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Commissioning Care Services for Older People

Achievements and challenges in London

Penny Banks

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ACHIEVEMENTS AND CHALLENGES IN LONDON

PENNY BANKS

This paper summarises the findings of a study into commissioning care services for older people in London (the full length version of the study is available at www.kingsfund.org.uk/publications). This research was undertaken to inform the King's Fund Care Services Inquiry. The study draws out trends and themes in the approaches taken by six London boroughs with their PCT partners and highlights factors that are helping or hindering commissioning practice across the capital.

About the author

Penny Banks is a Fellow in Health and Social Care Policy at the King's Fund. She carries out policy analysis and research with a special interest in integrated care and support for people who have long-term health and social care needs. Penny has spent much of her career working across health and social care boundaries at policy, service and practice levels in health, local government and voluntary sectors.

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Introduction

This study was commissioned to inform the King's Fund Care Services Inquiry, which was set up in response to concerns about the quality, appropriateness and adequacy of care services for older people in London. The King's Fund wanted to investigate how local authorities and their PCT partners were commissioning care services for older people in London, recognising that which services are commissioned, and how they are commissioned, determines to a large extent what is available in the care market. The King's Fund also wanted to explore allegations being made in the debate about a 'crisis in care', which implied that local authorities could be doing rather better in commissioning.

This paper summarises the main findings of the study, which are available in full in a downloadable document at: www.kingsfund.org.uk/publications.

From the outset we understood commissioning as a complex process that can take place at two levels: a strategic level, for entire populations; and also at a 'micro' level, for individuals. A recent good practice checklist (Department of Health 2003) describes commissioning as a 'cyclical process' that includes:

- understanding and forecasting supply and demand factors within the market to meet current and future needs of older people
- aligning system partners to agree on what needs to be achieved to meet demand
- joint strategy planning to meet these goals
- applying resources to achieve strategic goals
- reviewing and evaluating to adjust to changing needs.

Six boroughs in London took part in the comparative descriptive study during 2004. They were selected for their variations in demography, geography, local political control, and performance assessment ratings. The aim was to draw out trends and themes in the approaches taken by each of these boroughs to commissioning in London, and to highlight the factors that are helping or hindering commissioning practice across the capital.

Policy background: a new era for commissioning

Commissioning care services has become much more challenging than it was in the early years of the community care reforms. New policies to promote closer working between health and social care and whole-systems approaches mark a new era for commissioning. The expectation now is for commissioning to achieve integrated health and care services in people's own homes, meeting their needs in a holistic way that offers choice and control. This work should be combined with community initiatives to improve the quality of life for older people while at the same time reducing the demand for health and care services.

Assessing commissioning

To assess how well local authorities and primary care trusts (PCTs) are commissioning care services, we used criteria drawn from guidance on good practice. (For a full list of the criteria, *see* pp 14–17). These criteria cover two aspects of commissioning:

- the outcomes of effective commissioning
- the ways in which commissioning is undertaken.

The desired outcome of 'effective' commissioning is that it transforms a care system that in the 1990s was dominated by residential care, instability in the market, and inflexible services. Historically, the balance of care has been somewhat different in London, where there has been a larger proportion of home care services commissioned relative to care homes than in other parts of the country. For that reason, efforts to shift the balance of care towards home care are likely to appear less dramatic in London than they are elsewhere.

Findings

Outcomes of commissioning

All the areas studied partially met the outcomes of effective commissioning. However, for each indicator there were some serious shortfalls:

- **Adequate balance of responsive services** There was some evidence of flexible and responsive community services being strategically developed, enabling more people to stay at home. There were also changes taking place in the way the service system operated. These developments included:
  - establishing integrated health and social care teams with integrated budgets
  - extra-care housing (where people have their own flat or bungalow and access to 24-hour flexible support), with separate units for older people with dementia
  - new integrated resource centres offering a range of education, leisure and other opportunities alongside access to health, care, information, advice and other services.

  However, there were pressing concerns about the quality and quantity of key services to meet local needs – primarily residential and home care services. Particular criticisms included the practice of 15- and 30-minute home care slots for people 'being done to' (where service users are subjected to a rigid set of tasks that have to be completed in a set timeframe), and the quality of care provided in some residential homes. There was universal concern about the lack of adequate services for older people with dementia. Insufficient support services such as chiropody, occupational therapy and continence services were also flagged up, as were concerns about those older people who do not meet local eligibility criteria but nevertheless need some care and support.

- **Better functioning of the whole service system and stable market** While none of the boroughs studied felt there was an immediate crisis in care, they all identified high-risk factors, and at least two described their local service systems as being 'on a knife edge'.

  None of the boroughs reported problems in discharges from hospital being delayed because of lack of care, but there were reports of:
  - older people and their families feeling pressured to accept a residential home that was not their preference
  - frail older people undergoing several moves over short periods
  - increased numbers of older people being admitted to a residential home and dying within 24 hours
  - high rates of readmission to hospital.

  More substantial evidence is urgently needed about this aspect of 'better functioning of the whole system'.

- **A high degree of user and carer satisfaction** User and carer satisfaction was mixed across all the boroughs, ranging from generally high levels of satisfaction for those with agreed packages of care to widespread concerns around:
  – accessing services
  – charges
  – waits for equipment
  – isolation of older people
  – quality of home care services.

  Feedback from older people was consistent irrespective of their community or ethnic background. Carers from all communities reflected these views, as well as worrying about the reliability of services. Many carers felt they were 'invisible' to services.

- **Demand for care services reduced or delayed** All the boroughs were concerned about prevention. However, there were serious difficulties in funding this work, and there was some variation in how the different boroughs tackled this issue, both in terms of breadth of approach and involvement of other players. Some boroughs were trying to progress wider quality-of-life strategies supported by departments across the council, older people's organisations, primary care trusts (PCTs) and acute trusts.

Commissioning practice in London

Having established the successes and problems in London's services, we now look at whether these are a consequence of the ways in which care services are commissioned. Overall, practice varied across the six boroughs studied, but each met at least some of the following criteria for effective commissioning.

- **Partnership working** All the boroughs took a partnership approach. The strength of the partnerships between health and social services were heavily dependent on the extent to which there was a local history of joint working and strong and stable leadership. Partnerships were also being extended to include housing in strategic work between local authorities and PCTs. However, partnerships with independent providers were very varied, and some providers spoke of feeling 'a bit like Cinderella not invited to the ball'. Similarly, relationships with the voluntary sector were mixed, with some voluntary sector organisations reporting that they felt 'on the outside' of strategic discussions.

- **User-focused commissioning** Service users and carers had some involvement in the various processes of the commissioning cycle, but this did not appear to take place on a systematic basis, and their influence was limited. Commissioning at the individual level frequently amounted to standardised care packages, specifying a rigid set of tasks to be carried out in a specified time. This approach was at odds with the strategic vision of flexible services tailored to individual need.

- **Understanding the market** The boroughs demonstrated different levels of understanding of local needs and supply, and some were grappling with inadequate information and data-collation systems. They were all trying to take a whole-system approach, but were experiencing problems with predicting the impact that new service developments would have on the system as a whole.

- **Managing the market** All the boroughs studied were taking steps to manage the market through different types of contracts, such as block contracts, and, where possible, by raising fees paid to providers, to offer providers greater security. They also supported a range of training initiatives, such as NVQ (national vocational qualification) schemes for home care staff.

  Although there were clear values underpinning work on older people's services, and evidence of some service specific strategies, there was not always clarity about an overall strategy to redesign and commission services – indeed, there was some uncertainty about what the appropriate balance was between residential and home-care services. Some boroughs – particularly those where support for middle managers may have been less than adequate – experienced difficulties in delivering strategic intentions.

The study highlights the extensive role of joint or integrated commissioning – an approach that some boroughs have accepted only relatively recently, and which is new to PCTs. Organisational support and structures for this role are varied and appear to be still under development, as health and social services establish ways to work together more closely. There is also limited capacity to build and maintain the wide number of relationships needed when working across health, housing and social care sectors. Even the most skilled and experienced commissioners face considerable challenges in forecasting, whole-systems working, supporting cultural change, managing fragmented markets across numerous boundaries, decommissioning, and managing demand.

Market, policy and resource pressures

While some participants commented that the biggest challenge was their own capacity to make the changes, most identified external challenges to commissioning that were hindering progress in developing appropriate, high-quality services. These included:

- **Funding shortfalls** Due to cost pressures in the market, competing services, and other restrictions, boroughs are having to target services strictly and, in some areas, suppress demand through very tight eligibility criteria. These funding difficulties work against the aspirations of offering choice for older people and supporting an innovative market. In addition, funding pressures make it almost impossible to divert resources from services for those with severe and crisis needs to services supporting a good quality of life for older people in order to prevent their health and situation deteriorating.

- **Recruitment and staff retention problems** Most boroughs are taking a proactive approach to recruitment – for example, through campaigns in schools and apprenticeship schemes. However, a shifting workforce and reliance on temporary and poorly skilled staff, coupled with a lack of stable leadership, pose a very real threat to the effective implementation of local commissioning strategies.

- **The price of land and property in London** Commissioning is also thwarted by difficulties in new build where land and property are at a premium. The high property prices do not attract the independent sector into the market. It is also difficult to find premises to co-locate staff, and there is insufficient key-worker housing to attract nurses and care staff into the city.

- **Government agenda** The National Service Framework for Older People and Supporting People have been positive supports to improving services, but there are some fears that further government initiatives and new visions could destabilise plans in progress. More coherent targets across health and social care, and targets supporting a shift to prevention, would be helpful. Reimbursement policy (which penalises local authorities for delayed discharges due to unavailable community care services) has been a useful driver for joint working, but evaluation on its impact on the lives of older people is urgently needed.

- **Unresolved national policy issues** The unresolved issues of funding long-term care present major barriers to progress. These include continuing care, described by one commissioner as 'the biggest mess we have had to live with'. This policy has invited widespread criticism because of the time and resources required for dealing with retrospective complaints, as well as the public's confusion over the criteria for receiving free NHS continuing care. Another criticism is the highly bureaucratic way in which nursing care is assessed in care homes, and the diversion of expensive staff to carry out these assessments.

- **Relationships with regulation and inspection** The government push on quality supports commissioners in their work to drive up standards, but relationships between authorities and regulators are not yet fully established – particularly in the domiciliary care sector, where the introduction of standards and regulation is still relatively new. Some commissioners reported scarce or even unhelpful dialogue with inspectors of care homes.

- **Ageism** Deep-rooted ageism was a theme that threaded through much of the feedback, and this issue is a challenge for those commissioners seeking to change planning priorities. However, there is some evidence that the increasingly vocal and politicised lobby of older people, and their increasing involvement in local issues, is beginning to influence developments. Some local councillors were championing older people's rights as local citizens while, in other areas, community groups were lobbying to put older people on the agendas of local politicians.

Conclusions and recommendations

How effective is commissioning in London?

The overall picture of care services for older people in London suggests that local authorities with PCTs still have some way to go to achieve a transformation in services. Some authorities are well underway in tackling this agenda through commissioning processes. However, our findings show that for a number of older people in London, services have not changed substantially – particularly services for people with dementia, an area in which respondents unanimously reported gaps in services. Many older people are only just managing to live independently and fear for the future if their health and social circumstances deteriorate in any way.

More positively, there are signs of change taking place. Care and support services are making a significant difference to the lives of some older people, assisting them to live at home with confidence. There is evidence of some effective local commissioning, demonstrated by the development of an increasingly vibrant tapestry of flexible and integrated community services, and a degree of stability in local service systems. In some areas, additional work across the council is underway to improve the local environment and to ensure inclusion of older people. This is linked to developments in integrated services for older people.

But the process of change and development is far from complete. Local authorities and PCTs are still in the early stages of integrated commissioning, and there are some uncertainties about the merits of particular forms of integration, and fears about risk management, in a climate of serious cost pressures and performance ratings. Some steps are already being taken to develop best practice in commissioning in London, and to build commissioning skills through learning networks, training and consultancy. However, there is clearly more to be done to make sure there are enough people with expertise in commissioning for the future.

Challenges and opportunities: long term

Commissioning is likely to become more complex in the future. This is due to a range of external factors that will affect which services are commissioned, how many services can be commissioned, and how commissioning is carried out. These factors relate to market conditions and pressures in London, underlying policy and resource problems, and potential long-term challenges.

Pressures specific to London

Pressures resulting from the high land prices and labour costs in the capital are unlikely to ease. These factors pose major challenges to the speed at which local authorities and their PCT partners can decommission outmoded services and develop a full range of flexible

services. The reduction in Supporting People funding is also likely to slow down new developments in extra-care housing.

Competing interests for limited resources is likely to continue. This is a result of:
- the high proportion of younger people in the capital
- the increase in fragmented households
- great disparities between poorer and richer communities
- a high proportion of migrant labour.

This is particularly challenging because there is a forecasted rise in the proportion of over-85s in the older population in London, and an increased proportion of older people from black and minority ethnic communities who will need services that are accessible and responsive to their needs.

Underlying external problems

Several underlying external difficulties threaten progress in commissioning:
- unresolved problems in funding long-term care and in deciding who pays for care
- staffing shortages in health and social care
- the pressure to deliver on national targets that do not appear to support a shift to prevention and radical change
- since the introduction of national care standards, the reduced number of care homes that are accredited to provide a service for people with dementia
- ageism
- public expectations and debates about responsibilities of the state versus responsibilities of older people and families.

Longer-term challenges

A potential array of other factors are stacking up to present challenges for the future, including the collapse of pension schemes, the lack of affordable housing, a culture that does not prioritise saving, and various issues arising from the number of new graduates with significant debts.

In addition, as the markets are increasingly dominated by care providers that are fewer in number and larger in size, the power of care providers is likely to increase, limiting the influence that commissioners can bring to bear on the costs of services.

Challenges and opportunities: short term

In the immediate future, there are developments in the health and social care system that may offer opportunities as well as challenges for commissioning.

Developments in local authorities

New arrangements to bring together education and social services in the form of children's trusts are unlikely to reduce budgets for children's services, which have historically been higher than older people's budgets. This change will be an added incentive to local authorities to lever in resources from elsewhere to increase budgets for older people's

services, so pooling resources with the NHS will be even more crucial. However, older people's services will be competing with services for younger disabled adults and people with learning disabilities. Local stakeholders will need to continue their work to raise the profile of older people and alert councillors and NHS boards to the political risks of ignoring this agenda.

More positively, the expected increase in the number of older people using direct payments offer real opportunities for major change in services to older people, by offering them control over the services they choose to use. However, it is not yet clear what impact this shift will have on commissioning by social services and PCTs, nor how cost effective it will be. Safeguarding the quality of provision is likely to be a challenge.

Other opportunities are offered by the introduction of single assessment to improve person-centred assessments and thus commissioning at the frontline. The effectiveness of this policy will depend on how it is implemented, what training and ongoing support frontline staff receive, the ability of staff to take a needs-led approach (as opposed a service-led one), and the provision of good IT systems so that information can be shared across organisations.

NHS developments

In the NHS, a decision to devolve some commissioning responsibilities from PCTs to primary care practices could support the move towards care that is tailored to individuals' needs. Examples include providing care managers or community teams for people with complex needs. Practice-led commissioning gives GPs the incentive to be more engaged with PCTs, and may also strengthen the ability of the wider health system to reorganise health care delivery around primary care.

However, there may be tensions between PCTs, which, alongside their local authority partners, have the role to carry out strategic planning for older people locally, and the primary care teams, which are awarded the freedom to set their own agenda. Much will depend on how local schemes are developed, and whether or not this is done by partnerships between the PCT, practices and social services.

Similarly, the impact of foundation hospitals on commissioning partnerships between the NHS and local authorities also depends on how these new players see their relationship with their other partners in the health economy and beyond. Moves by foundation hospitals to offer community services and outreach work could impact positively on whole-system working if the focus for this work is primary care. If the focus is the hospital, there is the potential to destabilise new developments to integrate health and social care services around primary care and the possibility of further fragmentation of local service systems.

Finally, the introduction of third-party providers, such as Evercare for chronic disease management, presents a danger of further fragmentation in the health and social care system, although these have been introduced to co-ordinate services for individuals with complex needs. Much will depend on how these new providers (or any locally grown models) are introduced, and how far the whole system is mapped out to make sure their role is coherent with other forms of care and case management for older people.

Efficiency drives

The new requirement for social services to make efficiency savings, following the Gershon review of public sector efficiency (Gershon 2004), is encouraging a serious look at ways of reducing costs through increased London-wide procurement. However, commissioners stress the importance of distinguishing between procuring easily specified goods and commissioning care services. The latter is about ensuring service quality and service development and it calls for an in-depth knowledge of local needs, strong links with micro-commissioning (commissioning for the individual), and a shared local vision for services between social services and the PCT. For these reasons, regional procurement is seen as inappropriate for care services other than those for people with specific needs who are spread across the capital.

Indeed, it is questionable how much room there really is for savings. Our findings suggest that current commissioning practice scores reasonably well in terms of several indicators of cost effectiveness – for example:

- prices paid for care services are kept low
- there is a mix of services commissioned and where possible a shift away from highly expensive options
- contracting processes are being streamlined
- steps are being taken to rationalise the number of contracts with local providers.

There is still much to be learnt about the most cost-effective processes while ensuring diverse markets that offer genuine choice and appropriate services for older people from all communities.

There are also tensions between policy on patient choice and payment by results, and proposals for regional commissioning. However, regional collaboration may be useful for standardising some elements of contracting.

What needs to happen?

The policy and market environment will continue to change. While there are important opportunities in some of the forthcoming developments, overall the future of commissioning looks even more challenging. We are unlikely to see substantial improvements in care services for older people until these policy contradictions and resource and market problems have been resolved. The progress we have seen in changing services through commissioning may well stall unless the Government, as a priority, clarifies the vision for services to older people, and reviews funding for social care to ensure this vision can be realised.

As well as addressing these policy issues, the government must continue to support developments to build commissioning skills. It is unreasonable to expect a full shift to integrated commissioning and a complete transformation of older people's services at this stage, given all the policy, market and other pressures. Every support is now needed to build commissioning skills and to disseminate best practice across London through collaborative work. Regulation and inspection also have a role, to make sure all London boroughs and PCTs reach the high standards in commissioning that some are already well on the way to meeting.

Recommendations

Clarify the vision for services to older people

The forthcoming national strategy for older people and the vision for adult services need to acknowledge and accommodate the urgent and growing needs of older people with dementia and those older people with considerable health and support needs – often those at the end of their lives. There must be coherence between policies to promote well-being and citizenship, to improve services to people with long-term conditions, and to offer choice and control to older people and carers from all communities.

Review social care funding

To address the underlying funding pressures, central government needs to review social care funding. This review must relate to the new vision of care services for older people and should seek to ensure a level of funding that addresses staffing shortfalls and puts services to older people on a par with services to other people, such as young disabled adults.

Give key players incentives to get involved in driving change

In its reviews of council services and performance, the Commission for Social Care Inspection (CSCI) needs to routinely assess the level of involvement of:

- older people and carers from all communities in commissioning, and the outcomes of this involvement
- providers from the independent and voluntary sectors, to see how far they are directly engaged in the redesign of services and local systems and how far this involvement leads to better outcomes for older people.

Strengthen partnerships with specific aims

- All local authorities need be audited to ensure they are good places for older people to live, building on lessons from the Audit Commission pilots (Audit Commission 2004). Such audits will strengthen partnerships between local authorities and other public services, such as transport, to progress community and prevention strategies. In local authorities, departments other than social services have key roles in spearheading work on the health and well-being of older people locally.

- Collaborative working across boroughs and PCTs needs to be supported by the Association of London Government, Greater London Association of Directors of Social Services, and London's strategic health authorities, working together to develop strategic frameworks for best practice in commissioning, best-value approaches, and models of collaborative commissioning.

- Ways should be agreed to engage councillors and non-executives of PCTs across London in supporting change, such as by setting up a special taskforce comprising councillors and non-executives to champion developments and support new collaborative frameworks for commissioning.

Build commissioning skills and infrastructure to support best practice

- While there have been some important developments that have helped build commissioning skills, central government needs to consider other means too, such as introducing standards for commissioning and qualifications, and courses for commissioning teams and leads.

- More robust leadership development to support commissioning in a whole system is important to ensure leadership in driving the vision and putting in place the infrastructure to translate strategic intentions throughout the partner organisations. Strategic health authorities have a role to play in supporting work to develop the necessary infrastructure.

- In their inspections, the CSCI and the Healthcare Commission should play a key role in reviewing commissioning and checking that the infrastructure is in place to support the process. This includes assessing:
  - clarity about roles and accountabilities within and across organisations
  - quality of information, data sharing and communications systems
  - supervision and performance systems to translate strategic intentions throughout the organisations involved
  - progress in implementation of single assessments and support to frontline staff in undertaking assessments and commissioning for individuals that focuses on outcomes for older people.

- The government must give priority to developing social care information systems that link effectively with current national developments on health information systems.

- The government needs to undertake further research to study market forces, including monitoring the development of monopolies and forecasting potential trends in the market, and evaluating the effectiveness of different prevention approaches. It may best achieve this through establishing an intelligence unit.

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Criteria for effective commissioning

This section presents the criteria that we used to assess commissioning by the six boroughs in the study. It is made up of a table detailing the criteria themselves, and a list of the sources from which these were drawn.

Expected process	Criteria (what we would expect to see)
Working in partnership	■ Joint working between: – social services – health (primary care and and acute trusts) – housing authorities and organisations – other council departments (such as transport and leisure) – voluntary and community sector – private and independent sector providers – older people from all communities – carers from all communities. ■ Working together through, for example, planning structures, formal and informal meetings and forums ■ Engaging with a diversity of stakeholders in each of the above sectors (for example, small and larger providers, older people from black and minority ethnic communities).
Effective partnership working	■ Engaging in open communication where information and data is shared (having an information and communications strategy in place) ■ Acknowledging interdependence ■ Honouring commitments to take action, including financial investment ■ Sharing risk taking ■ Making consensual decisions rather than limited consultation ■ Agreeing ways to resolve conflicts, plus a fair arbitration process ■ Agreeing on intervention and protocols for helping any provider business in difficulty ■ Supporting involvement, such as reimbursing costs, including for independent sector partners where appropriate.
User-focused commissioning	■ Ensuring user involvement at every stage of the commissioning process ■ Setting up effective processes to routinely engage with users from all communities, particularly those who are 'hard to reach' ■ Focusing on quality and user outcomes evident in strategic vision, plans, monitoring and evaluation processes ■ Including a requirement within contracts for providers to seek service users' views.

Expected process	Criteria (what we would expect to see)
Understanding the market and obtaining intelligence: local needs (demand)	■ Collecting data about needs as well as qualitative information, at population and case levels, including: – population projections – feedback from users from all communities – views of carers – information from needs assessments – information on housing and accommodation needs – views of frontline staff – prevalence rates and trends – information from providers. ■ Understanding of needs of populations falling outside current eligibility criteria ■ Regular formal and informal communications with all stakeholders to obtain market information, including the Commission for Social Care Inspection and other regulatory bodies and users and carers.
Understanding the market and obtaining intelligence: mapping current service provision (supply)	■ Mapping and understanding current supply and providers of services: – in-house, independent sector, other providers – volume and trends in provision – quality of services. ■ Mapping and understanding budgets and resource allocation and unit costs, informed by: – local cost analysis of providing care with the independent and public sectors working together – knowledge of specialist provision by regional and national service providers – comparison of performance against national benchmarks and indicators.
Understanding the market and obtaining intelligence: forecasting supply and demand	■ Using capacity planning models and other models ■ Working with partners to assess influences on future supply and demand and the likely impact on market and service system. This will include identifying gaps in services and accommodation, oversupply, shortfalls and trends. Also, assessment to include not only numbers of beds required but also type of service needed, housing and accommodation, and mix and balance of local services ■ Using research, evidence and good practice to inform plans (including involvement in learning and other networks).
Managing the market: strategic planning with partners	■ Developing a joint commissioning strategy with an agreed vision and priorities promoted by leaders from all partner agencies ■ Agreeing the plan for change – decommissioning some current services and developing new services in line with strategic vision, specifying timescales, lead responsibilities, financial allocations, and arrangements ■ Drawing up clear plans to minimise disruption for older people where services are to be decommissioned ■ Putting in place plans to manage cross-boundary or regional commissioning where appropriate ■ Setting up initiatives to stimulate the number of minority ethnic providers.

Expected process	Criteria (what we would expect to see)
Managing the market: applying and monitoring resources	■ Clarifying management accountability for budgets ■ Agreeing systems to monitor budgets to ensure use of funds is developing the market and ensuring best user outcomes (link between quality and prices) ■ Using a mix of rewards or incentives to influence market behaviour – not only fee levels (investment/block contracts/ longer timescales for contracts) ■ Employing a range of contracting methods to fit commissioning objectives and ensure market stability and availability of appropriate quality services.
Managing the market: reviewing and evaluating implementation of strategy and development of new or reconfigured services	■ Setting targets in a strategic plan with agreed ways to monitor progress ■ Ensuring user involvement in agreeing performance criteria ■ Agreeing a method to review cost effectiveness and value of services ■ Making sure all stakeholders monitor performance ■ Monitoring contracts ■ Using findings from best value reviews ■ Carrying out regular reviews of the range and quality of services, along with performance evaluation.

Expected outcomes	What we would expect to see
Strategic and innovatory developments: shift in service configuration/ provision	■ Measurable/demonstrative progress on plans to reconfigure services ■ Shift in expenditure from traditional services to more flexible models and integrated services, including housing options – very sheltered/extra-care housing ■ Development of preventive services to reduce demand ■ Increased numbers of older people supported to live at home ■ Increased choice of options for older people ■ Older people not being accommodated outside of borough unless specifically requested by the older people themselves.
Strategic and innovatory developments: support to innovation and services promoting independence and self determination	■ Service improvements undertaken by staff at all levels who are supported as part of the overall strategy ■ Innovations and short-term initiatives that inform strategic plans and are not simply fragmented projects ■ Support to care providers to introduce innovations (for example, training, low interest loans, help with business planning).
Strategic and innovatory developments: better functioning whole system and stable market	■ Few bottlenecks or crises within the service system ■ Reimbursement/financial penalties rarely imposed ■ Contingency plans able to deal with unexpected events.

Expected outcomes	What we would expect to see
Quality services as defined by older people from all communities	■ Commissioning strategy making explicit references to services for black and minority ethnic older people ■ Contracts include quality standards as defined by older people ■ Ethnic monitoring information collated and used to inform commissioning ■ Services that meet the needs of local black and minority ethnic communities ■ Quality services for older people with dementia and those with special needs.
Increased capacity: resources maximised (staff, property and financial resources)	■ Joint working and training across disciplines and agencies ■ Shared occupancy or new use of buildings ■ Harmonised/compatible IT ■ Shared information systems ■ Shared client records ■ Pooled budgets and budgets managed and monitored to ensure strategic objectives are being met ■ Proactively levering in resources such as private finance ■ Joint workforce plans, including strategies for recruitment, induction, ongoing training, integrated health and social care workers ■ Ways of reducing transaction costs and eliminating unnecessary bureaucracy
Demand reduced	■ Preventive services, rehabilitation and intermediate care services.

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Linked publications

Other publications for the Care Services Inquiry

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Janice Robinson and Penny Banks

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