater responsibility over the commissioning of equipment and adaptations (32.1%), intermediate care (30.7%), and supported living (29.4%). For residential care, home-care, day-care and meals, budget responsibility was held at the council/SSD finance level in approximately one of four authorities in the sample.

Figure 1



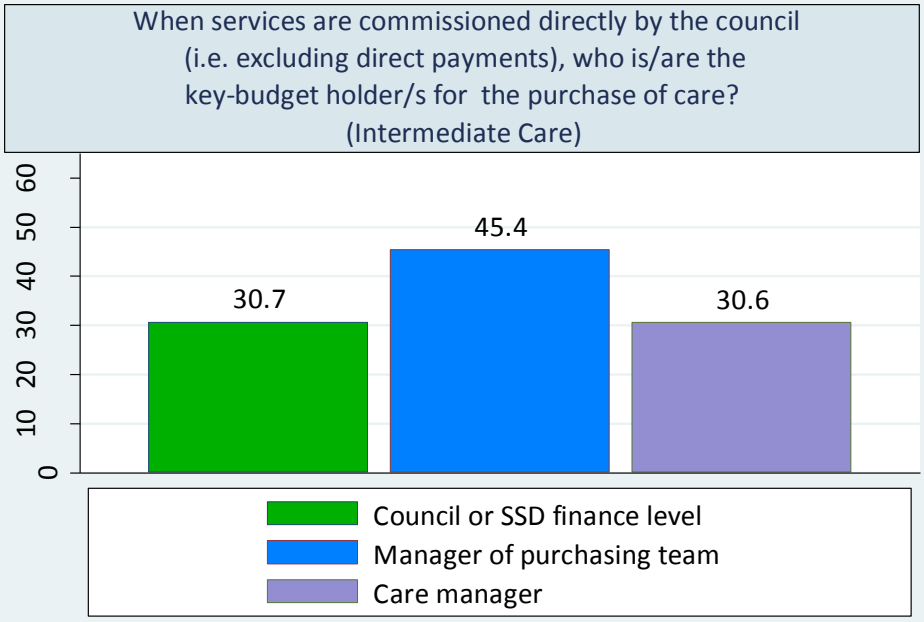
Note: 78 observations available

Figure 2



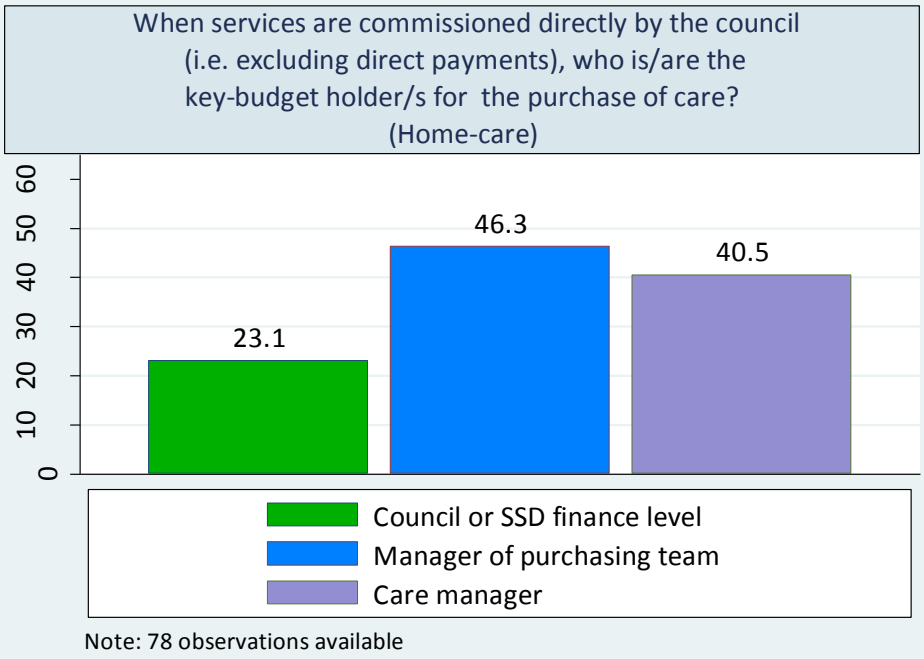
Note: 74 observations available

Figure 3



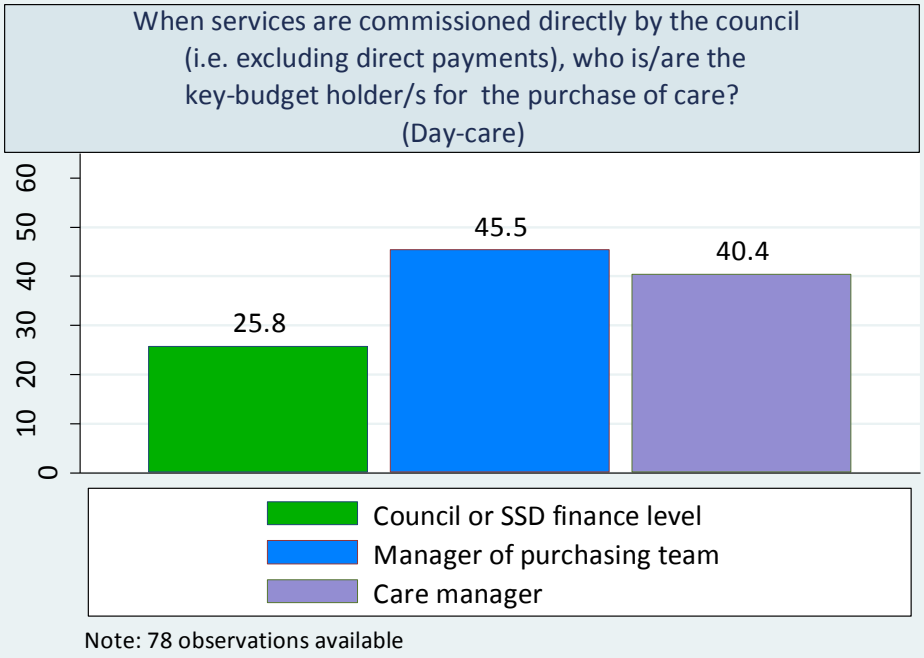
Note: 62 observations available

Figure 4



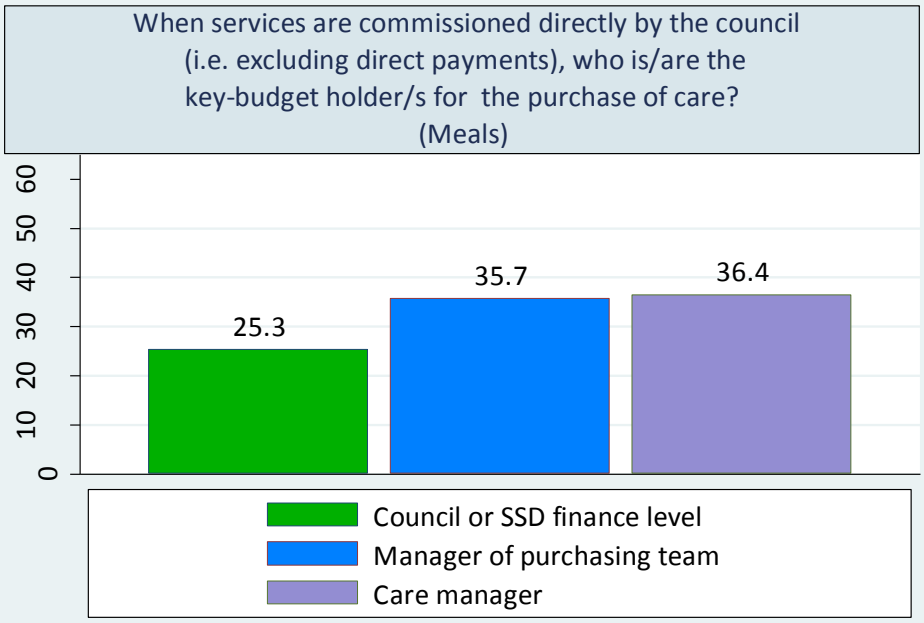
Note: 78 observations available

Figure 5



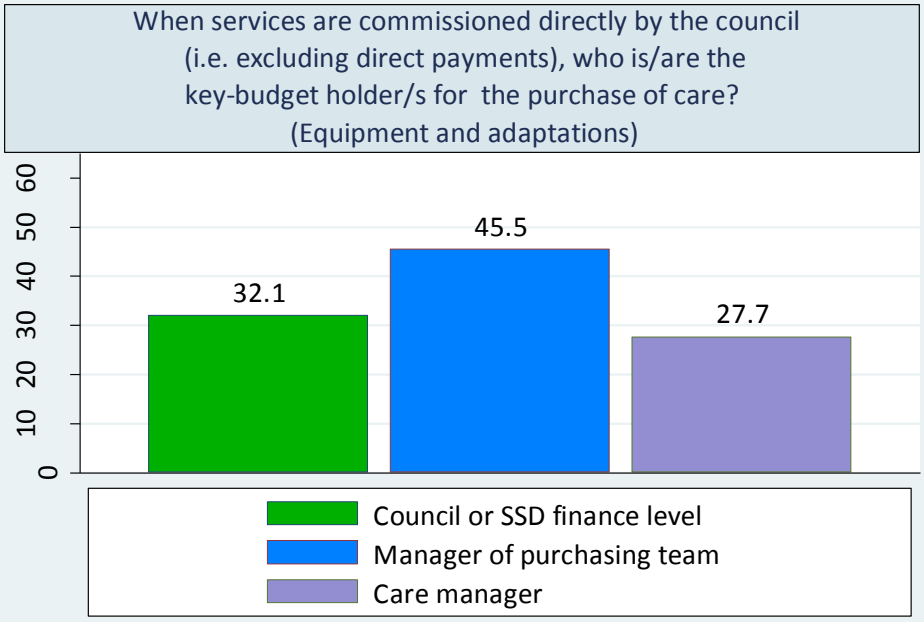
Note: 78 observations available

Figure 6



Note: 64 observations available

Figure 7



Note: 70 observations available

Sharing and coordination of commissioning activities

We examined whether local authorities involved different services or external organizations in their commissioning processes. When responding to these questions, local authorities were asked to distinguish between joint commissioning arrangements (Figure 8) and the pooling of budgets (Figure 9).

In terms of services, 64% of local authorities commissioned services for older people jointly with the housing department, almost 32% of authorities with transport services and 27% with leisure services. In terms of external organizations, the vast majority of local authorities (94%) commissioned services jointly with NHS organisations, 55% with voluntary organizations and 41% with another local authority.

Figure 8

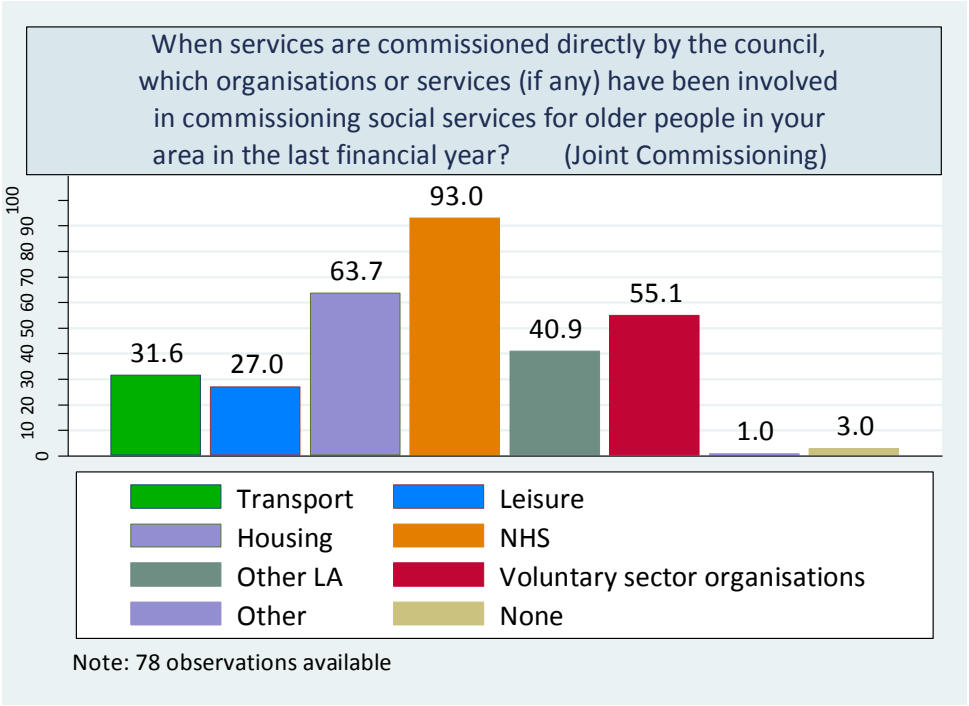
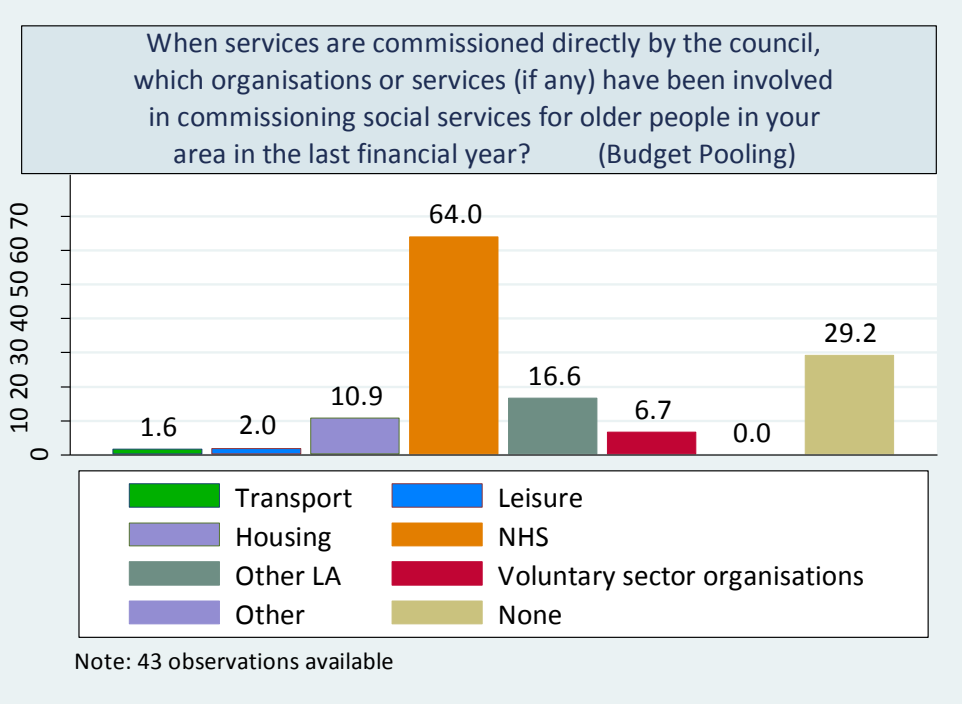


Figure 9 shows that the pooling of budgets occurred much less frequently than joint commissioning in general. Nearly one in ten of the authorities surveyed pooled budgets with housing services, and 17% pooled budgets with another local authority. However, almost two thirds of authorities had pooled budgets with an NHS organisation. Overall, approximately 30% of local authorities in the sample declared not to have undertaken any form of budget pooling with another organisation or part of the authority.

Figure 9

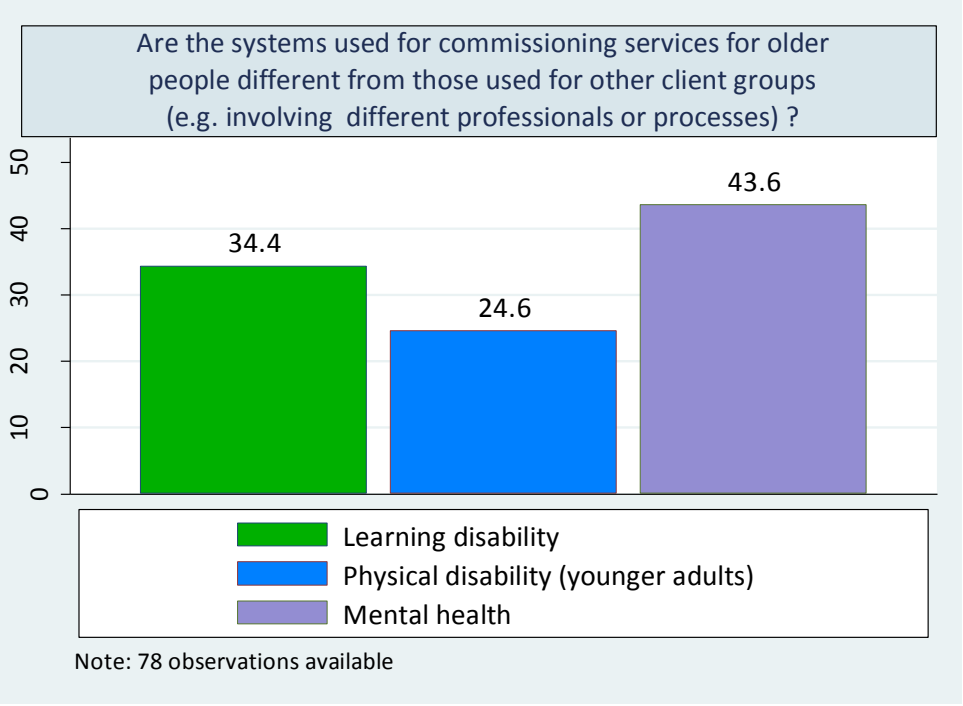


Note: 43 observations available

Commissioning services for different client groups

In a minority of authorities, the processes used for commissioning services differed across client groups. Figure 10 suggests that the differences were most frequent between the commissioning processes for older people's services and services for people with mental health problems. Hence, approximately 44% of authorities declared differences in the processes used for commissioning services for older people and for people with mental health problems, 34% in the processes for commissioning older people services and services for people with learning disabilities, and almost 25% in the processes for commissioning older people services and services for young adults with physical disabilities.

Figure 10



The market share of the independent sector

We asked local authorities to shed light on the extent to which the independent sector is involved in the provision of different types of social care services commissioned directly by councils.

Figure 11

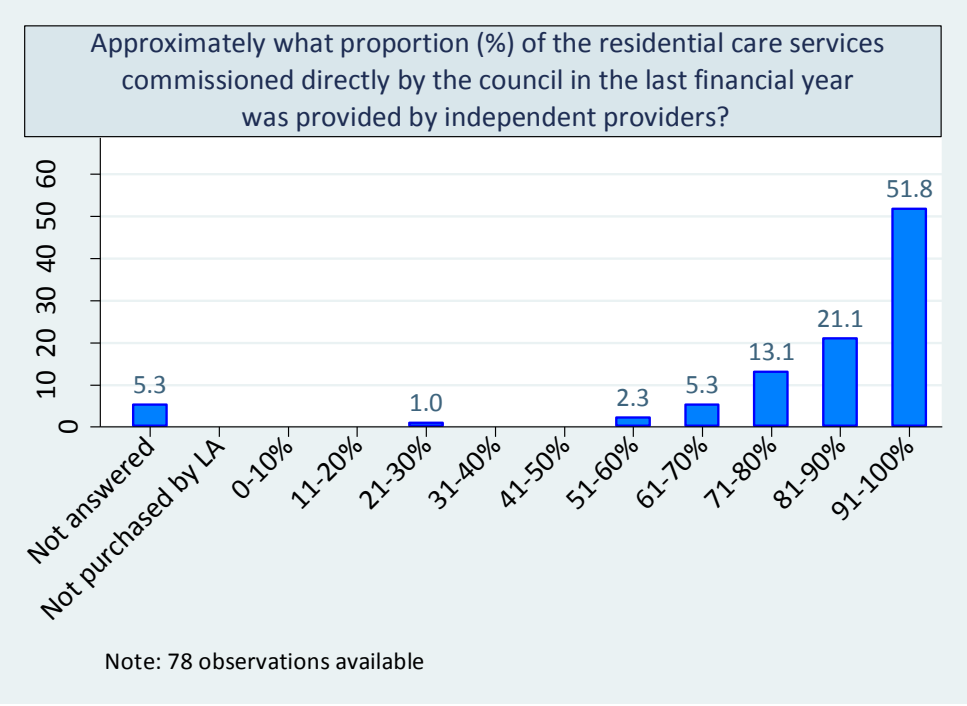
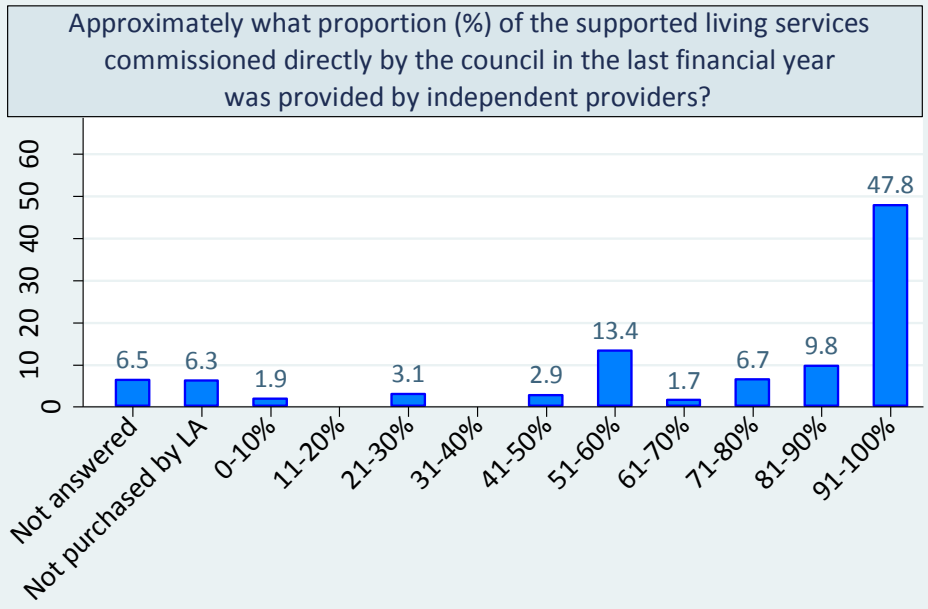


Figure 11 shows the major role played by the independent sector in the provision of local authority commissioned residential care in England. Overall, almost 52% of authorities responded that independent providers provided between 91 per cent and 100 per cent of the residential care services they commissioned. Roughly 86% of authorities commissioned more than 70% of their residential care from the independent sector.

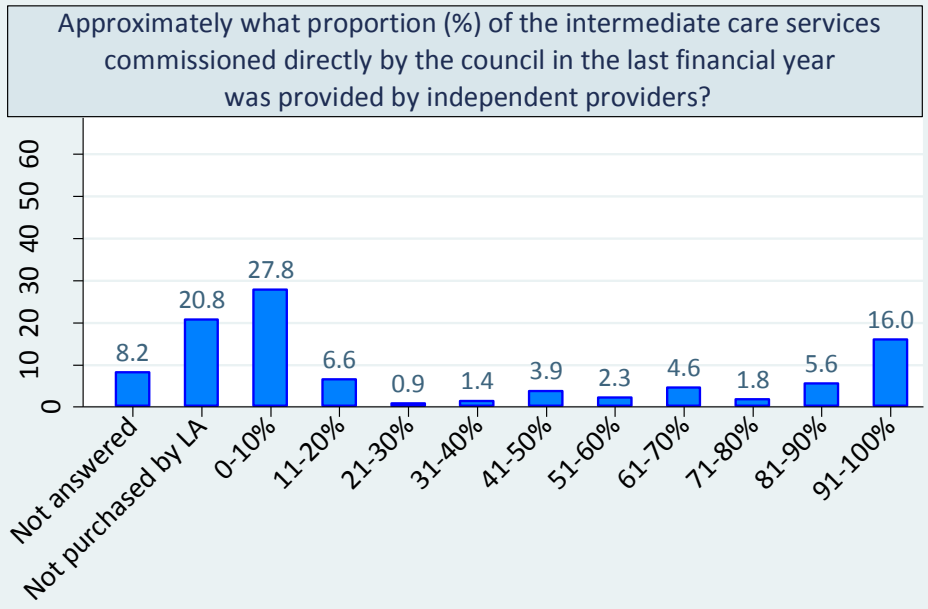
Figure 12



Note: 78 observations available

As in the case of residential care services, a prevalent number of authorities (almost 48%) declared that they commissioned at least 91% of their supported living services from the independent sector. In excess of 64% of authorities commissioned at least 71% of their supported living services from the independent sector.

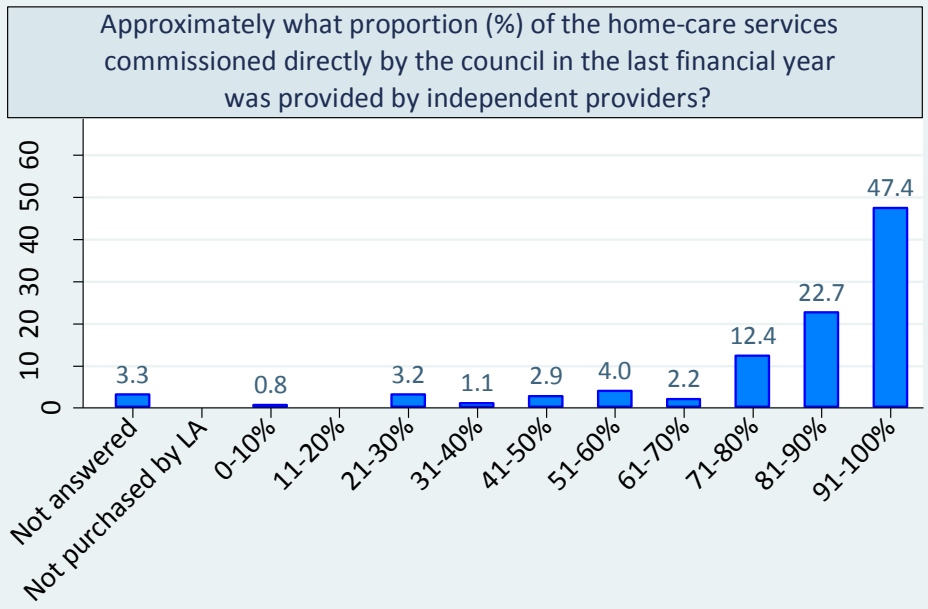
Figure 13



Note: 78 observations available

Approximately 21% of local authorities reported not to commission intermediate care services. A significant proportion (approximately 41%) reported to commission at least 50% of the service in-house and 28% commission less than 10% from the independent sector.

Figure 14



Note: 78 observations available

As in the case of residential care services, the independent sector plays a key role in the provision of home care services in most English local authorities. Almost half of local authorities indicated that they purchased in excess of 91% of home care services from the independent sector. In excess of 82% of authorities purchased at least 71% of home care services from the independent sector.

Figure 15

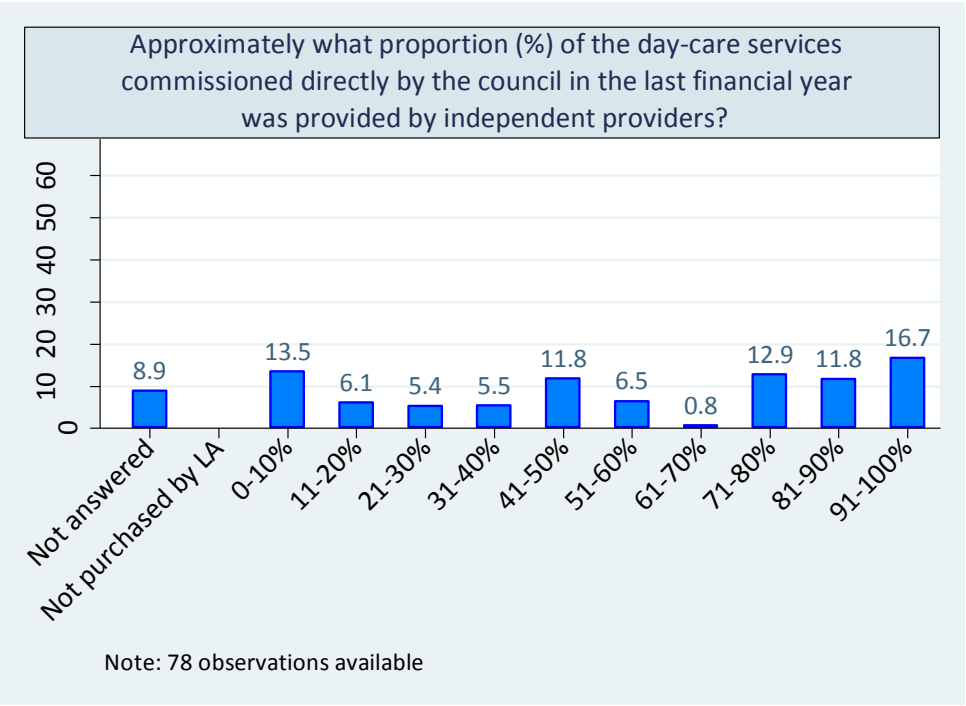
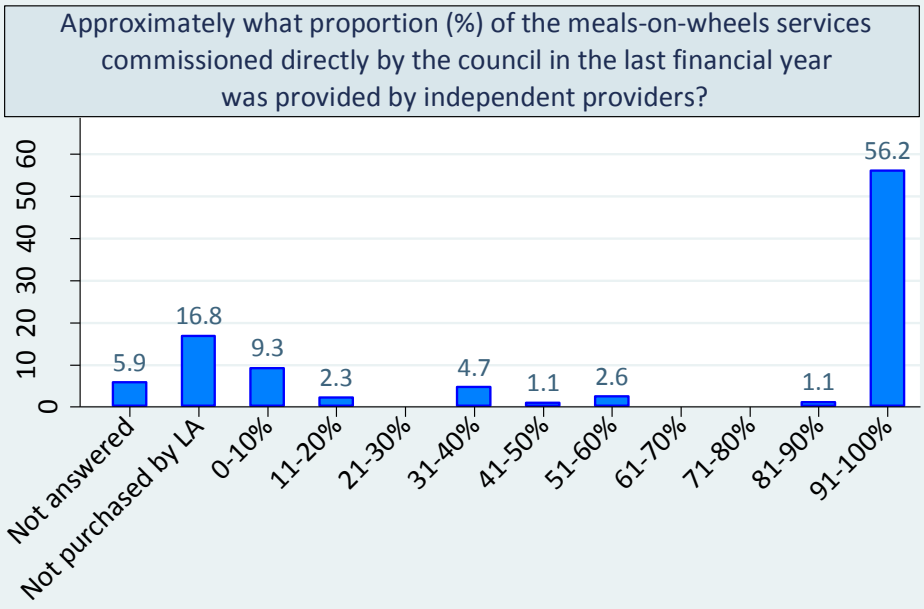


Figure 15 indicates a much greater variation in the role of the independent sector with respect to day care services than indicated in previous figures for home care and residential care services. Overall, more than 41% of authorities appeared to commission at least 71% of day care services from the independent sector.

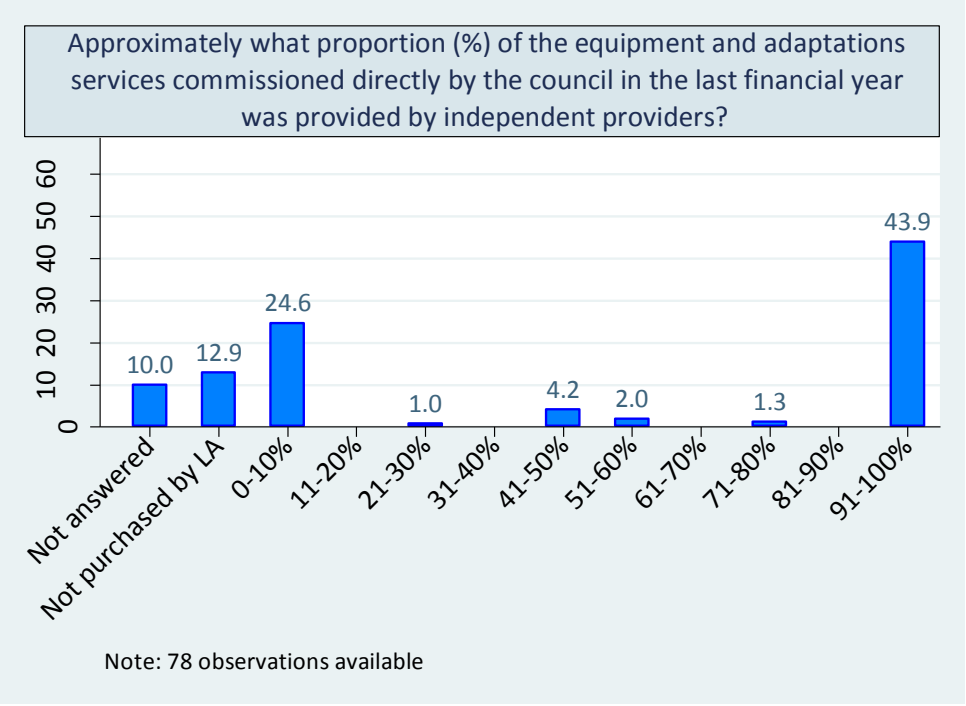
Figure 16



Note: 78 observations available

In many authorities (56.2%), meals on wheels were provided almost exclusively by the independent sector. A significant proportion of local authorities (16.8%) declared not to purchase the service at all.

Figure 17

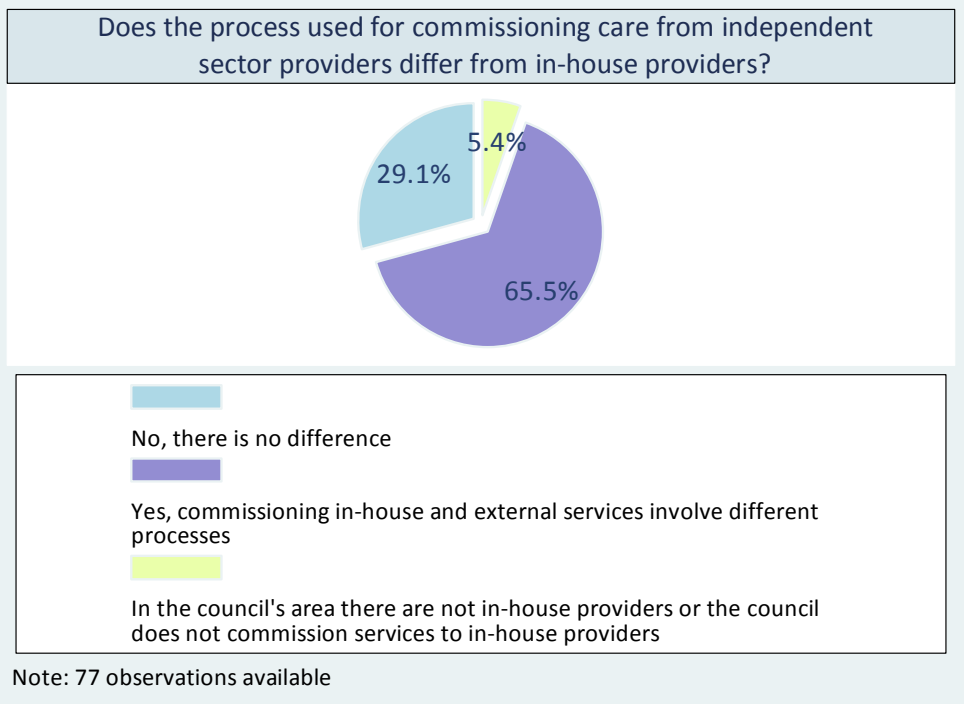


The role of the independent sector in the provision of equipment and adaptations among English local authorities appears to be polarised. Whereas approximately one in four English authorities provided less than 10 per cent of their equipment and adaptations through the independent sector, approximately 44% of local authorities used the independent sector to provide at least 91% of the service.

Differences in commissioning processes between independent and in house providers

Figure 18 shows that the large majority of local authorities (65.5%) disclosed differences in the processes used for commissioning in-house and external services. Roughly 29% of authorities indicated there were no differences, and 5.4% did not commission from in-house providers.

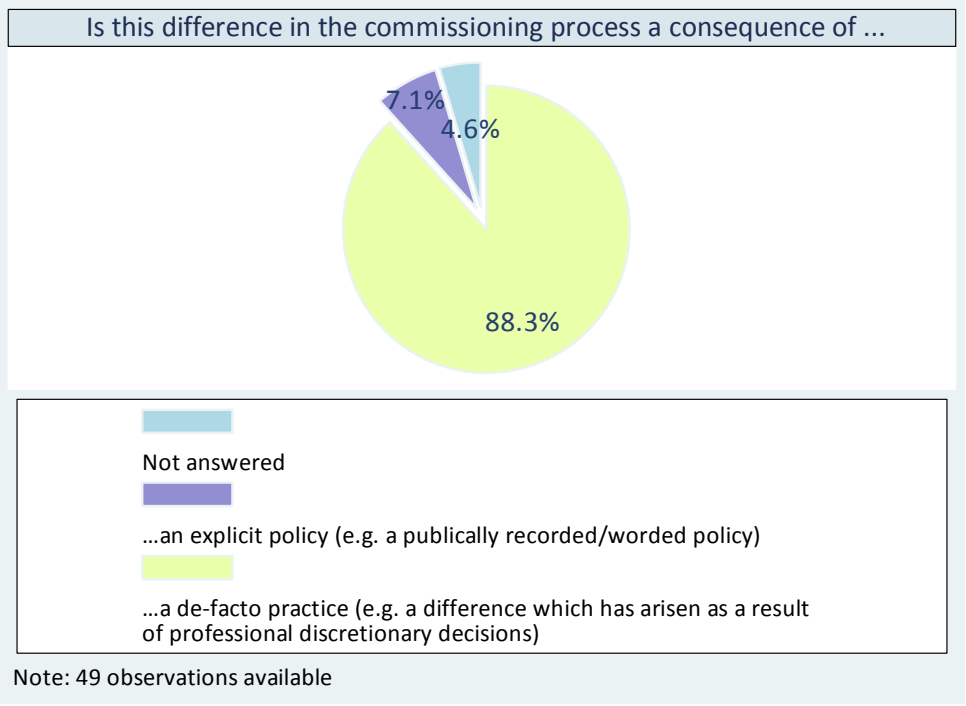
Figure 18



Note: 77 observations available

From those authorities who stated the existence of differences in the processes for commissioning services between the independent and in house providers, we asked whether such differences were the product of explicit policies or whether they emerged as a de-facto practice. In approximately nine out of 10 cases, the differences were stated to be the product of a de-facto practice (see Figure 19).

Figure 19



Note: 49 observations available

Contracting with the independent sector

Contract types

We explored the range of contracts used to commission different services from the independent sector (see Figures 20 to 26). The dominant contract type used varied across services. Spot contracts were noted as the main contract type most frequently in relation to the commissioning of residential care (76% of authorities), supported living (43%), home care (44%) and day care services (43%, the same proportion as block contracts). Block contracts were used as the main contract type for commissioning residential care in less than 10% of authorities in the sample, but were the main contract type for supporting living in 35% of authorities, for intermediate care in 45% of authorities and for day care in 44% of authorities.

Figure 20

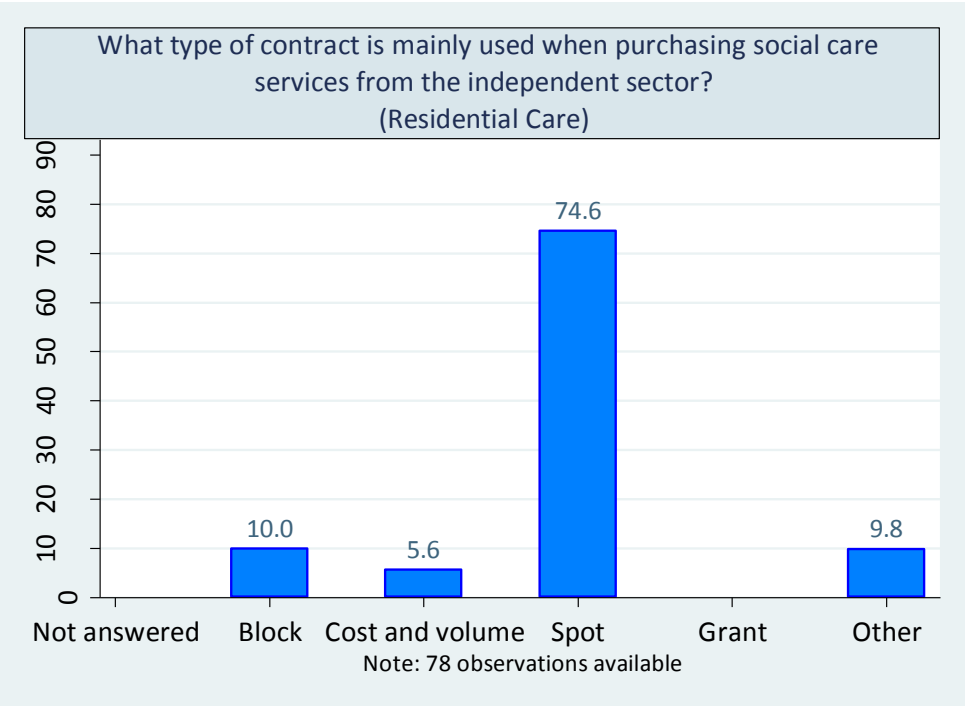


Figure 21

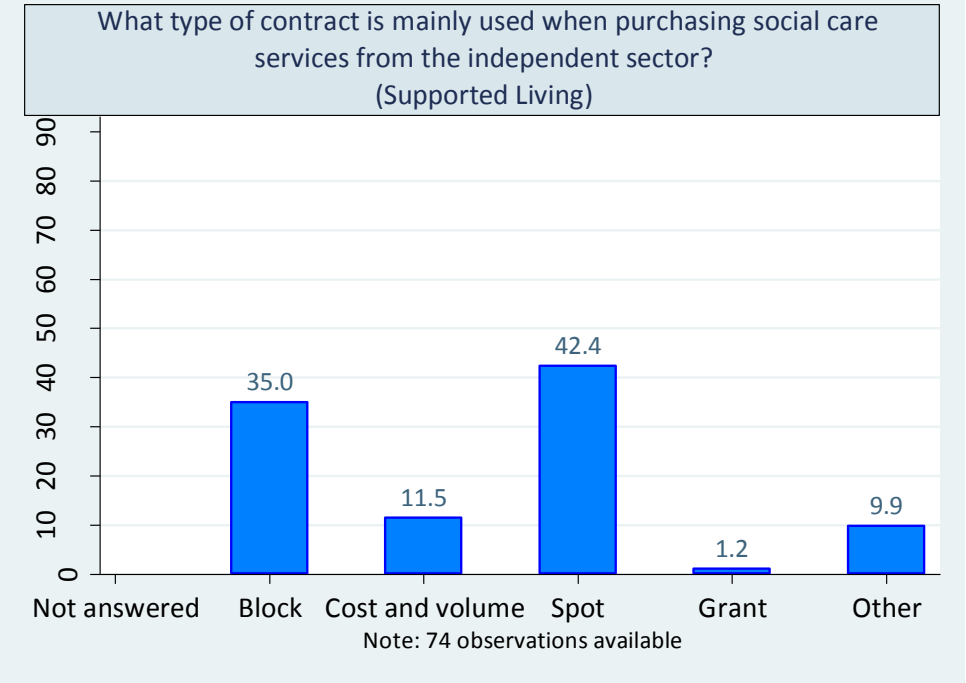


Figure 22

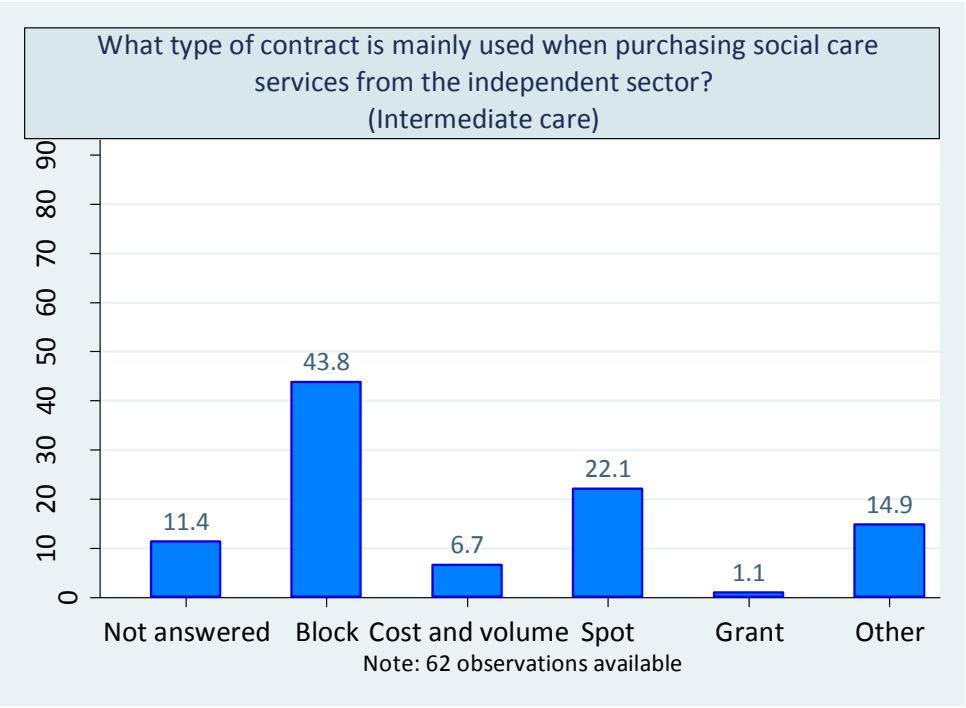


Figure 23

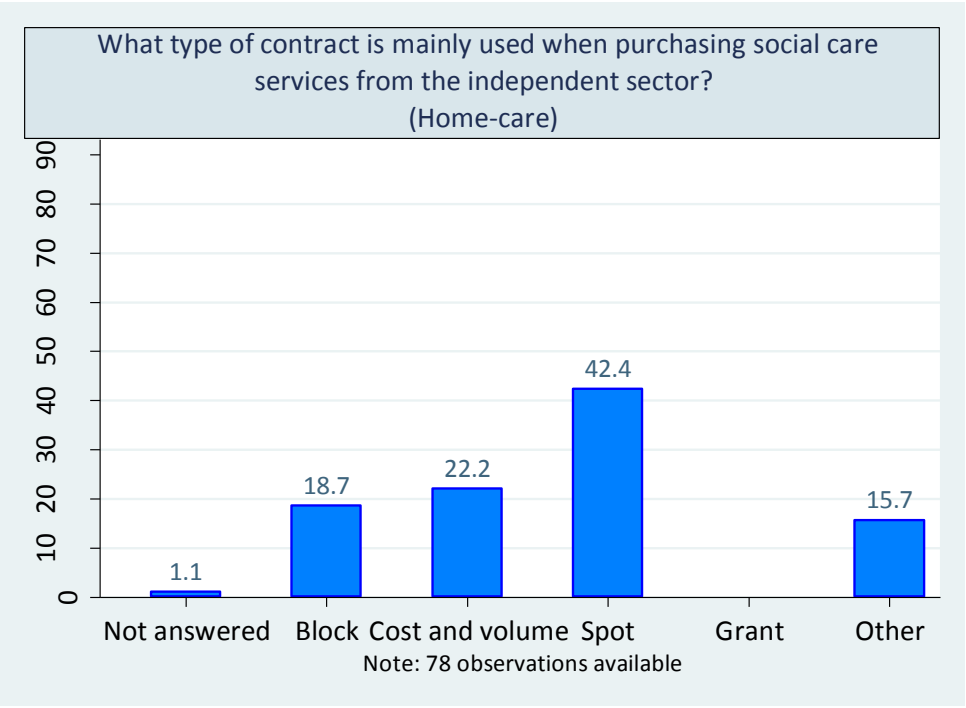


Figure 24

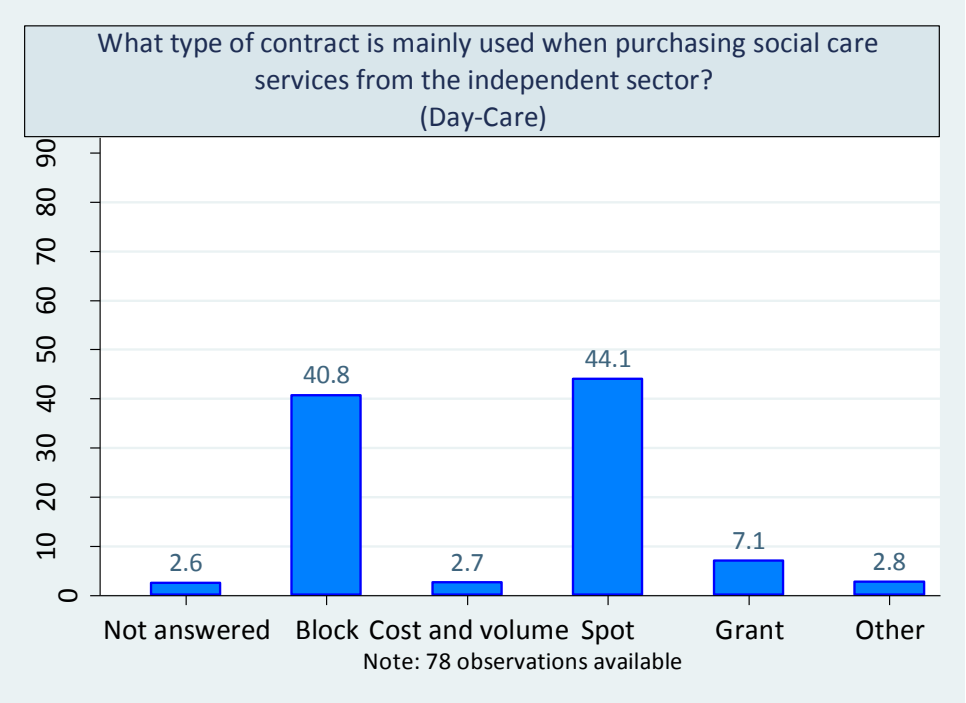


Figure 25

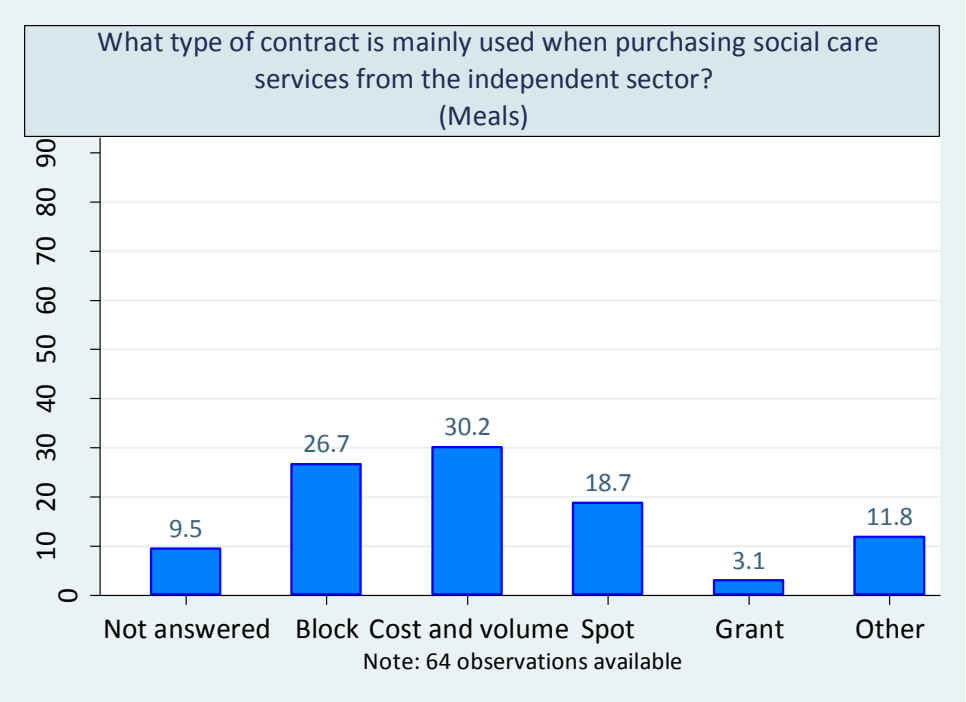
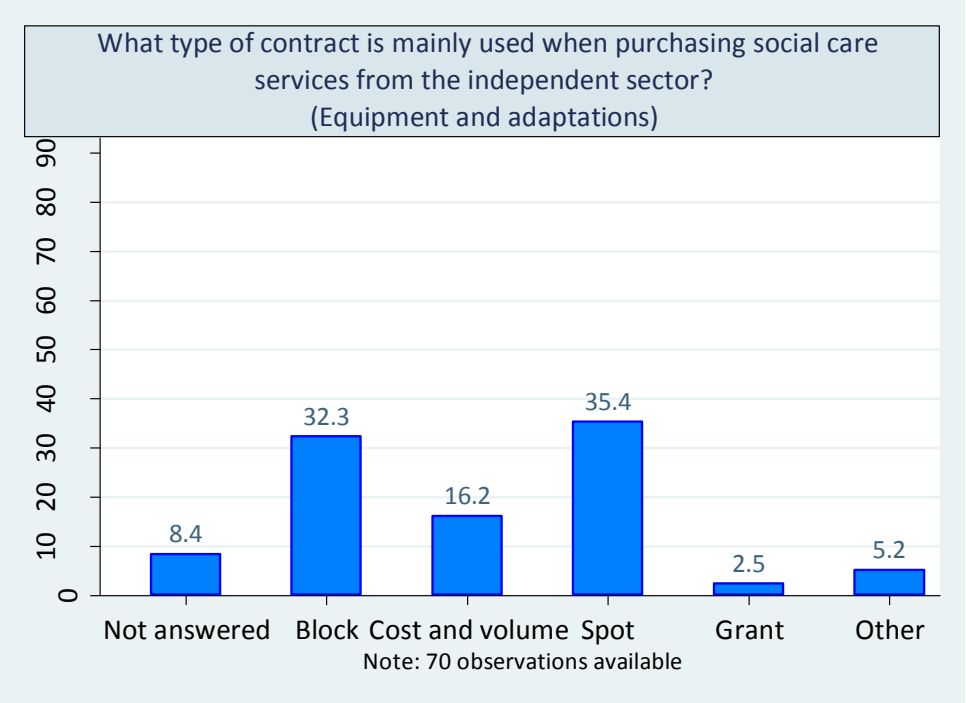


Figure 26



This set of question focuses in greater detail on the use of block contracts by local authorities.

Figure 27 shows that 63% of authorities either did not use block contracts for commissioning residential care or commissioned less than 10% of their services using block contracts. Approximately 6% of the authorities in the sample used block contracts for commissioning more than 50% of their residential care services.

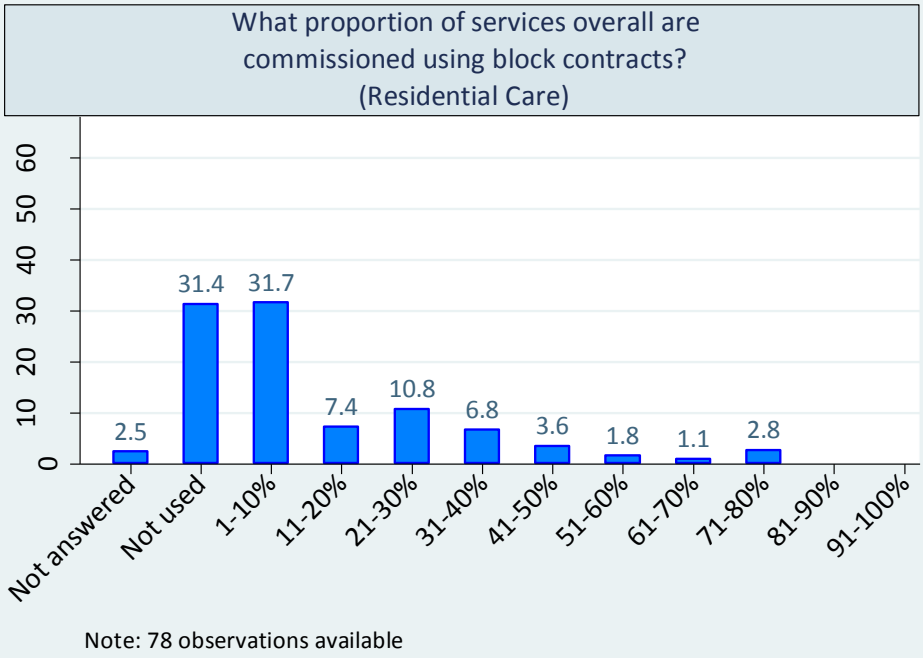
Block contracts were also rarely used for commissioning home care services. Figure 30 shows that almost 46% of local authorities in the sample did not use block contracts at all for commissioning home-care, and a further 19% used block contracts to commission 10% or less of their home care services.

The use of block contracts was more prevalent for the commissioning of other services, however.

- Almost 17% of local authorities used block contracts for contracting over 90% of their supported living services (over 28% of authorities did not use block contracts for this service type at all).
- 39% of local authorities in the sample commissioned more than 90% of their intermediate care services through block contracts. Over 32% of authorities did not use block contracts for intermediate care services.
- Approximately 41% of the authorities in the sample either did not use or used block contracts for commissioning less than 10% of day care services. 18% of authorities commissioned in excess of 90% of their day care services using block contracts.
- Block contracts were either not used at all (in virtually half of the sample) or used almost exclusively (in approximately 35% of the sample) to commission meals. A similarly polarised

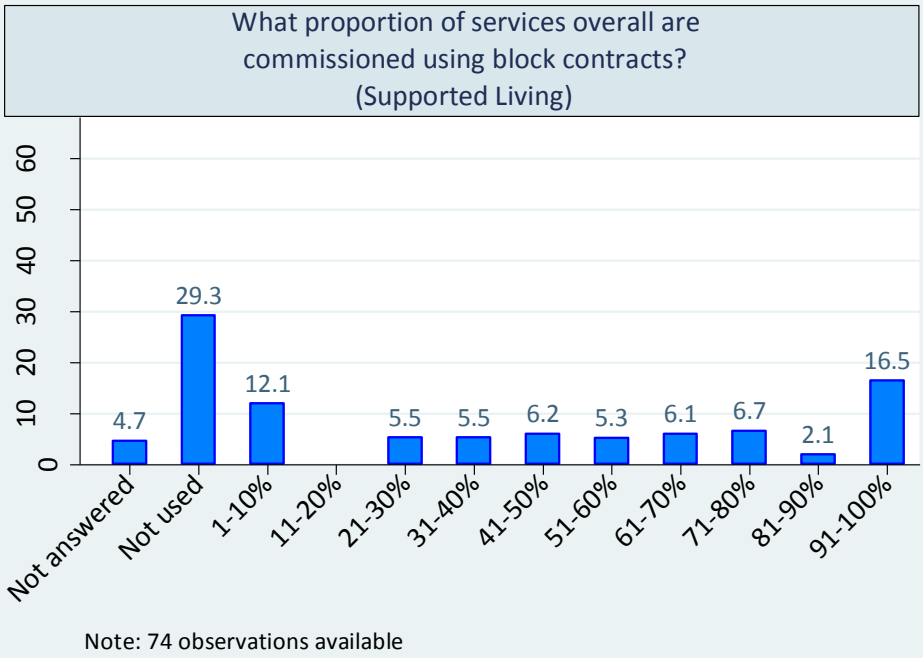
pattern was found for the use of block contracts for commissioning equipment and adaptations.

Figure 27



Note: 78 observations available

Figure 28



Note: 74 observations available

Figure 29

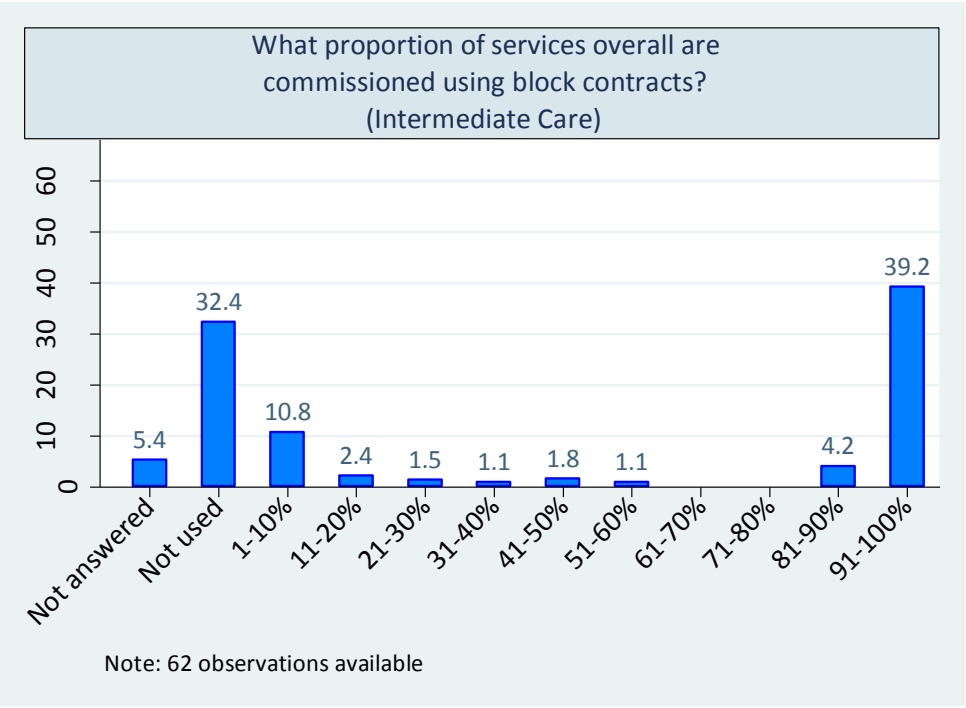


Figure 30

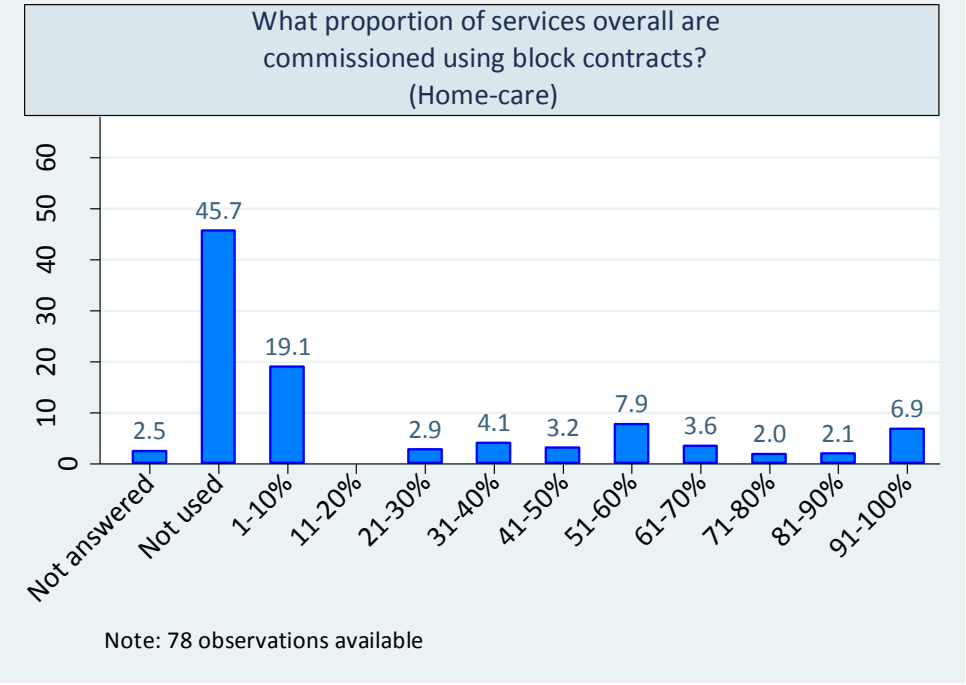


Figure 31

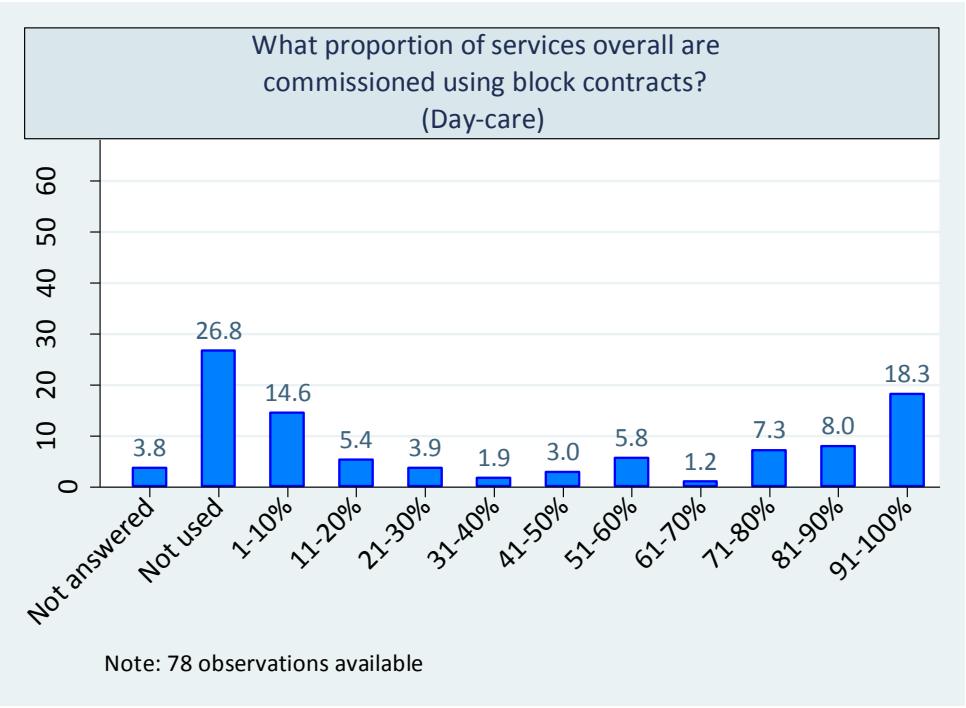


Figure 32

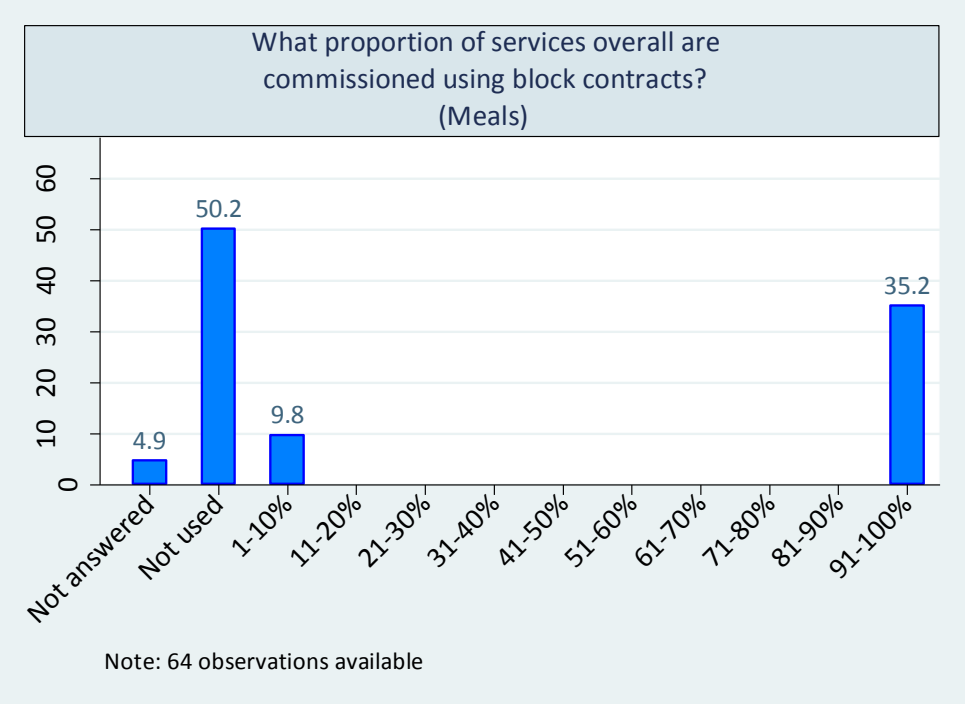
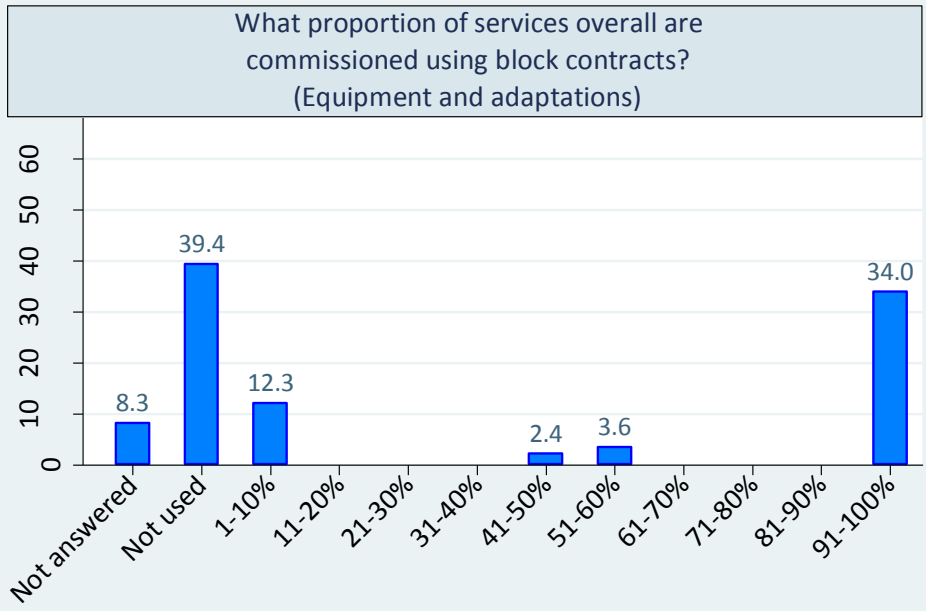


Figure 33



Note: 70 observations available

Duration of contracts

The duration of contracts between local authorities and providers can provide an indication of the stability and maturity of local market relationships.

In excess of two thirds of the authorities in the sample indicated that the typical length of their contract with residential care providers exceeded three years (see Figure 34). For a third of the sample, the typical contract duration exceeded five years. Almost no authorities reported typical durations of their contracts with residential care providers shorter than one year.

Figure 34

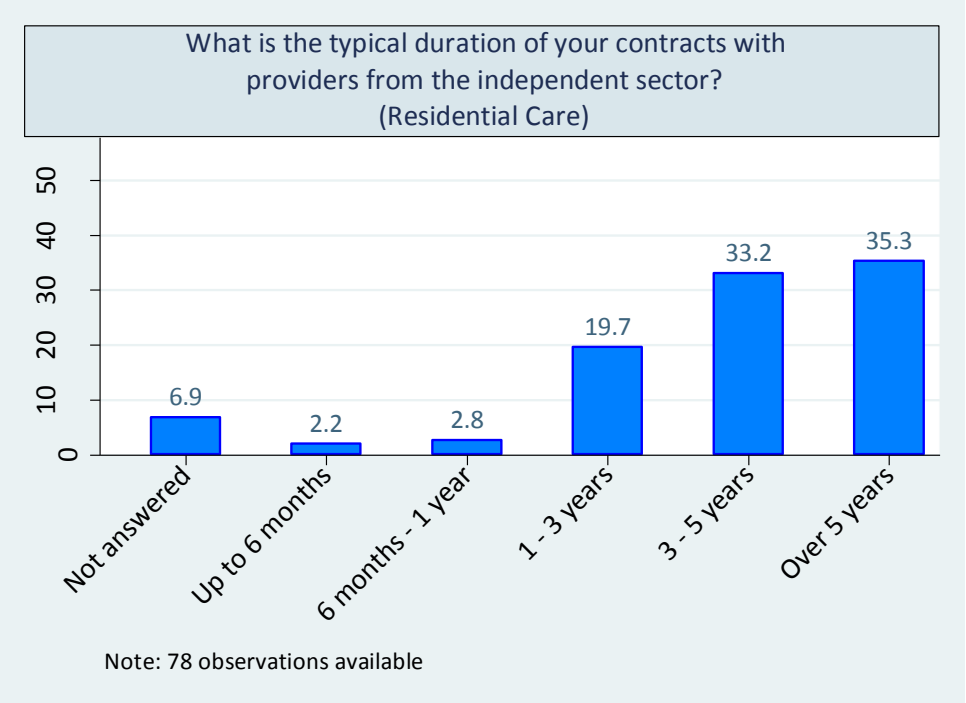
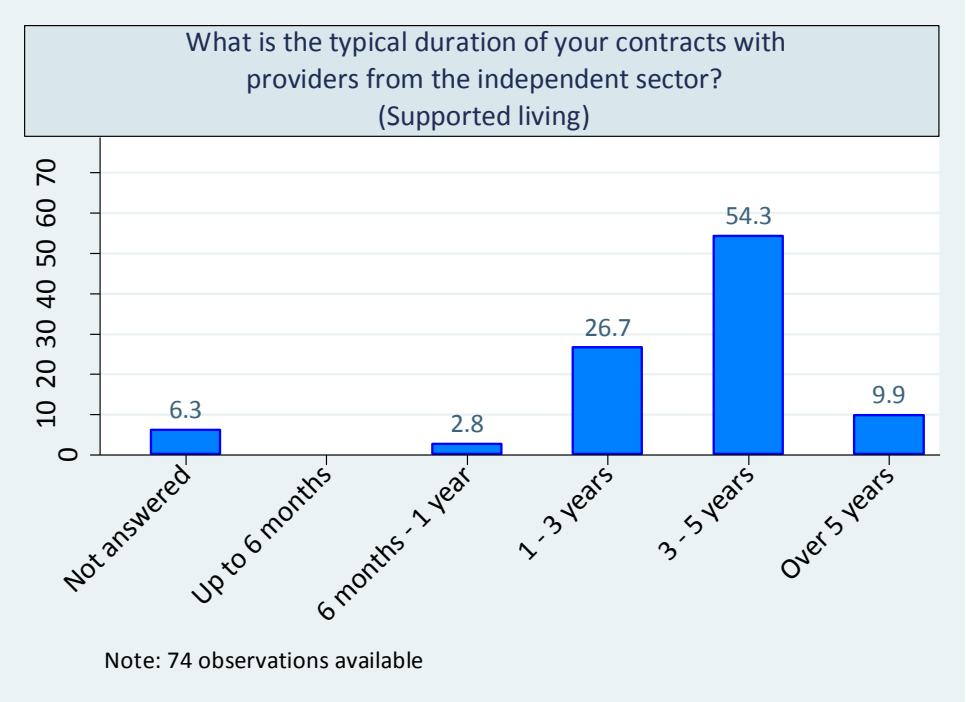


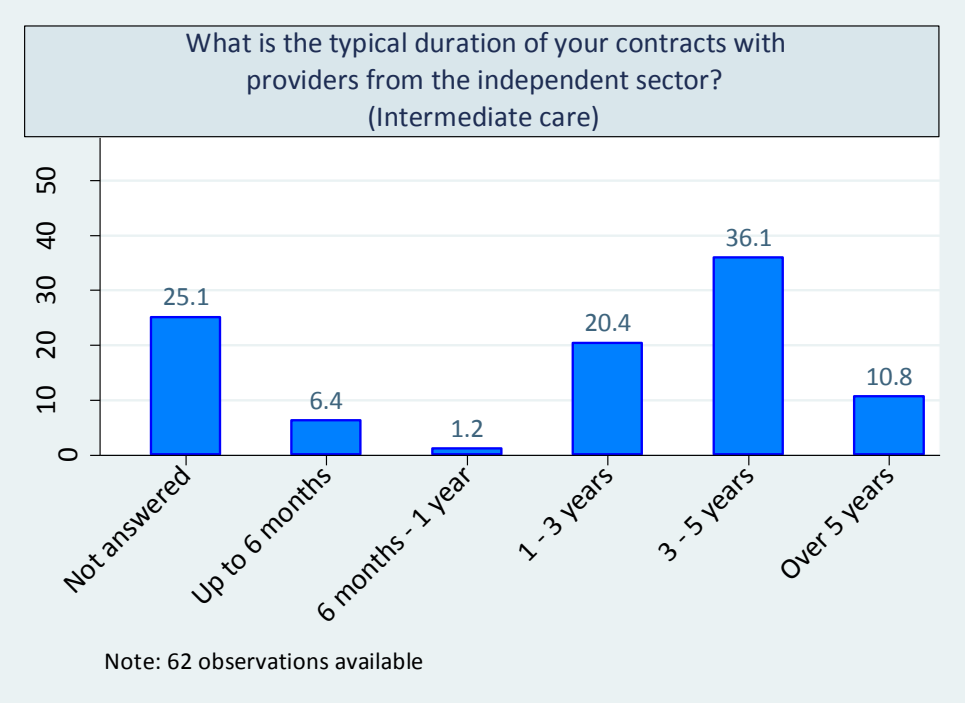
Figure 35



As for residential care, almost no authorities reported typical contract lengths shorter than one year for supported living services (see Figure 35). However, a smaller proportion of authorities indicated contract lengths beyond five years for this type of service.

Figure 36 suggests similar patterns for intermediate care services. The model reported that the duration of contracts was between 3 and 5 years. Approximately 21% of authorities indicated average contract duration of between 1 and 3 years.

Figure 36



By far the most prevalent average contract duration for home care services among local authorities in the sample was 3 to 5 years (see Figure 37). Almost no authorities reported average contract periods longer than five years or shorter than one year.

Figure 37

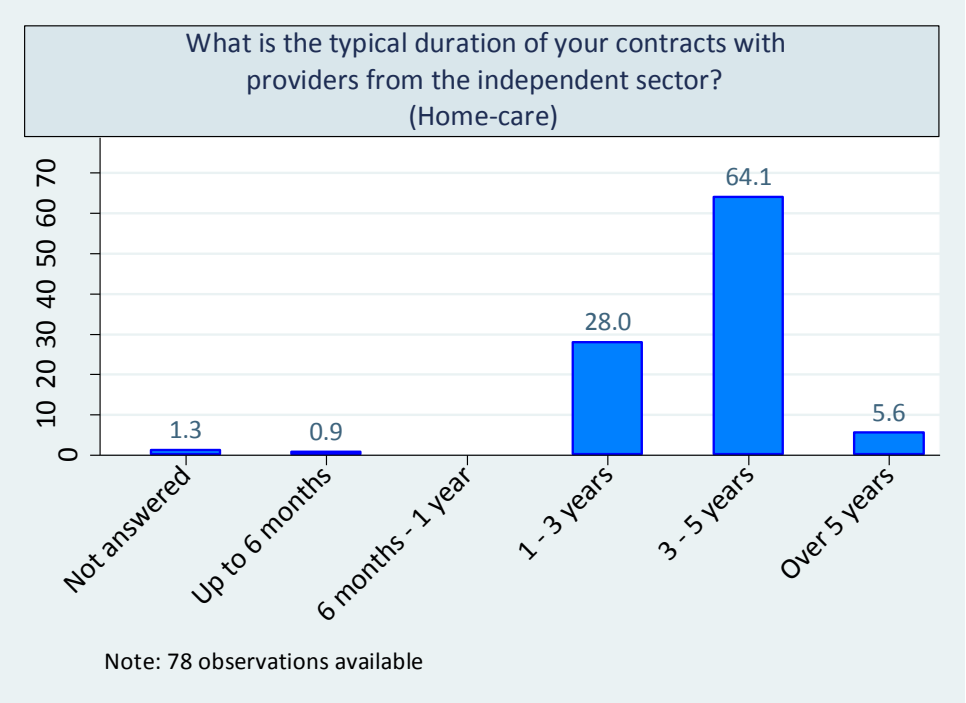
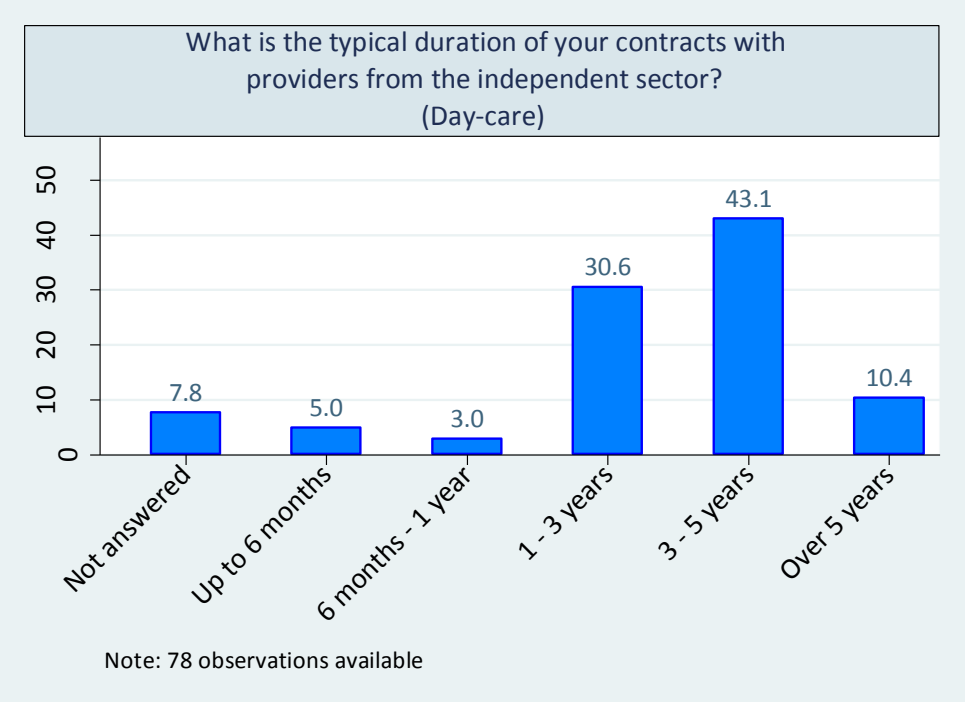
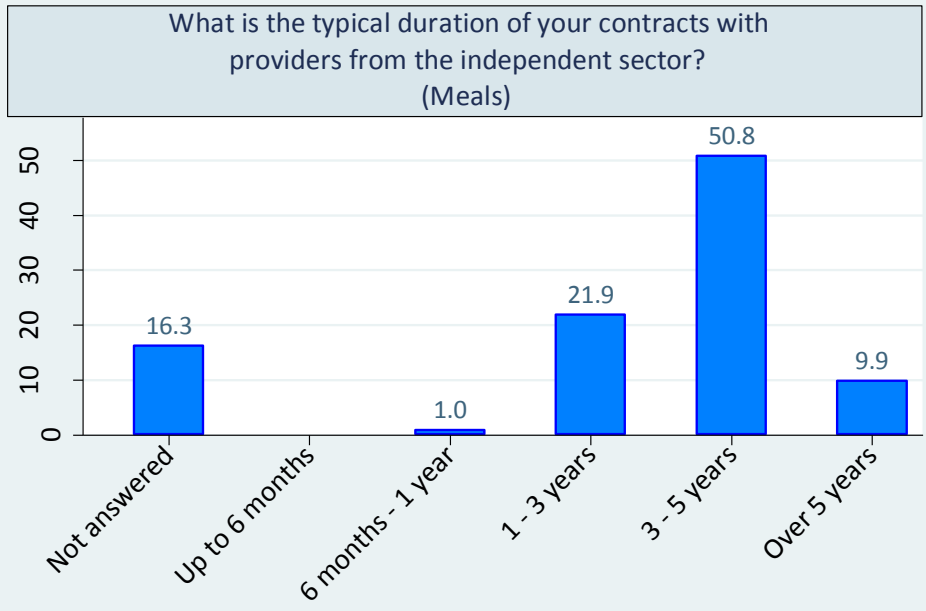


Figure 38



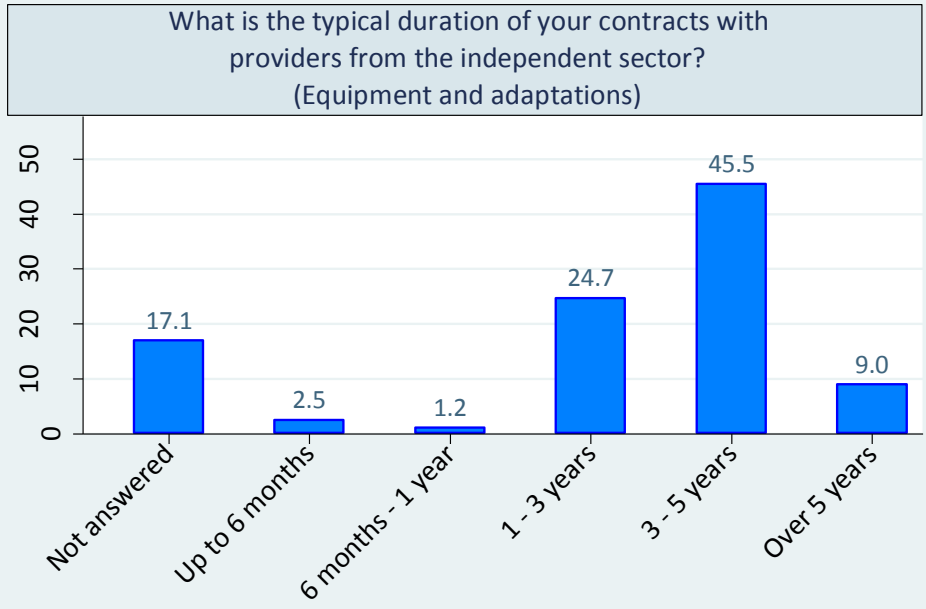
Figures 38, 39 and 40 suggest a similar contract duration average for day care, meals and equipment and adaptations than for home care services.

Figure 39



Note: 64 observations available

Figure 40



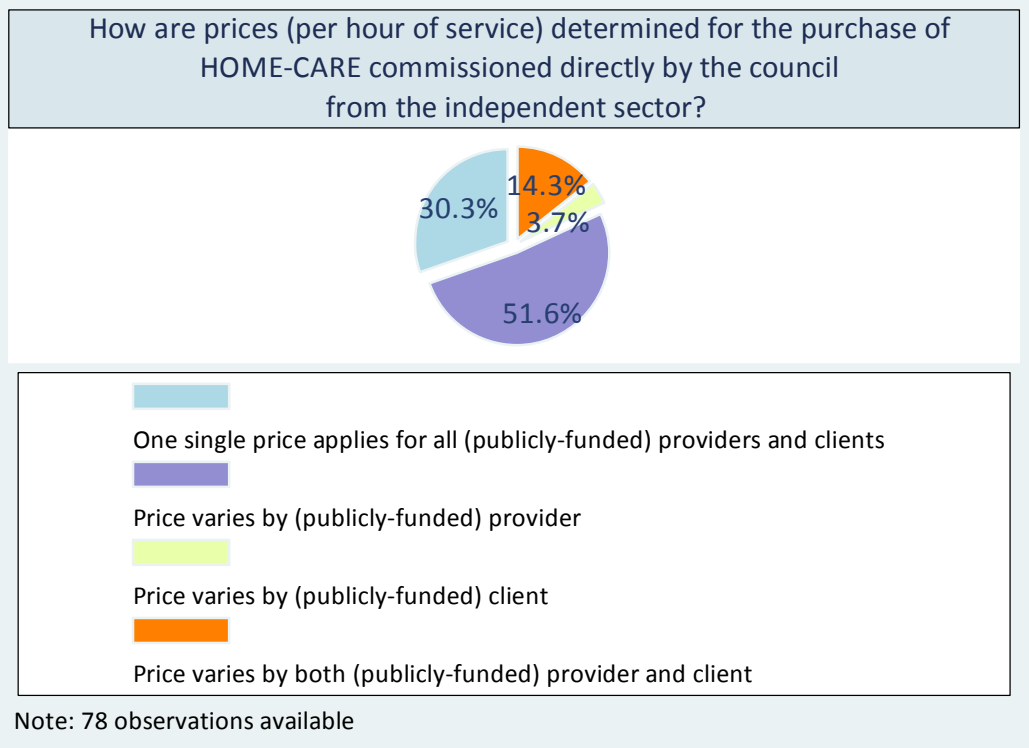
Note: 70 observations available

Setting prices

One of the objectives of the survey was to establish the mechanisms used by local authorities to set the price paid for services, whether such prices varied across clients and providers, and if so, the basis for such differences in price. Therefore, a set of three questions were asked to explore pricing policies for residential care, home care and day care services.

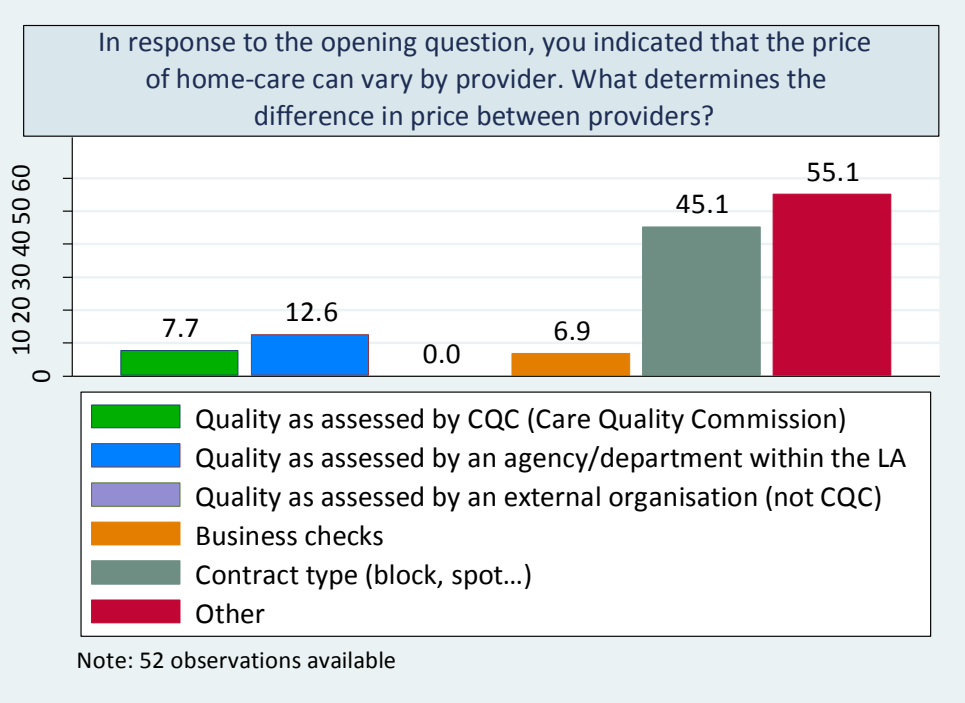
More than half of the weighted sample declared that the price they paid for home care services varied only by provider while 30% indicated that the local authority applied a single price across all providers and clients. In 14% of local authorities, prices varied between both providers and clients while price in the remaining 4% varied only between clients.

Figure 41



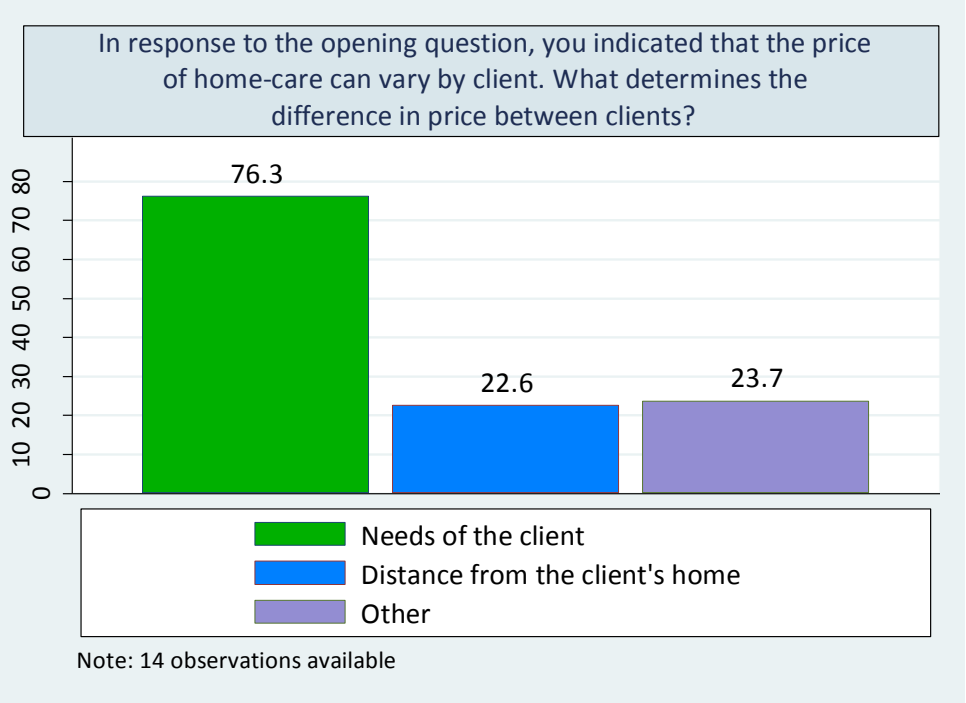
Note: 78 observations available

Figure 42



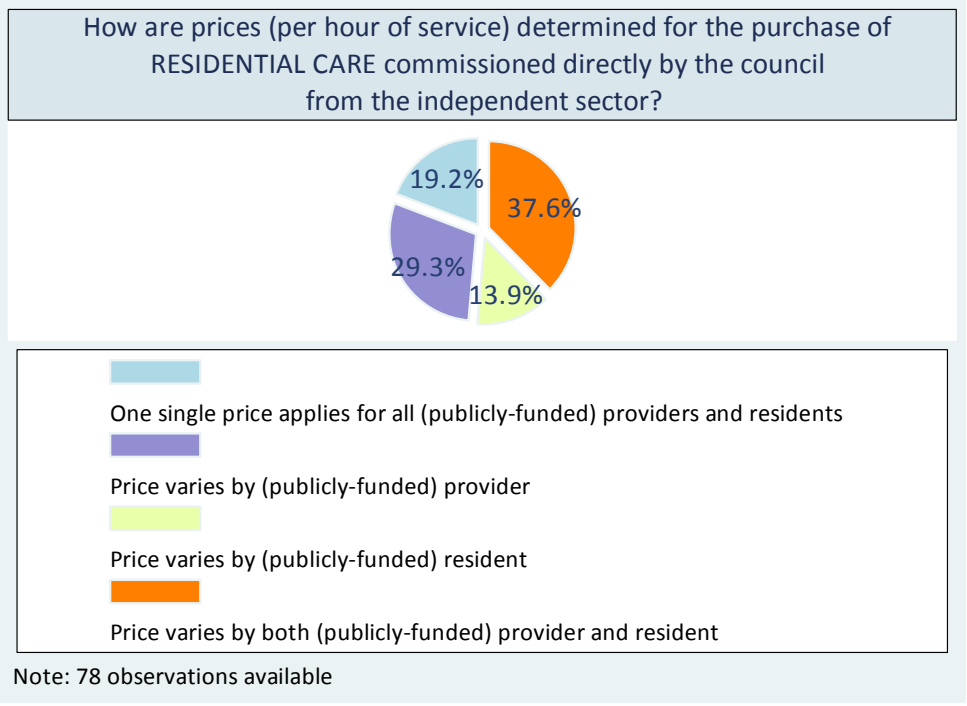
In 45% of local authorities, home care price differences between providers were linked to differences in contract types. Only a small proportion of local authorities adopted quality-based measures for price discrimination.

Figure 43



A vast majority of local authorities that discriminated home care prices between clients did so on the basis of need. Approximately one fifth varied home care prices depending on the distance from the client's home.

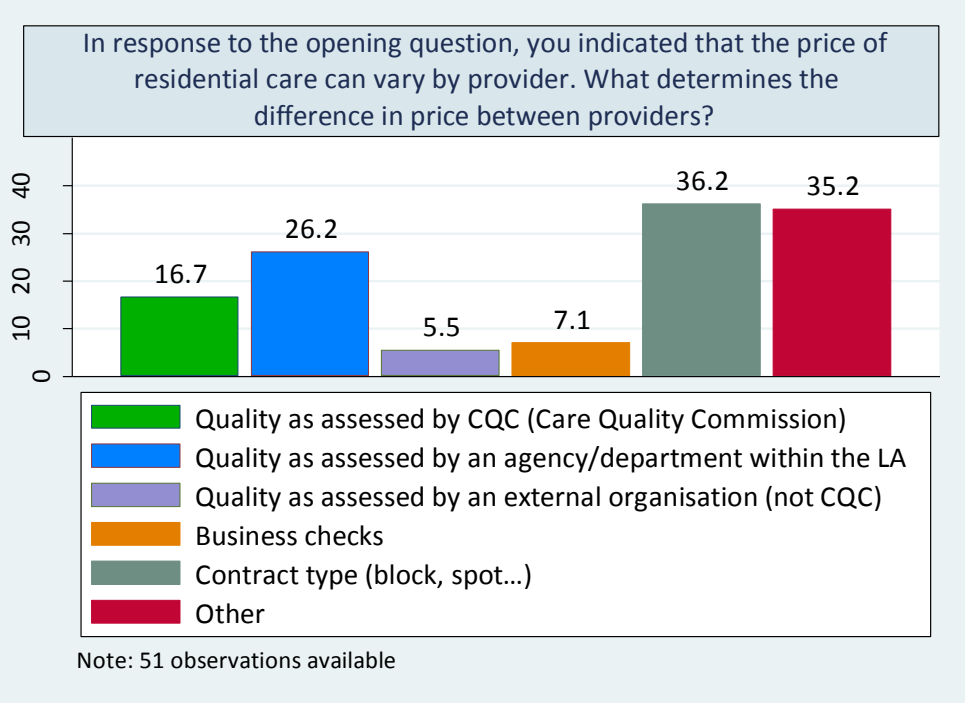
Figure 44



Note: 78 observations available

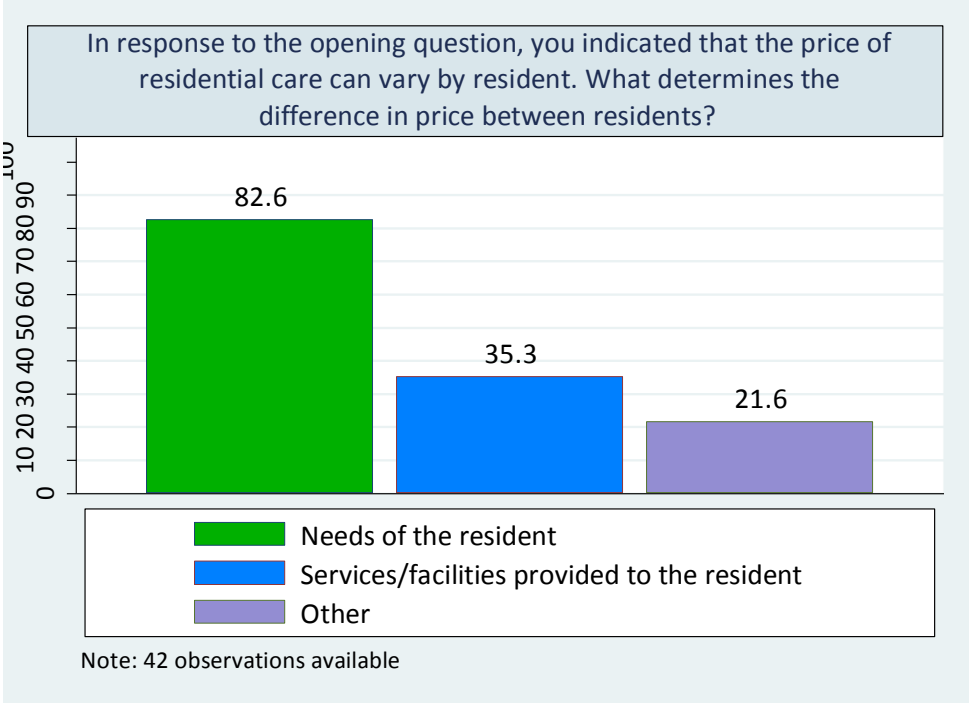
Approximately 38% of the local authorities varied residential care prices between both providers and residents, and 29% only between providers.

Figure 45



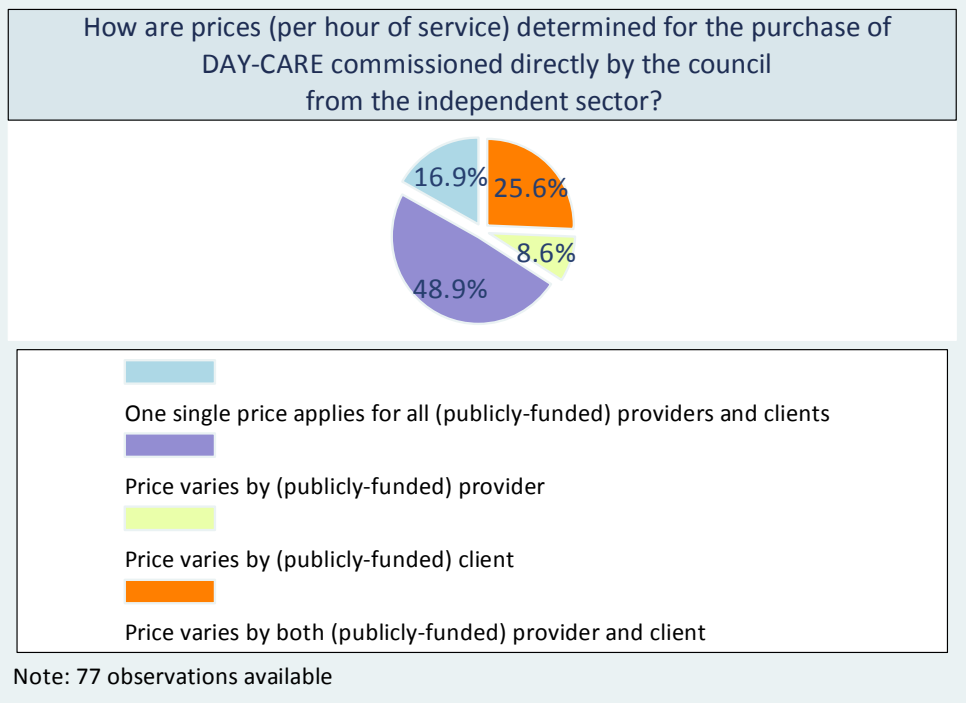
As for home-care, a frequent factor influencing variations in price between residential care providers was the type of contract adopted. Service quality was quoted as a factor linked to variations in price much more frequently for residential care than for home care.

Figure 46



By far the most common factor linked to variations in price by resident was the specific needs of the resident followed by the nature of the service and facilities provided.

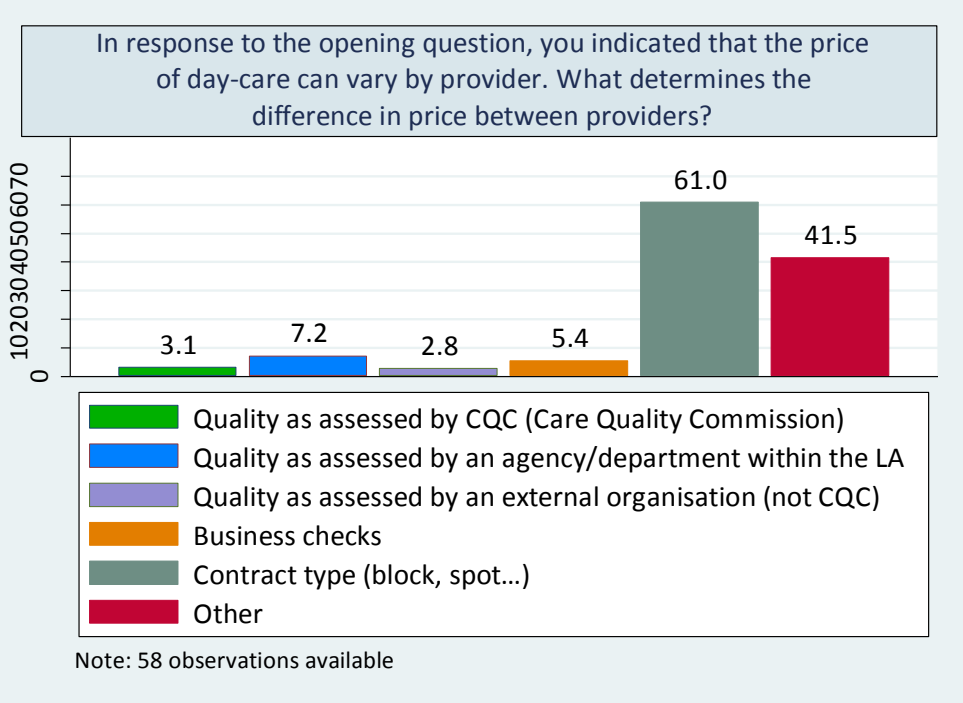
Figure 47



Note: 77 observations available

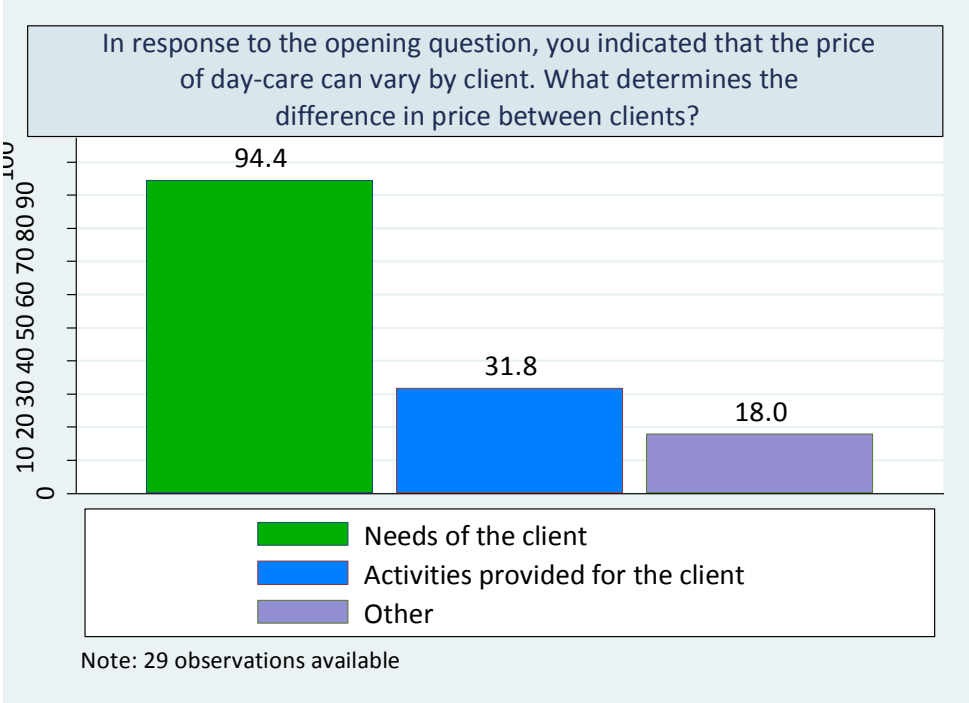
Almost half of local authorities declared that day-care prices varied only by provider while prices varied in one of four local authorities by provider and client.

Figure 48



Variations in day-care prices by providers were frequently linked to contract type and rarely to differences in quality.

Figure 49



Almost all local authorities that varied day-care prices between clients did so on the basis of client needs and approximately one-third on the basis of the activities provided.

Quality and monitoring

Contract monitoring

We tried to establish whether local authorities performed any follow-up monitoring of contracts with the independent sector with a frequency of at least 6 months in order to ascertain the level of control over the quality of services commissioned.

Figure 50 indicates that fewer than 30% of authorities in the sample monitored or followed-up 80% or more of their contracts with residential care providers at least every six months. Approximately one in five authorities monitored fewer than 20% of contracts with residential care providers on at least a six-monthly basis.

Figure 50

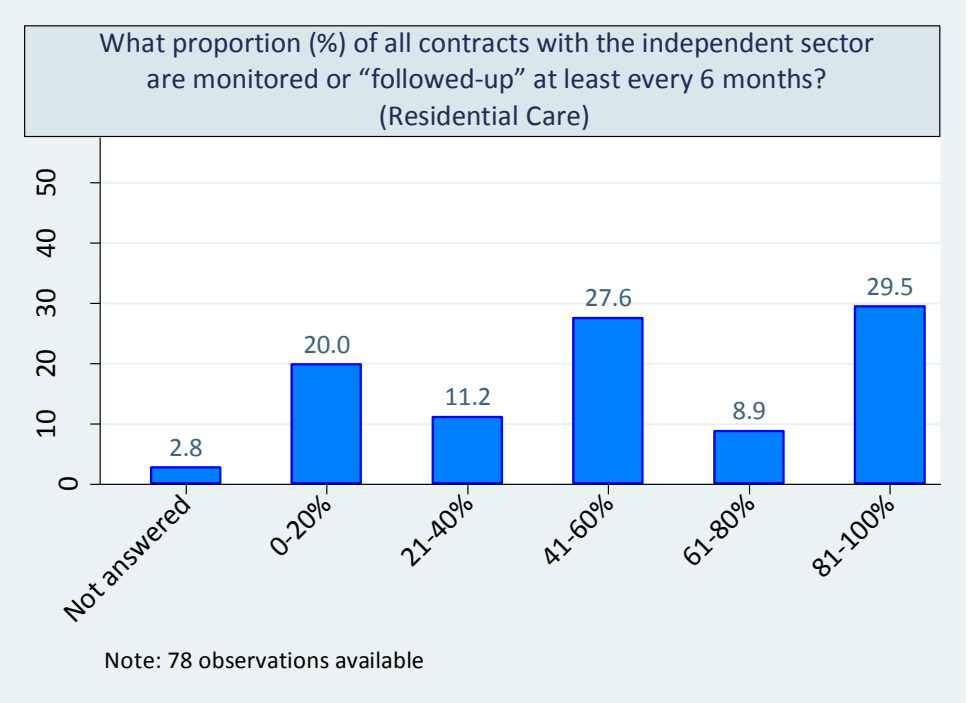
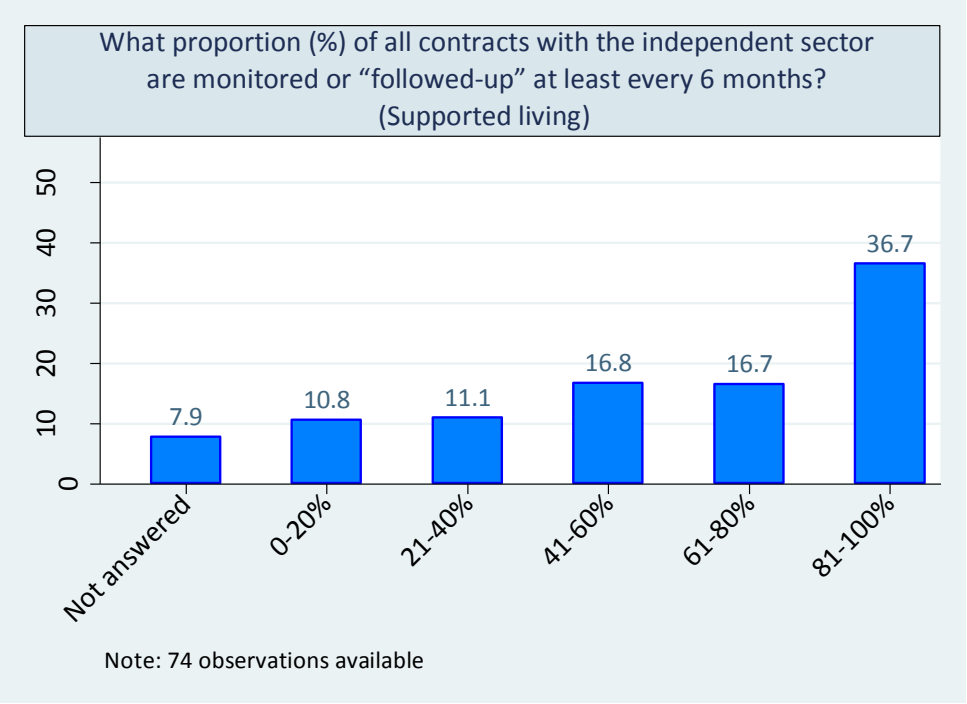


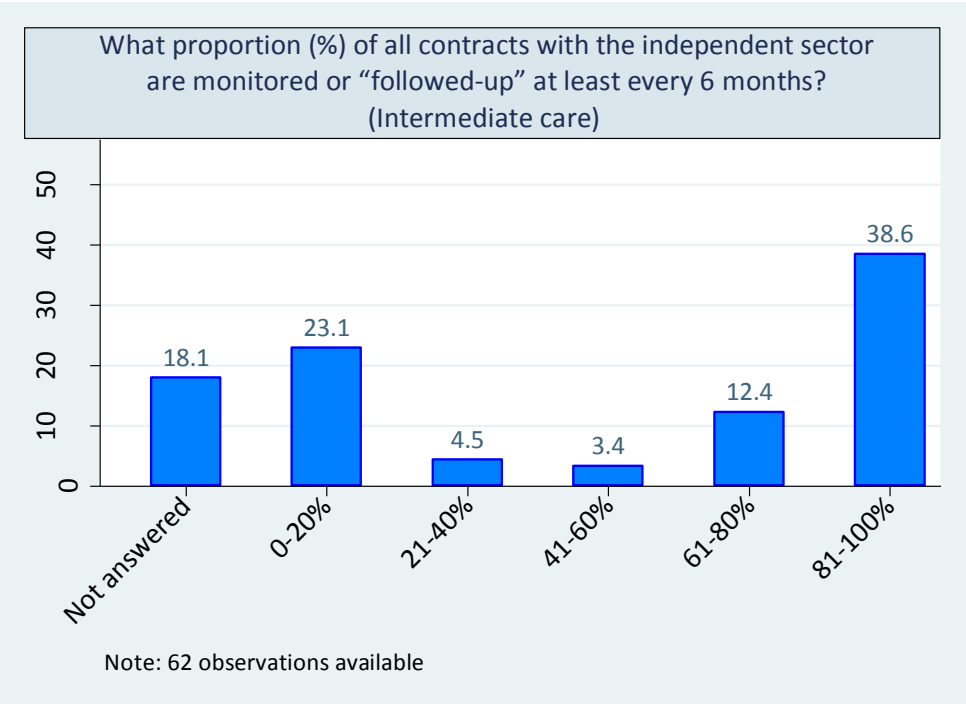
Figure 51



Approximately 37% of local authorities performed a six monthly follow-up for at least 80 per cent of contracts for supported living services (see Figure 51). Approximately 39% of local authorities monitored between 81 to 100% of the intermediate care contracts with the independent sector. In

contrast, about one quarter of local authorities performed those controls for fewer than 20% of the contracts (see Figure 52).

Figure 52



The majority of authorities monitored home care contracts on a six monthly basis. One in 10 authorities monitored less than 20% of home care contracts at least every six months.

Figure 53

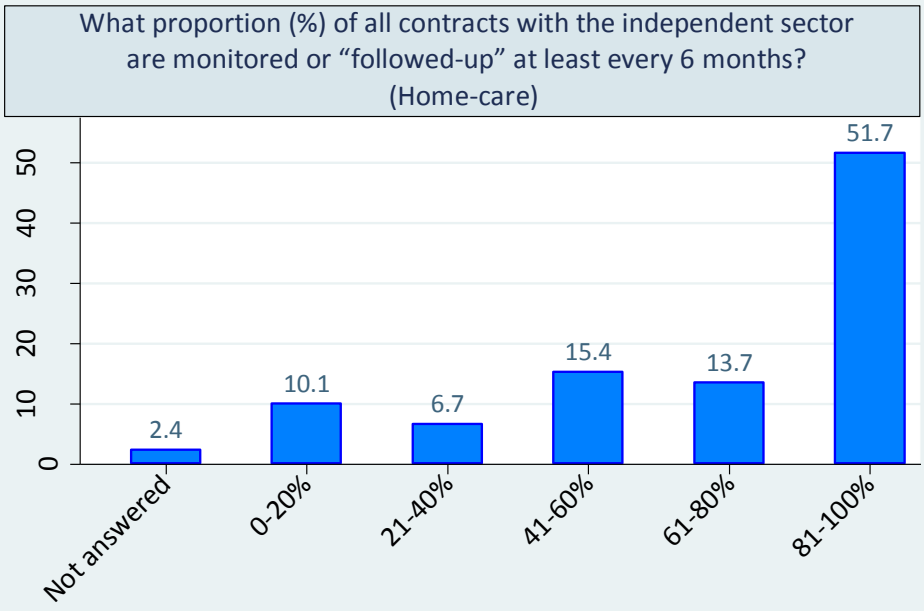


Figure 54

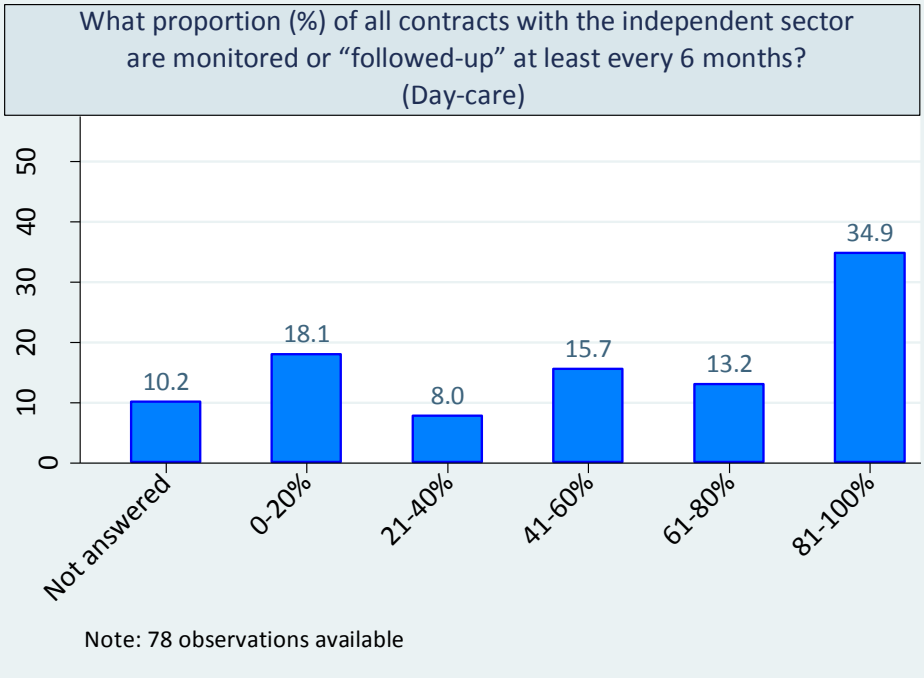
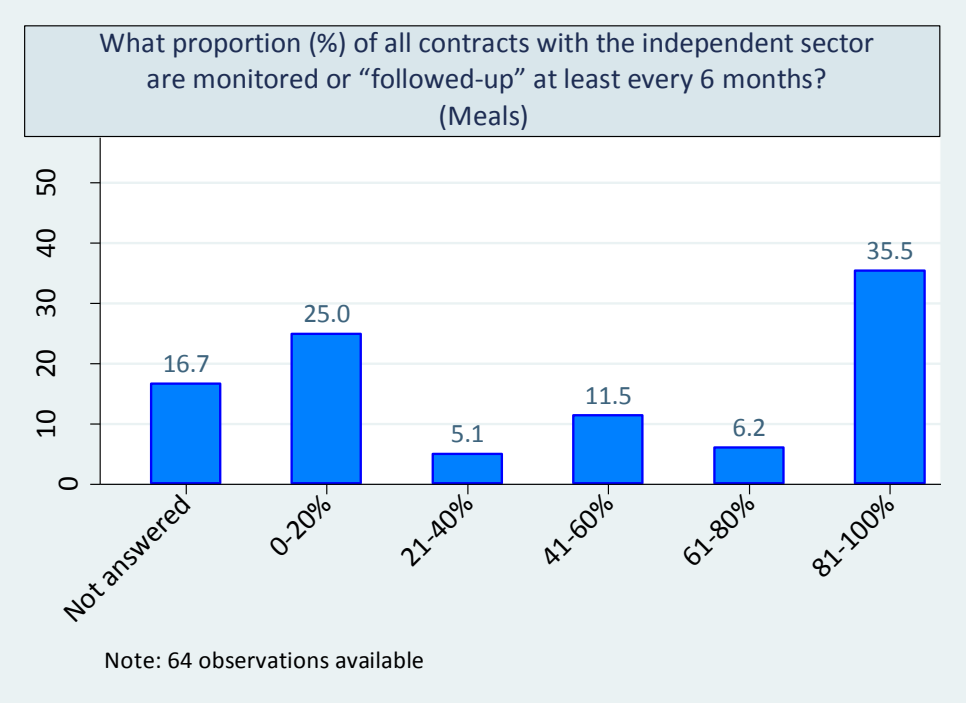
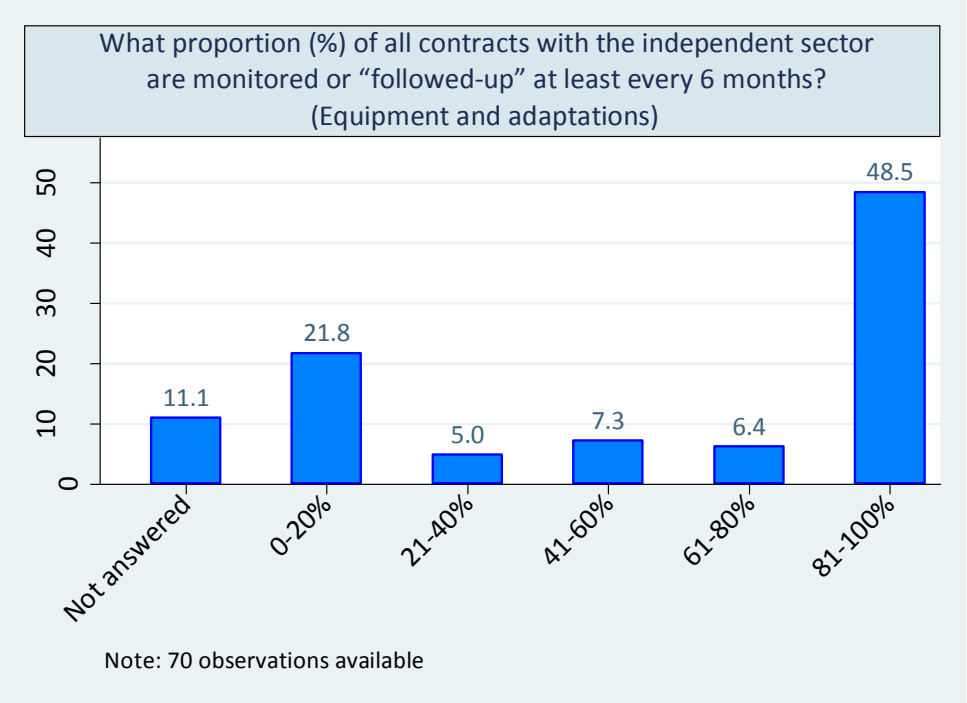


Figure 55



Figures 54 and 55 show similar patterns for day care and meals with around 35% of authorities monitoring in excess of 80% of contracts every six months while one in four or less monitor fewer than 20% of contracts.

Figure 56



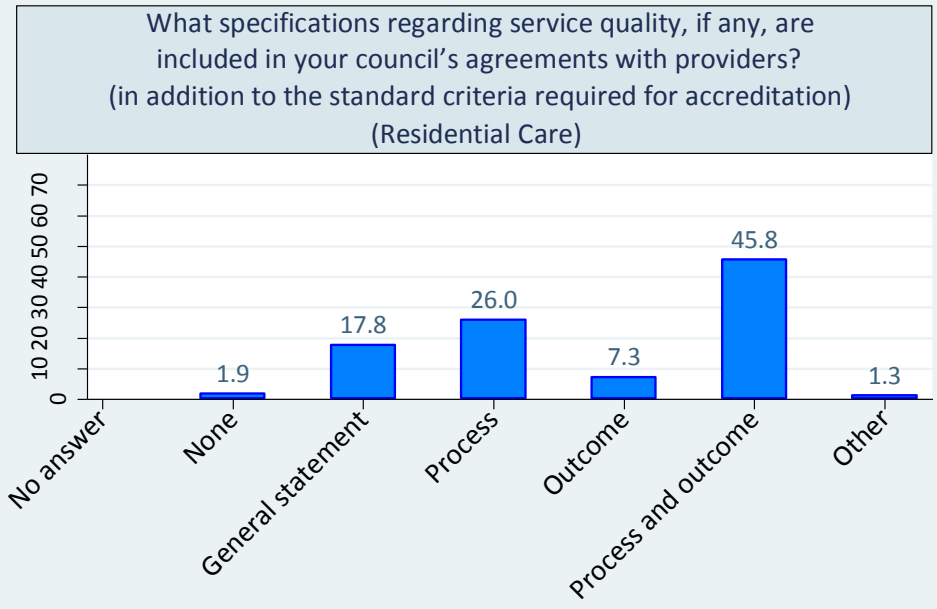
Almost half of local authorities in the sample followed up 81 to 100% of the contracts for equipment and adaptations with the independent sector. Approximately 22% of authorities did so for fewer than 20% of contracts.

Quality specifications in service agreements with providers

The survey enquired about service quality specifications (in addition to the standard criteria required for accreditation) that authorities might include in their agreements with providers. Again, this question was repeated for the different service types covered in the survey (see Figures 57 to 63).

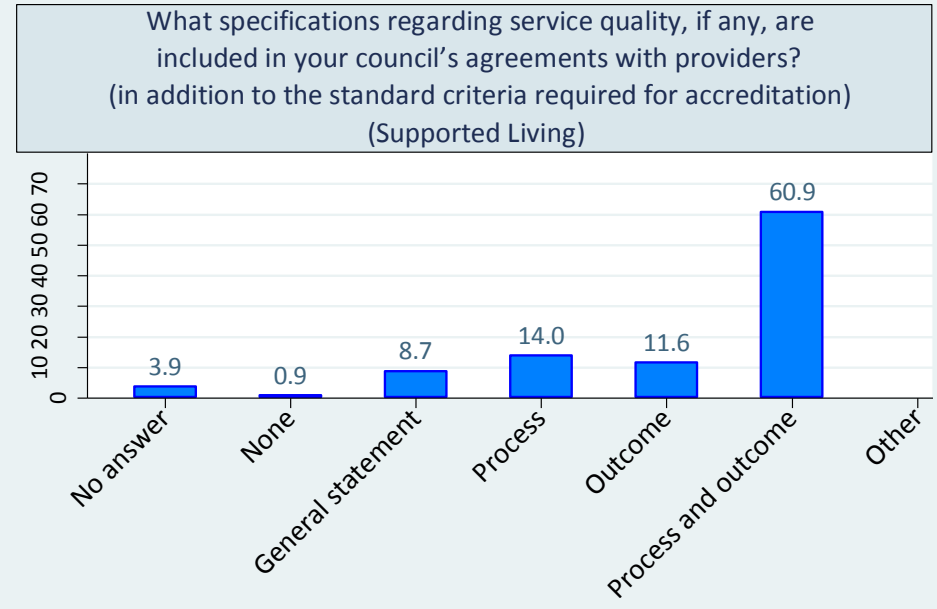
Across all services, the most prevalent type of quality specification included in service agreements with providers related jointly to aspects of outcome and process of the service. Almost all authorities included some additional quality specification in the agreements with their providers regardless of the service type. Process related specifications were most frequently mentioned with regards to meals on wheels.

Figure 57



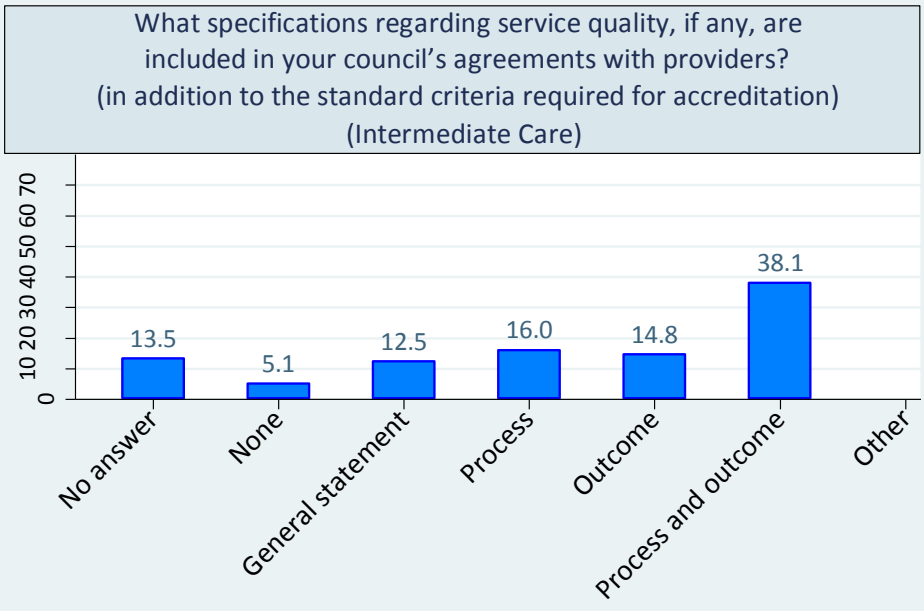
Note: 78 observations available

Figure 58



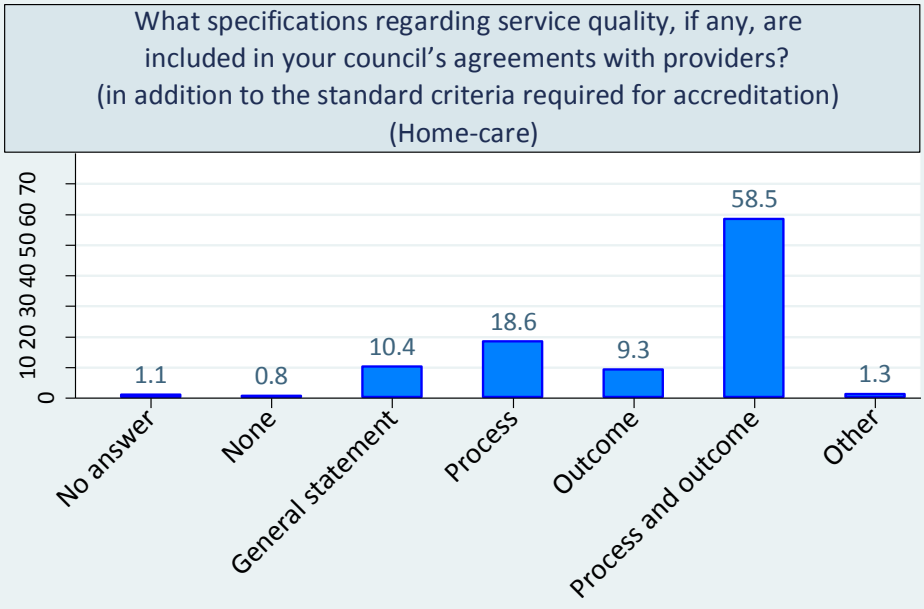
Note: 74 observations available

Figure 59



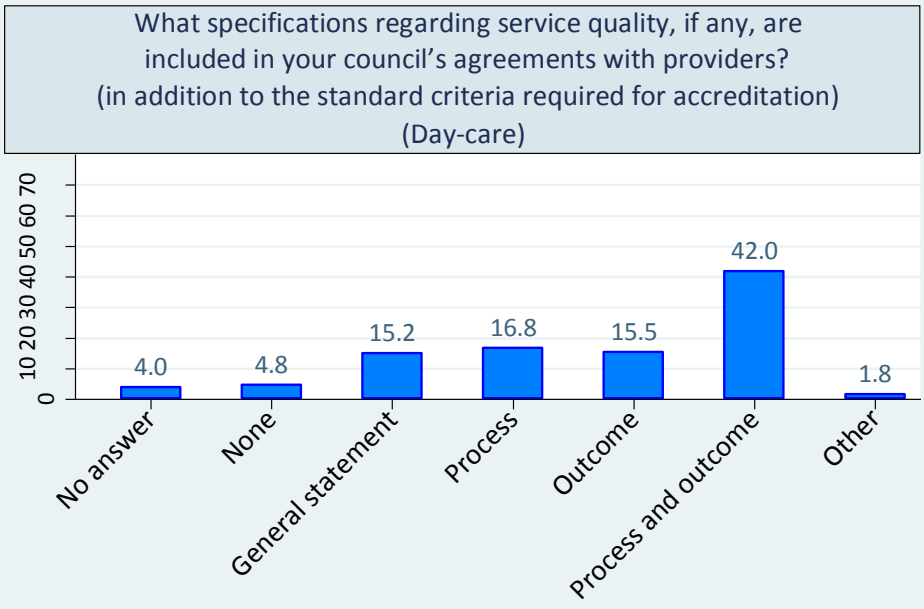
Note: 62 observations available

Figure 60



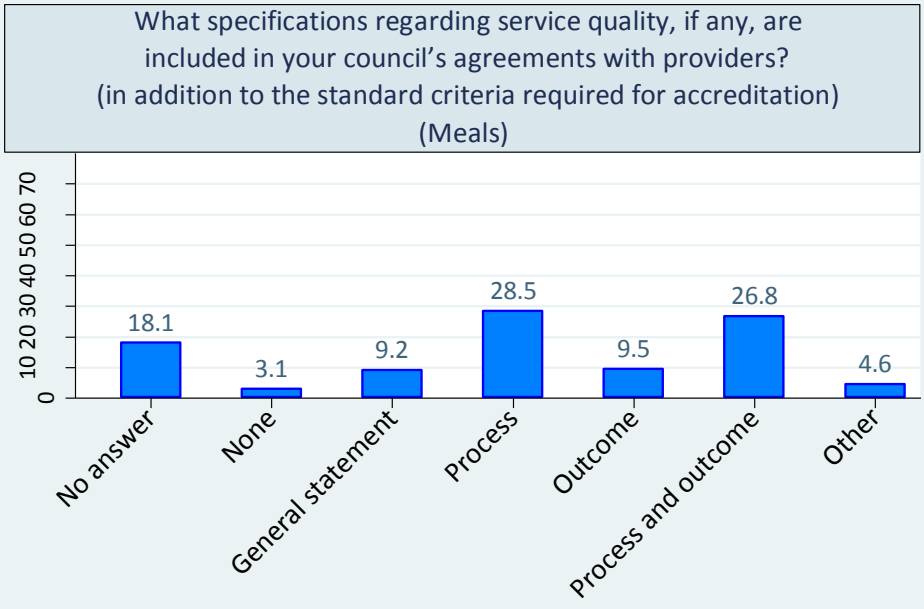
Note: 78 observations available

Figure 61



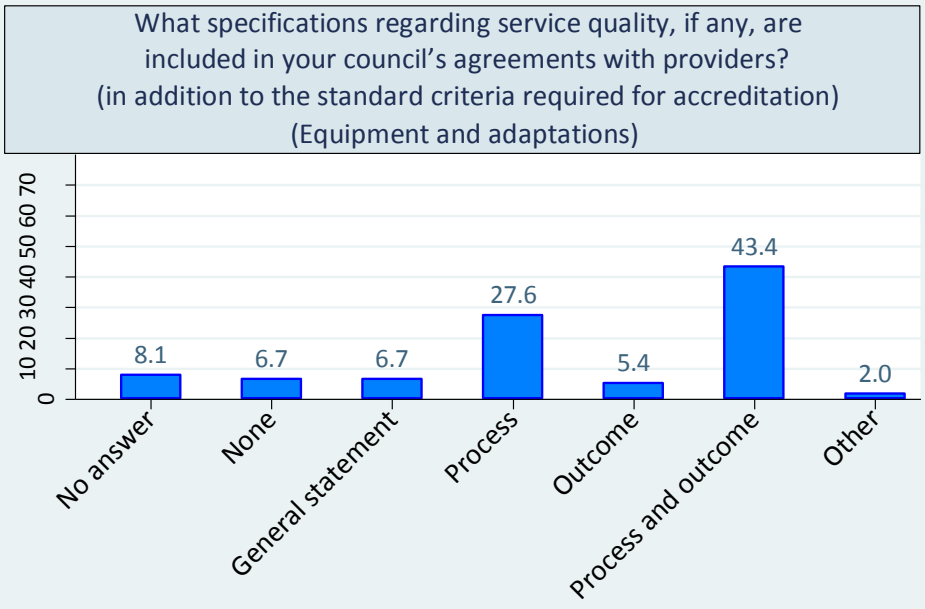
Note: 78 observations available

Figure 62



Note: 64 observations available

Figure 63

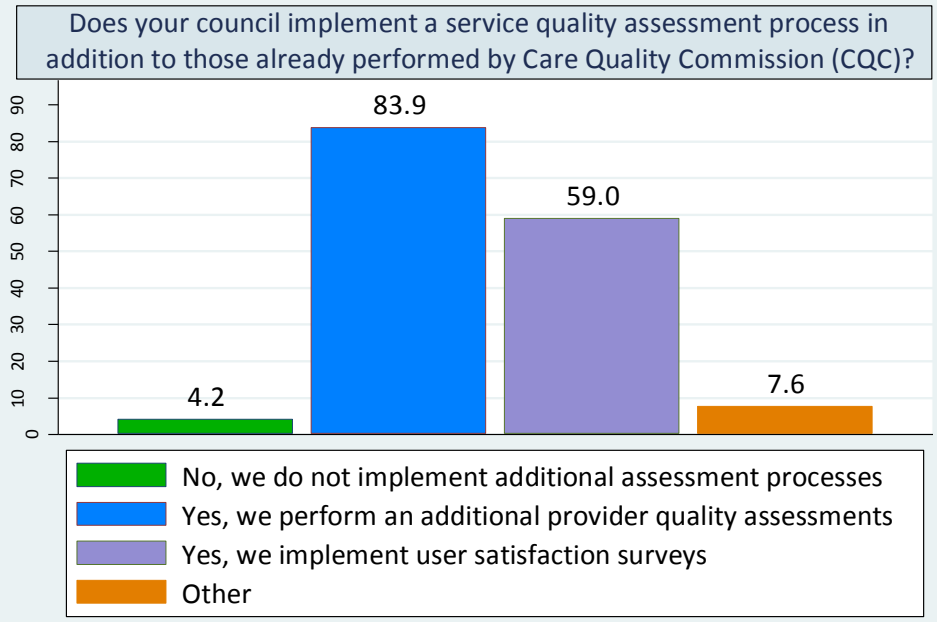


Note: 70 observations available

Service quality assessment processes

Approximately 85% of the weighted study sample stated that they implemented service quality assessments in addition to those performed by CQC. A significant 59% of authorities performed quality controls based on user satisfaction surveys. Only 4.2% of authorities did not implement additional quality assessments (see Figure 64).

Figure 64



Note: 77 observations available

Figure 65

Note: 78 observations available

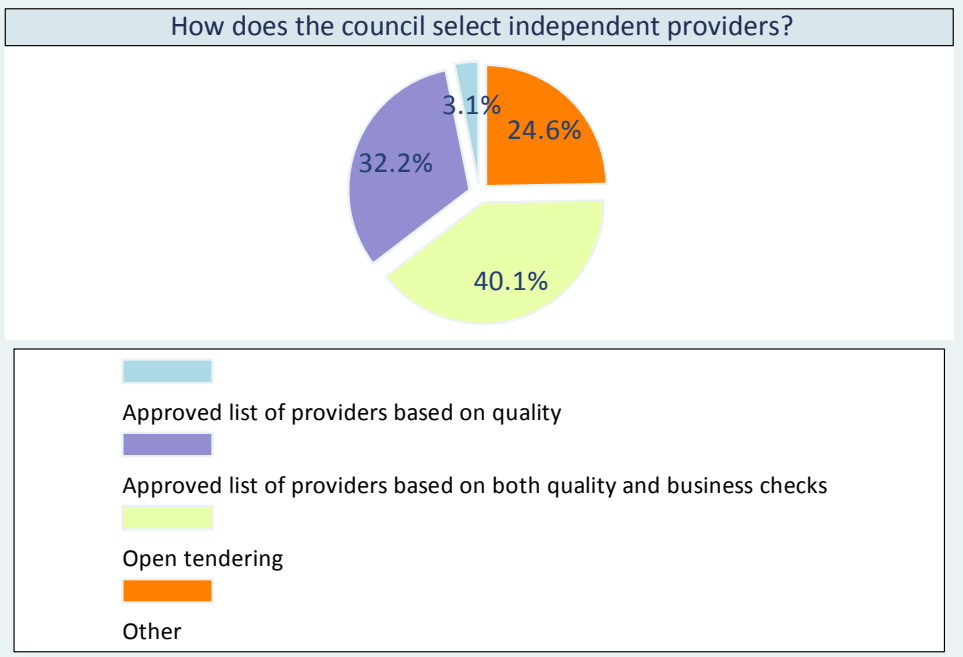
The vast majority of local authorities (89%) performed quality and costs reviews to evaluate the presence and quality of services present in the area in order to inform their strategic service commissioning process.

Providers

Selecting providers

Figure 66 suggests that 40% of local authorities in the sample selected the independent providers they worked with on the basis of open tendering, and 32% established a list of providers based on both quality and business checks.

Figure 66

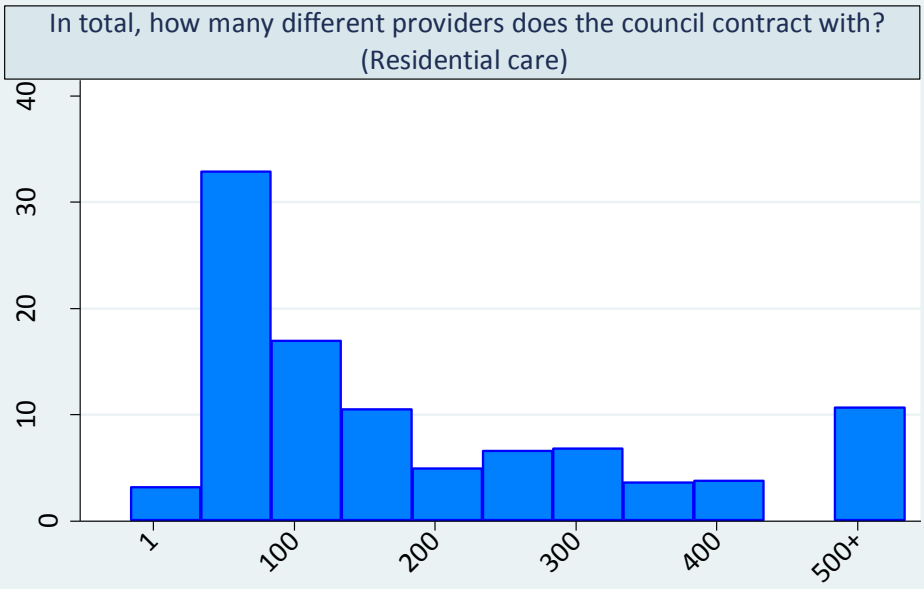


Note: 78 observations available

Number of providers

The survey enquired about the number of providers for different types of services commissioned by local authorities in England in order to ascertain the degree of local supply choice and competition.

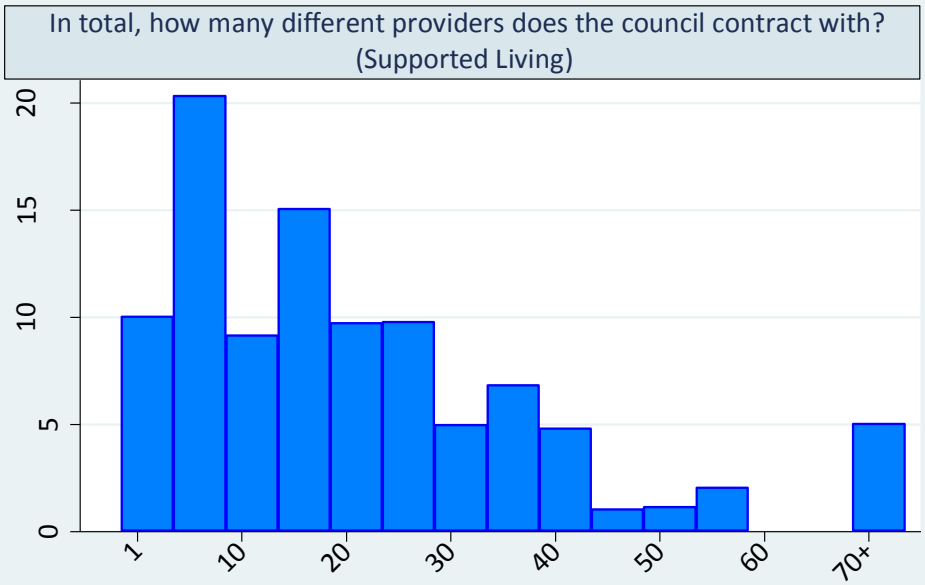
Figure 67



Note: 71 observations reporting a positive and non-missing value.
Mean value=203 and median value=126.

Figure 67 suggests a very high degree of variability in the number of residential care providers contracted by local authorities in England. Typically, local authorities appeared to contract with 100 or less residential care providers. However, one in 10 authorities appears to deal with over 500 providers.

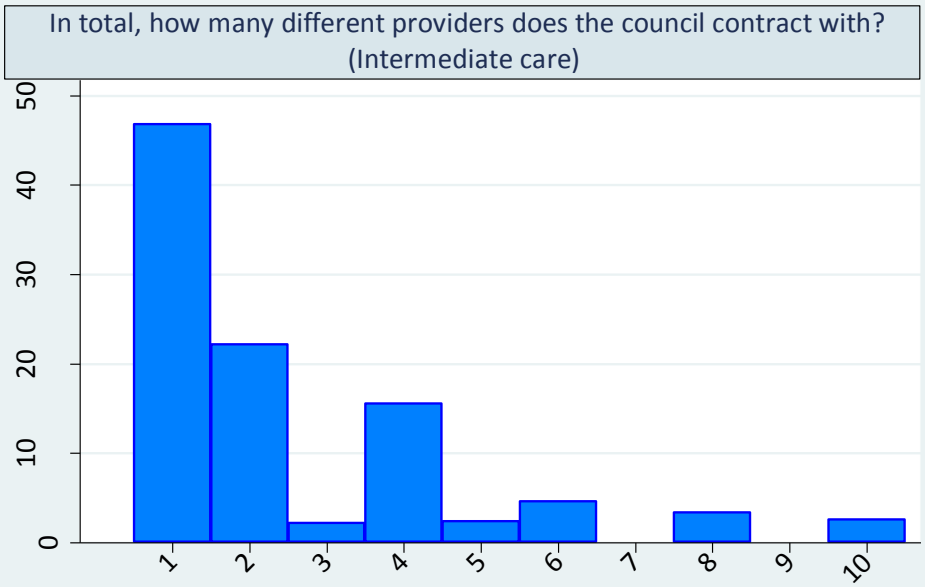
Figure 68



Note: 63 observations reporting a positive and non-missing value.
Mean value=21 and median value=17.

Not surprisingly, the number of supported living providers contracted by local authorities is much lower than for residential care services. Typically, local authorities contracted with between five and 20 providers.

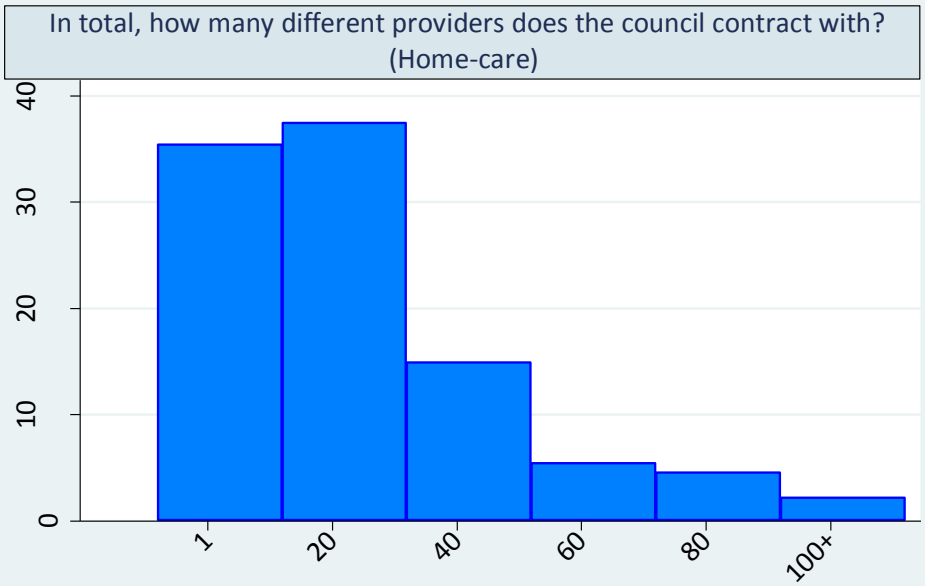
Figure 69



Note: 39 observations reporting a positive and non-missing value.
Mean value=3 and median value=2.

The number of intermediate care providers used by local authorities was even smaller and typically involved either one or two providers of the service (see Figure 69). Many local authorities seemed to provide this service in-house.

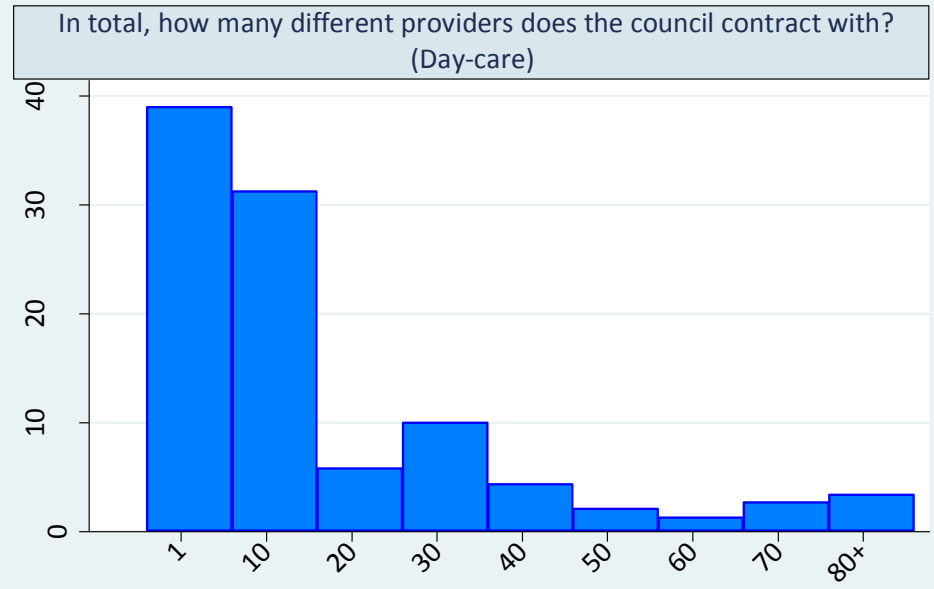
Figure 70



Note: 72 observations reporting a positive and non-missing value.
Mean value=28 and median value=20.

Although not reaching the numbers of residential care, local authorities appear to contract with a significant number of home care providers. The results in Figure 70 again suggest significant variability in the number of providers used by local authorities in England.

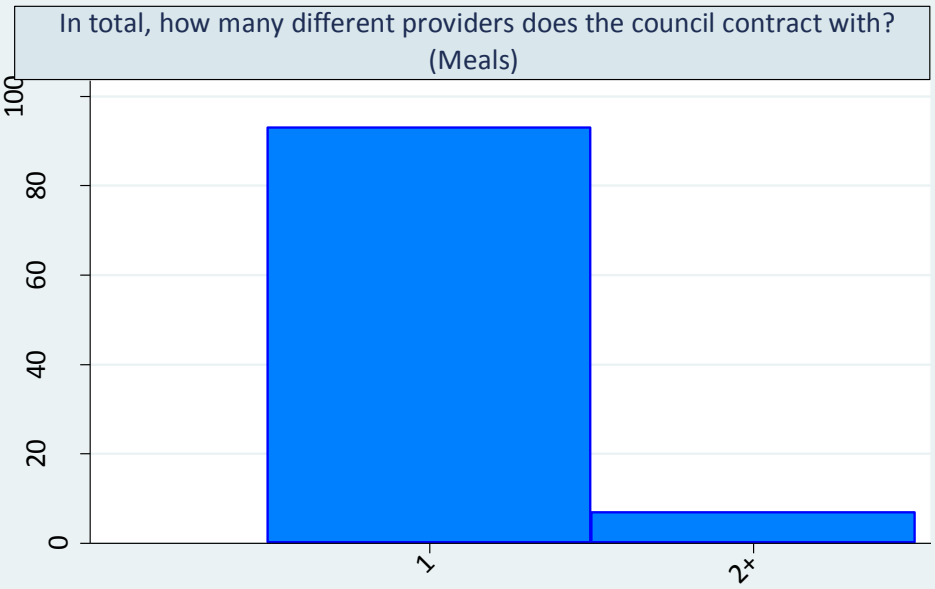
Figure 71



Note: 66 observations reporting a positive and non-missing value.
Mean value=17 and median value=7.

Typically, local authorities in the survey held contracts with 10 or fewer day care suppliers.

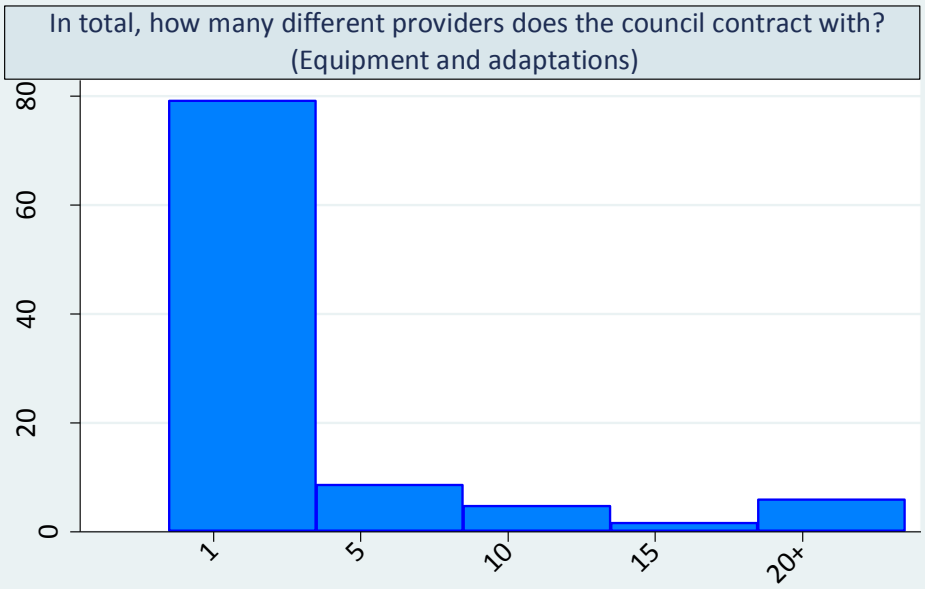
Figure 72



Note: 48 observations reporting a positive and non-missing value.
Mean value=1 and median value=1.

More than 90% of local authorities in the sample dealt with one single provider of meals on wheels. Figure 73 shows that a similar situation holds for equipment and adaptations, although some exceptions exist.

Figure 73



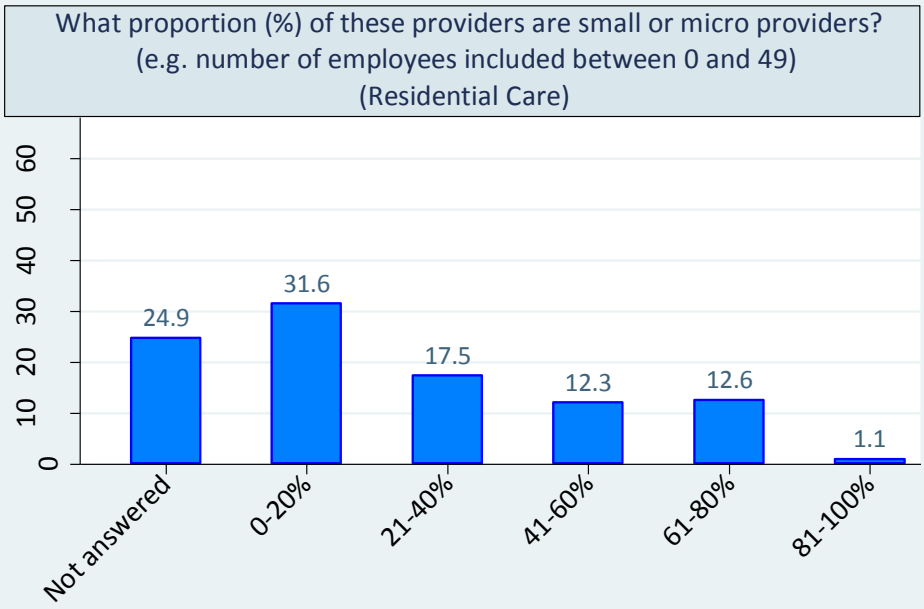
Note: 53 observations reporting a positive and non-missing value.
Mean value=5 and median value=1.

Micro providers

In addition to information about their numbers, the survey enquired about the size of service providers and the proportion of them that could be defined as small or micro providers (defined as having fewer than 50 employees) in particular. A significant proportion of local authorities in the survey struggled to provide information about the proportion of micro providers in their area.

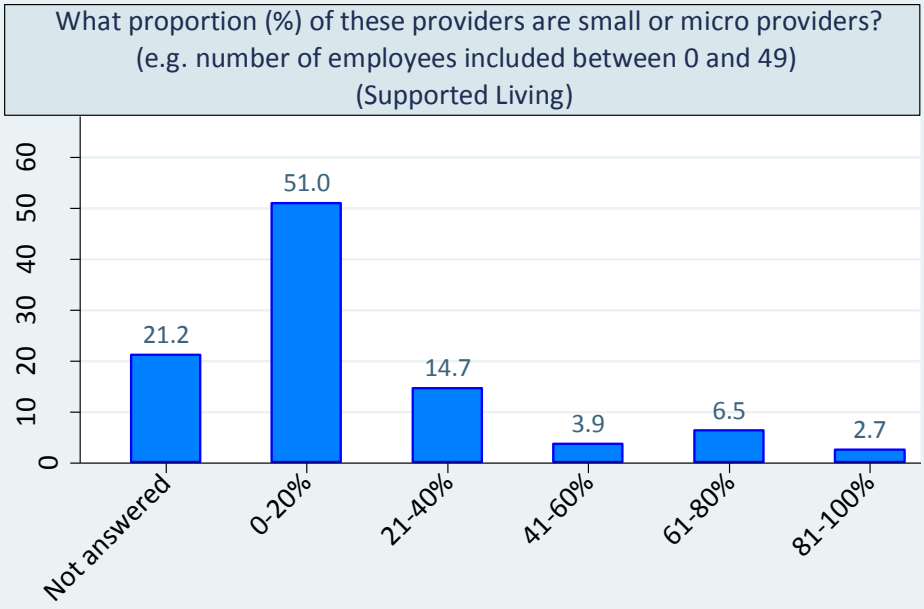
Approximately 31% of authorities in the sample suggested that micro providers constituted fewer than 20% of the total number of providers of local authority-commissioned residential care services while a similar distribution have been found in day care. This proportion increased to (or considerably exceeded) one half of authorities regarding the other services explored in the survey (see Figure 74 to Figure 80).

Figure 74



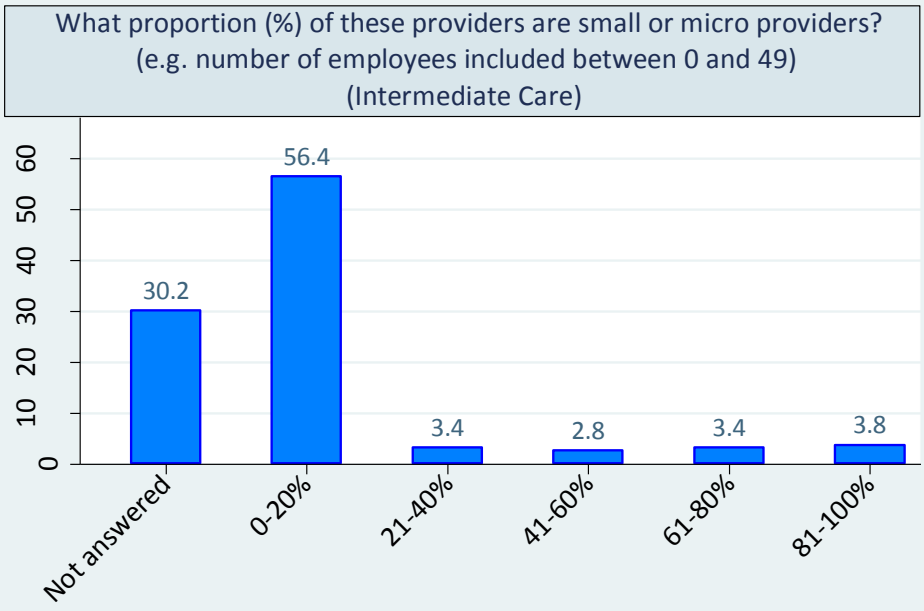
Note: 78 observations available

Figure 75



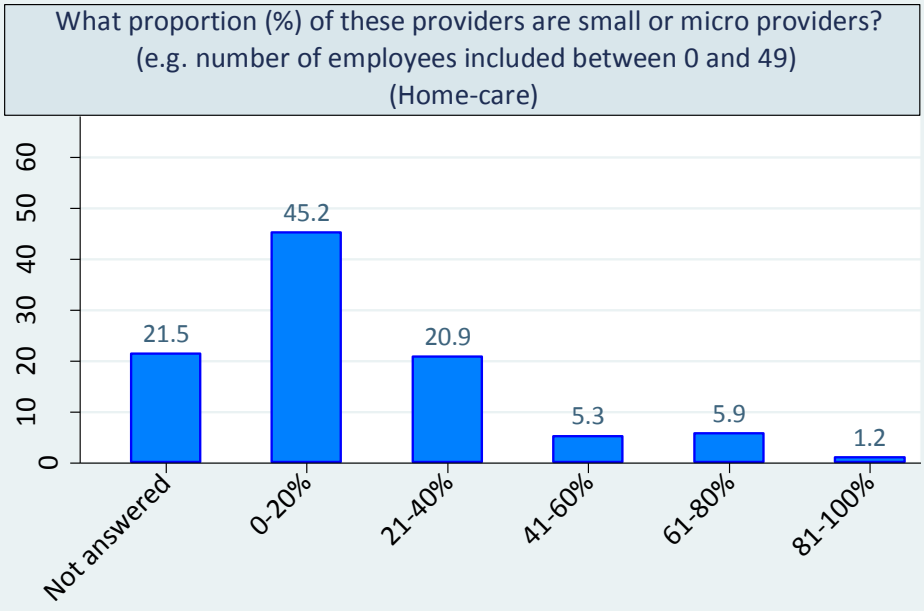
Note: 74 observations available

Figure 76



Note: 62 observations available

Figure 77



Note: 78 observations available

Figure 78

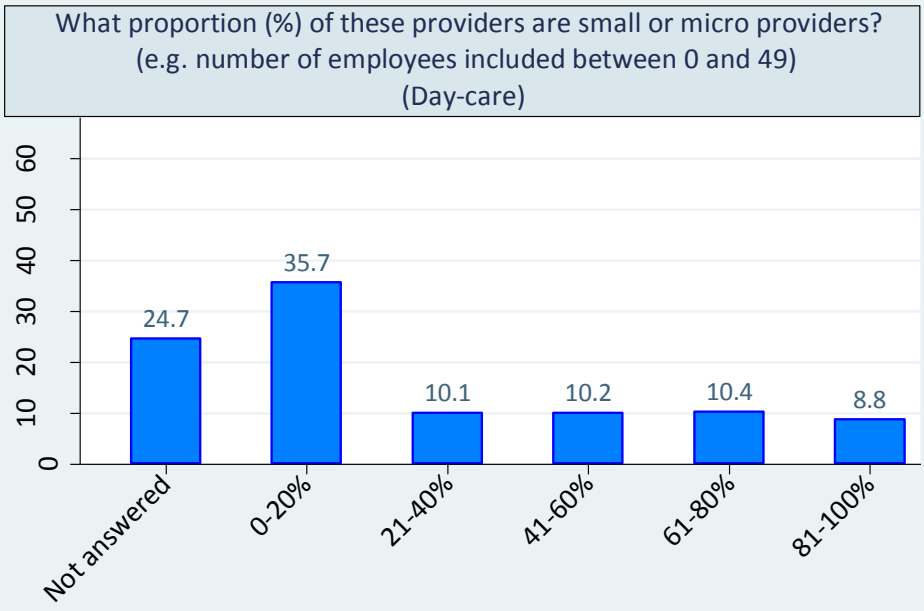


Figure 79

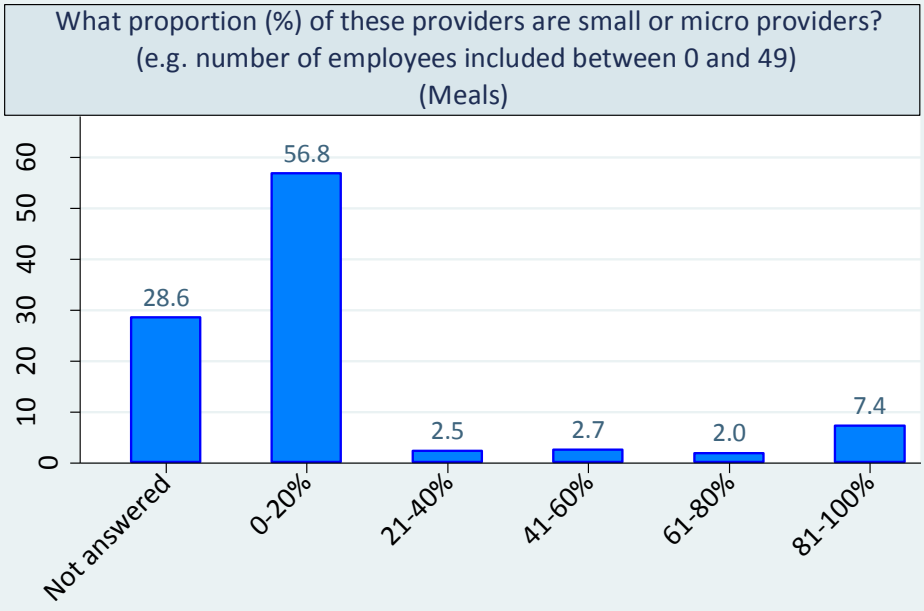
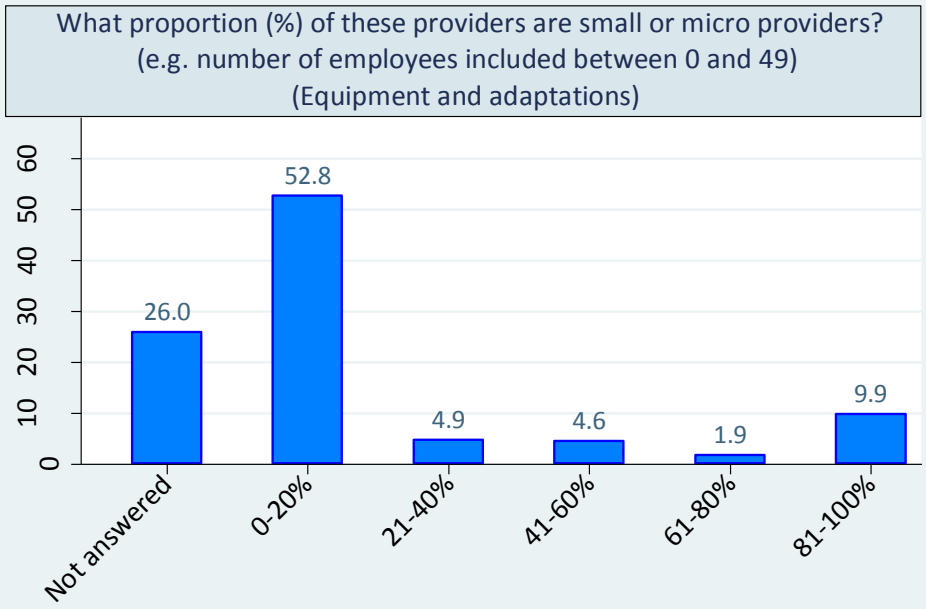


Figure 80



Note: 70 observations available

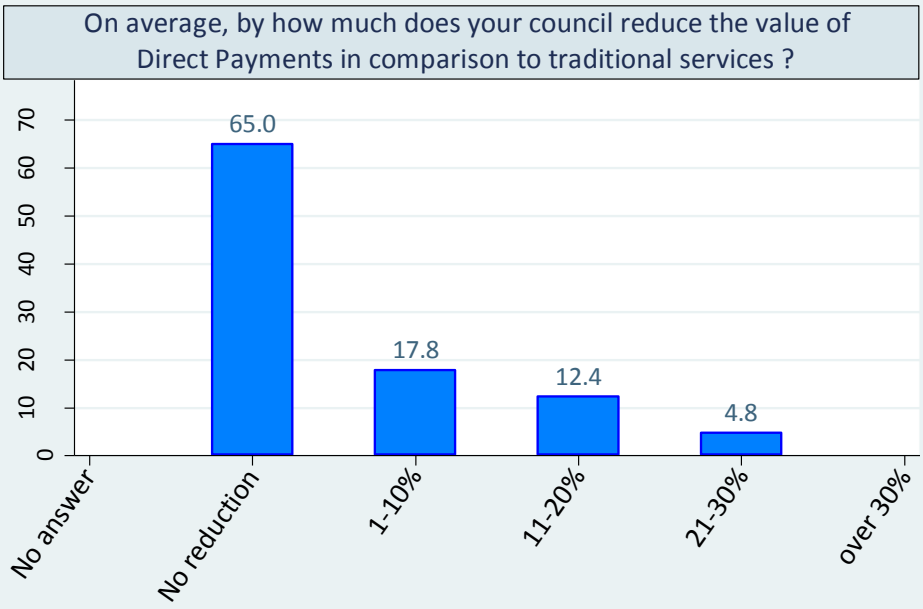
Direct Payments and Personal Budgets

Resource and commissioning arrangements for personalised services

In view of the very significant implications that the "personalisation" of social care could have on the way services are commissioned and on the outcomes of the system, the survey included a series of questions about the way in which local authorities implement new "personalised" types of support for social care users.

The first such question explored whether local authorities reduced direct payment levels (relative to the cost of the standard care package for the same needs) in order to reflect the potential for savings that users of direct payments might be able to exploit by using alternative supply sources for their care. Overall, approximately 65% of authorities in the sample stated that they did not reduce the levels of resources allocated to individuals when those received their care through direct payments. Figure 81 suggests that 18% of authorities reduced direct payment levels, but by less than 10%, and that 12% of authorities reduced the value of the direct payment between 10 and 20% of the cost of the standard package. No local authorities declared to reduce the resources allocated to individuals of more than 30%.

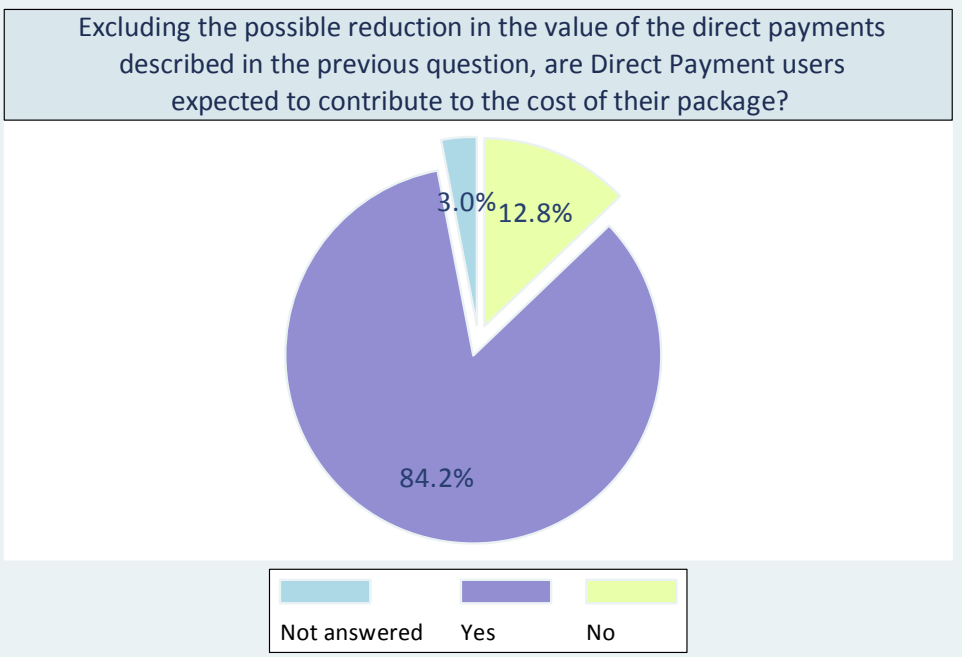
Figure 81



Note: 78 observations available

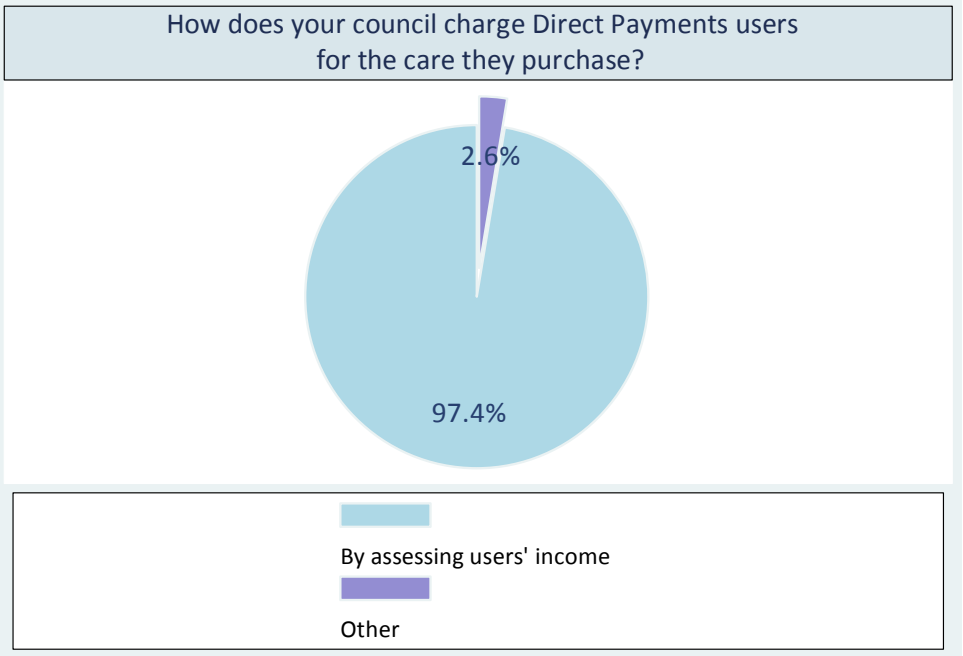
A very large majority of authorities (84 per cent of the sample) indicated that service users would be expected to contribute financially to the cost of their direct payments (see Figure 82). Furthermore, Figure 83 indicates that in practically every authority, the user's financial contributions to the direct payments package would follow the traditional assessment of the user's income and assets. No authorities stated they were applying a flat user contribution to the cost of direct payments.

Figure 82



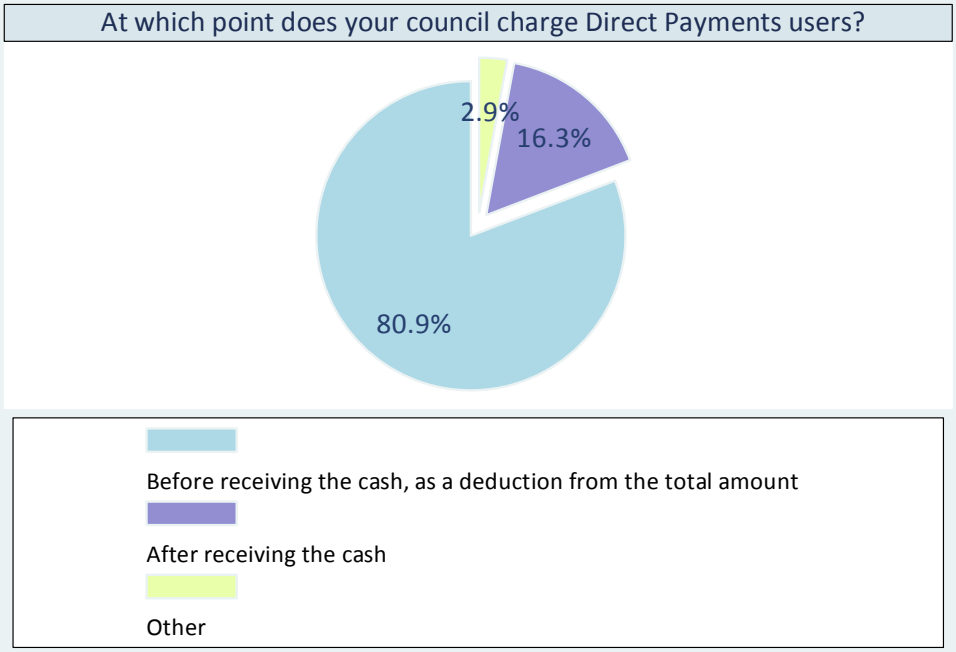
Note: 78 observations available

Figure 83



Note: 65 observations available

Figure 84

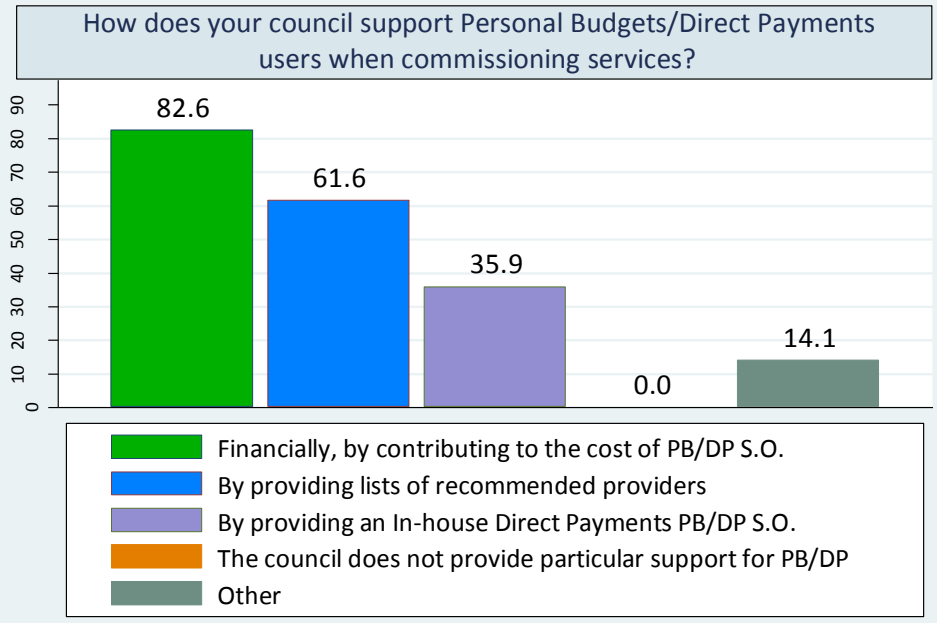


Note: 65 observations available

In a large majority of authorities, direct payment users paid their contributions as a deduction to the total amount received from the local authority, rather than after receiving the payment.

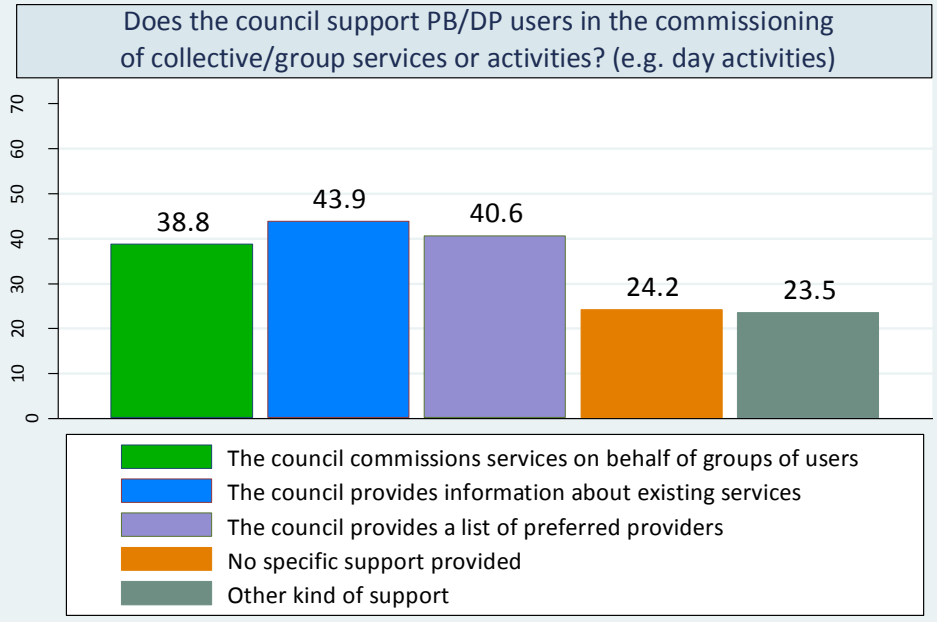
All the authorities in the sample stated to be supporting personal budgets/direct payments in their role as service commissioners. The majority of authorities (83%) provided financial contributions to the cost of support organisations; 62% of authorities provided a list of recommended providers and 36% provided access to an in-house direct payments support organisation.

Figure 85



Note: 76 observations available

Figure 86

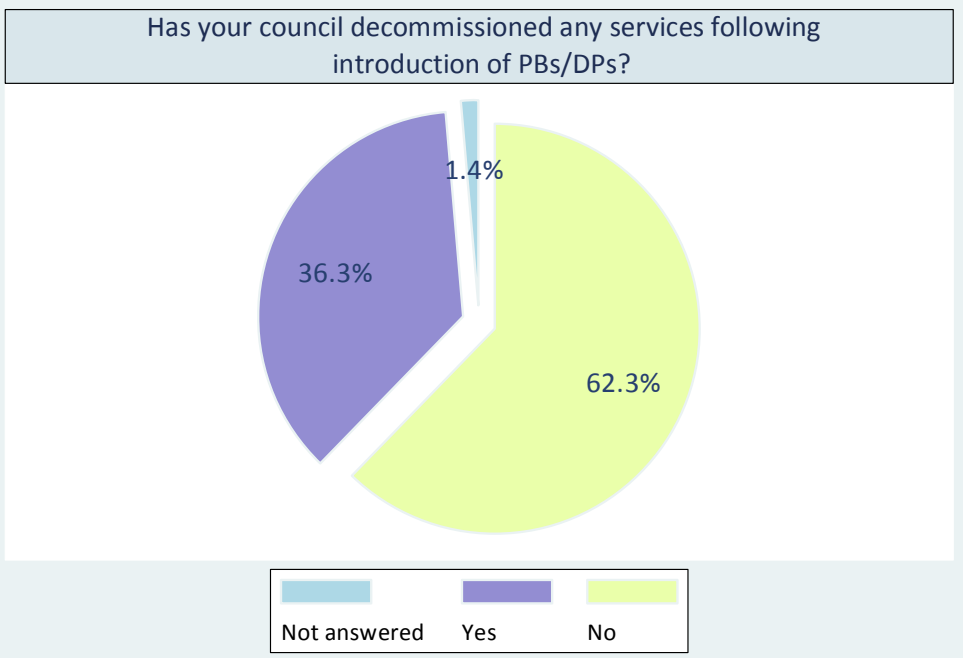


Note: 76 observations available

One of the areas where market failures could arise when individuals commission their own care is the purchase of collective services (e.g. dance classes). Approximately 39% of authorities stated that they commissioned services on behalf of groups of users, 44% of authorities stated that they

provided information about existing services, and 41% stated that they provided a list of preferred providers for such services. Overall, 24% of authorities stated not to be providing specific support for the commissioning of collective services.

Figure 87



Note: 78 observations available

Although a majority of local authorities stated that no decommissioning of services had occurred as a result of the introduction of direct payments/personal budgets, it is worth noting that this did happen in 36% of authorities in the study (see Figure 87).

Resource allocation

The questionnaire included a set of questions regarding the processes used by local authorities to determine the levels of resources allocated to different users. The survey enquired about alternative arrangements for different support mechanisms including care managed services, hybrid budgets, indirect payments and direct payments. Local authorities were allowed to select more than one option per question.

Figure 88

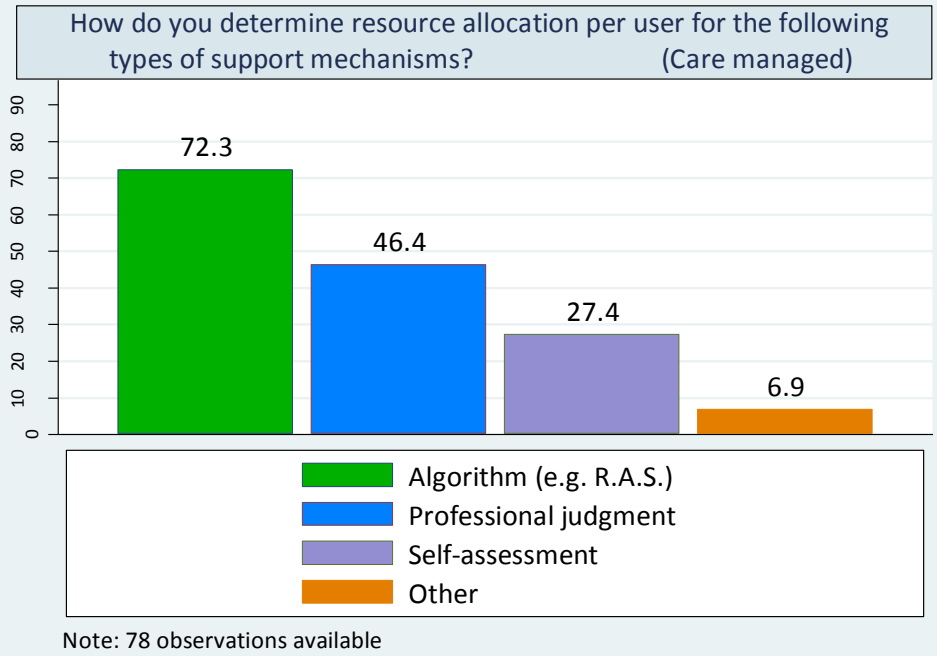
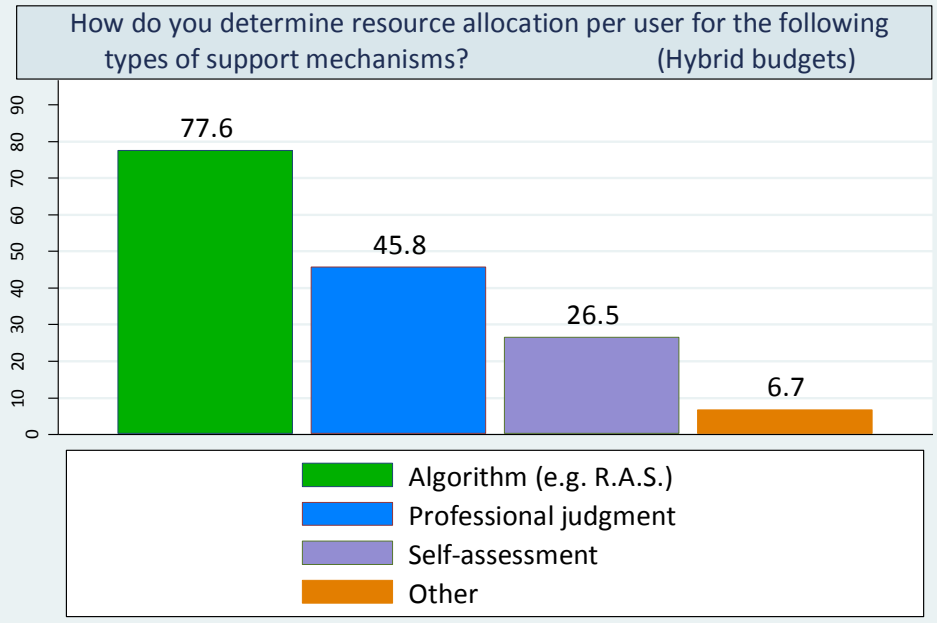


Figure 88 suggests that approximately three quarters of local authorities used algorithms to determine the levels of care managed resources at the individual client level. In addition, almost half of authorities indicated that professional judgement was part of the allocation process, and 27% of authorities used self-assessment tools.

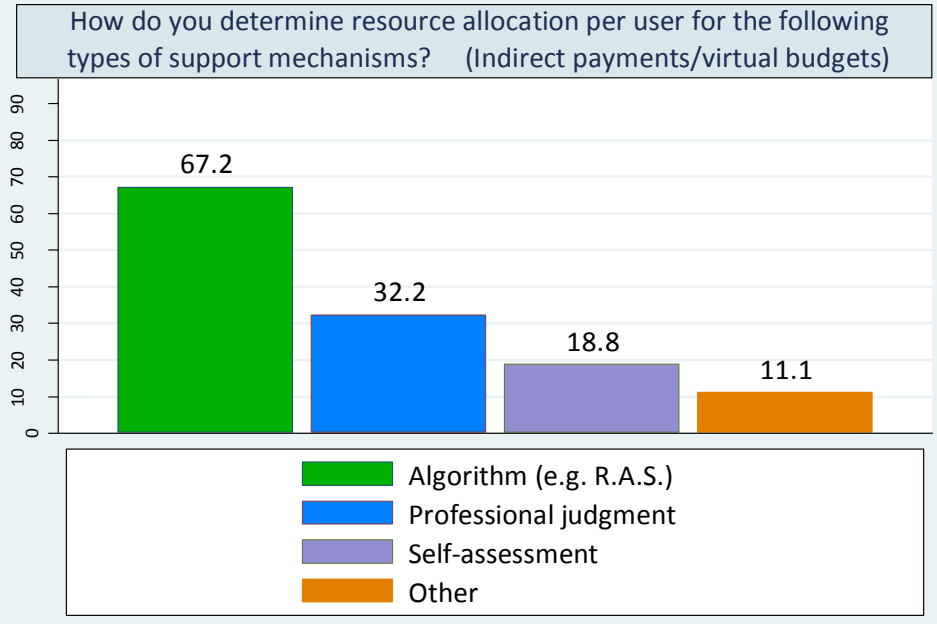
The relevance of the different mechanisms for allocating resources did not appear to vary significantly depending on the support mechanism used (see Figures 89 to 91).

Figure 89



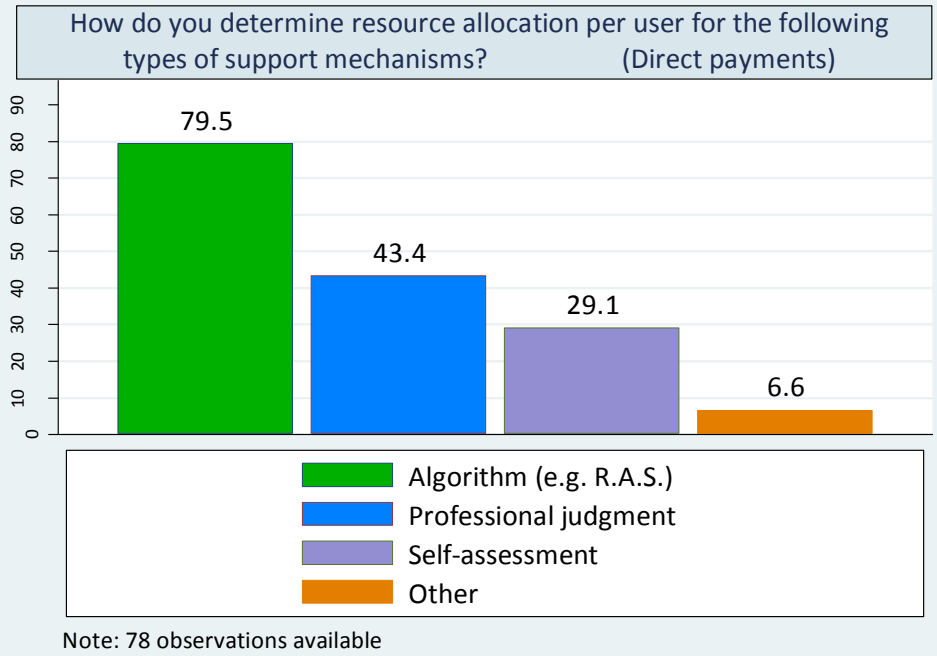
Note: 78 observations available

Figure 90



Note: 78 observations available

Figure 91



Note: 78 observations available

Discussion

This study provides a wide range of information open for discussion. In order to give a more interesting perspective to the interpretation of the results, we compare, where possible, its findings with the results of the 2001 study. However, it is worth noting that the samples of councils included in the two studies are not necessarily comparable.

Characteristics of commissioning: Commissioning characteristics have changed dramatically during this decade. For instance, purchasing power seems to have been devolved to lower levels, as most councils state that key budgets are held by purchasing team managers or by care managers. In 2001, most councils (up to 80%) reported that the LA/SSD level or purchasing team manager was the key-budget holder; however, in 2011, the percentage of local authorities that assigned key-budgets to care managers appeared to be over 30% with variations depending on the service considered[3].

Sharing commissioning responsibilities is very frequent, as most local authorities declared in 2011 to have implemented joint commissioning and budget pooling strategies, and in particular with the NHS. This approach seems to be positively in line with the increased emphasis on the joint commissioning of health and social care services. Local authorities also showed a tendency to coordinate their commissioning of social care services with other internal services such as housing,

[3] In the 2001 version, councils were asked about the key-budget holder while in the 2011 study we allow the respondent to select more than one holder.

transport or leisure. Instead, external commissioning coordination seems to be common with voluntary organizations and with other (probably neighbouring) councils. Finally, budget pooling, a more direct version of integration, seems a quite infrequent phenomenon, in general, with the exception of the NHS (option ticked by 64% of councils).

Commissioning to the independent sector: After two decades in which reforms to social care provision have increased its level of externalization, it is necessary to investigate the level of market share reached by independent providers. The survey results suggest that most of the services directly commissioned by local authorities nowadays appear to be directly supplied by independent providers with the exception of intermediate care and day-care services, for which the situation is more balanced and variable by council.

Furthermore, the survey suggests that commissioning independent or in-house providers implies different processes for 65% of councils. However, in 2001 only a percentage varying between 30% (for residential care) and 42% (for domiciliary care) of the responding authorities suggested the existence of a difference between the two cases. However, while in the current study only 7% of councils admitted the existence of an explicit policy, and that the differences in processes were based on an explicitly stated policy (with 88% stating that the difference is based on a de-facto practice), in 2001 this option was selected by more than half of the sample[4]. The drop in such explicit policy statements is consistent with the opening of the market to the independent sector.

Contracts type: Some services, such as residential care and home-care, are more often provided under a spot contract. A similar proportion of spot and block contracts are instead observed for supported living, day-care services and equipment and adaptations, while a combination of block, cost and volume and spot contracts characterizes the provision of meals on wheels. Instead, block contracts prevail in intermediate care. Among the "other" contract-types, not included in the main options, local authorities often specified making use of framework agreements.

Results are similar to what was found in 2001 where, for external provision, spot contracts where the more common form for residential, nursing and domiciliary care followed by block contracts and cost-volumes. Regarding in-house provision, block contracts were the most prevalent option in 2001.

In 2011, block-contract use appeared to be variable with some authorities not using block contracts at all and some authorities using them for more than 90% of services. However, results show the use of block contracts to be minimal for residential care and home-care services.

The duration of contracts with independent providers is nearly always above one year for all services with an important fraction of them lasting between 3 and 5 years. In residential care, the majority of councils sign contracts lasting more than 5 years. On average, the duration of contracts seems to have remained in line with the evidence of 2001.

[4] In 2001, an option was available regarding the existence of an "implicit policy". Its absence could have contributed to the increased number of responses for the "de-facto practice". However, it is striking to note the drop in explicit policies stating the existence of different processes.

Setting prices: In respect of the home-care sector, purchasing prices of directly commissioned services are set at provider level in half of the councils, although in 30% of cases a single-price policy exists.

In 2001, two of three councils declared that purchasing prices varied by provider for external provision while a similar proportion used a single-price policy for in-house provision.

In 2011, fewer than 20% of councils declared that prices in home-care are determined on the basis of quality also. In 2001 the percentage of authorities taking account of quality when setting prices for home-care was just above 30% for external provision and more than 40% for in-house provision.

While quality checks seem to play a less important role in home-care commissioning nowadays, client needs, but also the type of contract, were the main drivers of price. Other factors affecting price included the existence of a tendering process, the location, complexity and specialism of the service. Overall, local authorities seem to take market factors in to consideration when setting prices. However, in a couple of cases, respondents declared that providers have a relevant power for defining final prices.

In respect of residential care, in most cases the price paid for the service can vary by provider and resident or by provider only. A single-price policy, used in 2001 by almost 40% of respondents, seems much less common today. A significant number of councils (one in four) declare that they directly control the quality of the provider before agreeing prices, while one in five authorities base their evaluation on quality assessment by external organizations (including CQC). Overall, quality checks in residential care have maintained similar levels of permeation with respect to 2001 when they ranged between 30% and 40%. Apart from the suggested options, other influential factors indicated specifically by local authorities are market forces from the tendering process and the use of a Care Funding Calculator system.

When prices are differentiated by user, the main determinant appeared to be individual need while fewer authorities consider the level of facilities provided in care homes.

In day care, prices vary either by single provider or by provider and client. Quality checks seem to be less influential in day care, and probably due to the difficulty in comparing quality specifications for such a wide-ranging service. The typology of contracts agreed with providers seems to be the main driver, while tendering processes and geographic location of the services (especially for rural areas) are indicated as other influential factors. At the user level, needs are by far the main price drivers.

Quality and monitoring: For all care-types, more than 80% of the contracts are monitored/followed-up at least every 6 months. In residential care, however, an equally important proportion of authorities only monitor 41-60% or 0-20% of contracts every 6 months, perhaps because of their duration.

Contractual agreements with providers generally cover processes and outcomes together, while in fewer cases those agreements include only process or only outcome specifications. Ex ante process specifications also emerged as a very common practice (in more than 70% of the cases of external provision) in the 2001 study.

In terms of quality and outcome assessment, most councils (more than 80%) stated that they performed a quality assessment on the services performed by providers while around 60% stated that they implement user satisfaction surveys.

Finally, almost all the councils stated that they review the cost and quality of the services available in the local area in order to inform strategic commissioning.

Providers: Many providers (around 40%) are selected through open-tendering processes while approved lists based on quality and business checks are also very frequent. Within the "other" category, councils often specified a mix of open tendering and approved list of providers. In the previous version of the survey, open tendering played a minor role (less than 20% of the cases) while a preferred list of providers with full accreditation was the favoured option, and especially in domiciliary care.

Local authorities declared cooperation with a varying number of providers and most likely depending on the extent of local supply and demand. However, in cases such as meals on wheels or equipment and adaptations, there seems to be some market concentration, as all the local authorities declared contracts with a very small number or providers.

There seems to be a significant presence of micro-providers working together with councils. This presence is particularly prevalent for meals on wheels, intermediate care, equipment/adaptations and supported living.

Direct Payments/Personal Budgets: Most local authorities do not reduce the value of Direct Payments when compared to traditional services, for instance, because of transaction costs. Around 35% of councils claimed that this reduction might occur up to a level of 30%.

Users are, in most cases (more than 80%), required to contribute to the cost of Direct Payments. Almost all councils charge users by assessing their income rather than a flat-rate charge. Charges are generally deducted before users receive the cash amount.

DP/PB users are supported by councils with funding Direct Payments Support Organisations (DPSO) with a list of recommended providers or, less often, through an in-house DPSO.

About 40% of the councils declared to support PB/DP users with information on existing services or providing a list of preferred providers. A similar proportion of councils commission services on behalf of users.

Finally, around 35% of councils declared to have decommissioned some services after the introduction of PB/DP. Resources are allocated through algorithms (e.g. RAS) for all types of support mechanism while professional judgement methods also play an important role.