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The shape of things to come – developing new approaches to commissioning public care

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Abstract
The White Paper, 'Our Health, Our Care, Our Say' suggests eight key steps that commissioners of care services need to achieve. Whilst few would disagree with any of the individual steps suggested, as a whole they potentially add up to a considerable change to commissioning and contracting as currently configured. This paper considers the implications of those changes, outlines a demand and supply driven model for considering future activities and suggests a number of key changes that need to be made to the roles of those commissioning public care.

Keywords: Commissioning, contracting, strategic needs assessment, demand forecasting, provider relationships, service planning, social care management

Introduction

In March 2007, the Department of Health published its *Commissioning Framework for Health and Well-Being*, following from the White Paper *Our Health, Our Care, Our Say*. It outlined eight steps for the delivery of effective commissioning:

- *Putting people at the centre of commissioning;*
- *Understanding the needs of populations and individuals;*
- *Sharing and using information more effectively;*
- *Assuring high-quality providers for all services;*
- *Recognising the interdependence between work, health and well-being;*
- *Developing incentives for commissioning for health and well-being;*
- *Making it happen – accountability;*
- *Making it happen – capability and leadership.*

Few in social care would disagree with the steps or the values that underpin them, yet the guidance potentially symbolises a watershed in the way that social care is purchased and delivered.

The case for change

As the Commission for Social Care Inspection (CSCI, 2006) notes:

> *An assessment of councils' approaches to commissioning has highlighted very mixed practice in analysing needs, demand and supply; in relationships with stakeholders; in market development; and in 'commissioning for quality' with involvement of local people.* (p. 45)

The same report goes on to state:

> *Commissioning for many older people's services was primarily based upon historic patterns of service delivery and most councils were commissioning as single agencies and not in partnership with health, housing, independent and voluntary sector partners.* (p. 63)

The Health Policy Forum (HPF, 2006) clearly believed that little was different within the health service when they argued:

> *NHS commissioning is starting from a low base in relation to designing and purchasing services in a way that properly takes account of people's needs*

> *and demands. It seems that needs assessment in NHS commissioning has to 'move beyond public health'. That is not to say that epidemiological data analysis is not vital as part of health planning and commissioning but it is clearly no longer sufficient as the sole basis for making decisions about how priorities will be set and resources allocated through procurement and contracting.* (pp. 21-2)

If Local Authorities (LAs) and Primary Care Trusts (PCTs) are to embrace the new approach desired by government then they do so at a time when commissioning and contracting is about to become much more complex. For example:

- The scale of demographic change that is about to occur for some authorities will mean their current configuration of services will be neither affordable nor sufficient to meet need. This is not only relevant in terms of a greater number of older people but is also true for physical and learning disability as increased longevity and longer survival of individuals with complex health and care needs has an impact.
- Service users in general and older people in particular, have been a relatively powerless voice in the past, given a culture that historically has emphasised being grateful for what you receive. The growth of equity and wealth amongst older people together with a desire for choice and improved quality is likely to drive demand for improved service provision. Some of this finds expression in the moves towards self directed care. However, whilst this has already had an impact in physical and learning disability in terms of older people it is not easy to interpret what impact this may have.
- Control over provision has also rapidly changed over the last twenty years from being LA dominated to being predominantly in the private sector. Some sectors of the market now exist entirely outside LA care purchasing. There is also a gradual recognition that services contracted for by cost and volume do not necessarily deliver the outcomes that are needed.
- The impact that practice-based commissioning in health care may have has also yet to emerge. Clearly there will be a need to balance a desire for locally-based decisions as against the strategic role of the PCT and the need to achieve economies of scale.
- Social care in the past has spent comparatively little time focussing on understanding the 'whole system' in which it operates, whether it is understanding what needs are to be met, or what supply is to be put in place. This is in contrast to the private sector where companies often invest considerable amounts of time and money in understanding their customers and competition. If they do not, their product range becomes out of date, they cease to be competitive, shareholders lose confidence and eventually their business is jeopardised.
- Finally, with LAs no longer being major providers the managerial task has not only changed but, increasingly, knowledge of services is likely to be lost as well. In the future, provider relationships cannot be based solely on arms length contractual and legalistic arrangements, but will of necessity, be driven by commissioners requiring the very knowledge that providers will possess to effectively purchase services.

Many of the above issues are not new, yet the challenge for managers rests not in addressing them individually but in understanding what shape they collectively imply for the management of public care in the future. This paper offers a model based around a better understanding of supply and demand; an approach which activates the shift from being providers of services to

being enablers and facilitators across a much wider range of provision.

Overall, the task is more complex than the old production line approach to management, i.e. how do we manage the queue of potential service recipients or that particular service. The new approach to commissioning poses questions such as: how do we interpret and understand the demands of the public? What are the key decision points along the care pathway where people may potentially be diverted from long term-dependency? What needs to be the new relationship between service users/carers and commissioners? On the supply side, it is about how we influence, shape and grow care provision to match the demands of the community and what partnerships and arrangements are required in order to secure sufficiency of supply as against demand. Such changes clearly call for the development of new skills and thinking by those who act as commissioners of public care, together with changes to information systems in order to reflect the questions those managers will be asking.

The need for strategic thinking to drive commissioning

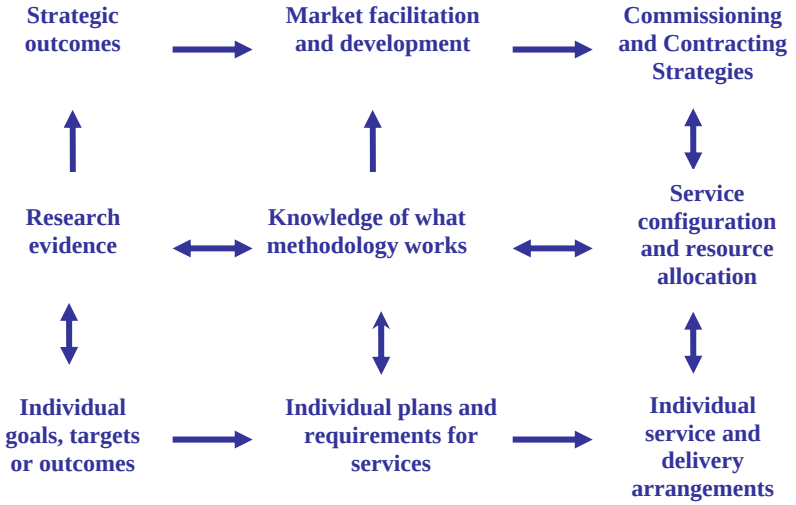
Traditionally, planning in the public sector has been on a year by year basis or at best on a three year cycle. Strategic commissioning calls for managers to take a much longer view. This should facilitate planning for demographic change, to enable commissioners to signal long-term intentions to the market, and to free-up thinking outside the constraints of existing service provision. This commissioning question - how is public funding to be best spent to ensure that supply is available at an affordable price to meet the needs of all of the population can, in essence, be described through two activities:

- Understanding Demand – what are the desired goals for the population to be served and what is the rationale that underpins those goals and needs? These essentially are the outcomes that commissioners wish to see achieved.
- Understanding Supply – what services need to be in place to deliver the outcomes and what is the evidence that these services will deliver the desired effects? These are the outputs that need to be delivered or made available to meet the outcomes.

What is not clear from these statements is how these wider commissioning tasks fit with the individual provision of a service, particularly in an environment where an increasing number of service users may purchase their own services. The diagram below attempts to illustrate this relationship by showing how individual goals and services relate to strategic outcomes and outputs.

Figure 1 can be read in a number of different ways, either top down in relating strategic commissioning to individual requirements or bottom up in terms of individual needs and goals driving strategic aspirations and decision-making. Therefore, the bottom row could represent a direct payment or individual budget route to provision or a service that is contracted for, on an individual's behalf, by a local authority or PCT. Regardless of the purchasing mechanism, what resource is individually or collectively received, will be influenced by what outcomes it is expected the service should achieve and a knowledge of what does or does not work.

Figure 1 Relating individual contracting to strategic commissioning



For example, in exploring the relationship between individual goals and research, our expectations of recovery from a condition or illness are in part influenced by how knowledge and research have informed professional and public opinion alike. This in turn may be influenced by research which explores the impact that different treatment regimes have. As the diagram shows, some of the influences and processes are two-way, e.g. 'service configuration and resource allocation' both influences and is influenced by 'what methodology works'. Whereas 'what methodology works' should affect how commissioners influence the market but not vice versa. Essentially, what is being suggested here are two key factors:

1. That research, knowledge, and evidence act as the 'jam in the commissioning sandwich' driving individual and organisational aspirations;
2. That effective commissioning and contracting needs to move from defining a set of organisational outputs (how many beds, places, etc.), to focussing on agreed outcomes (what can be achieved by the service provision, does the person get better?).

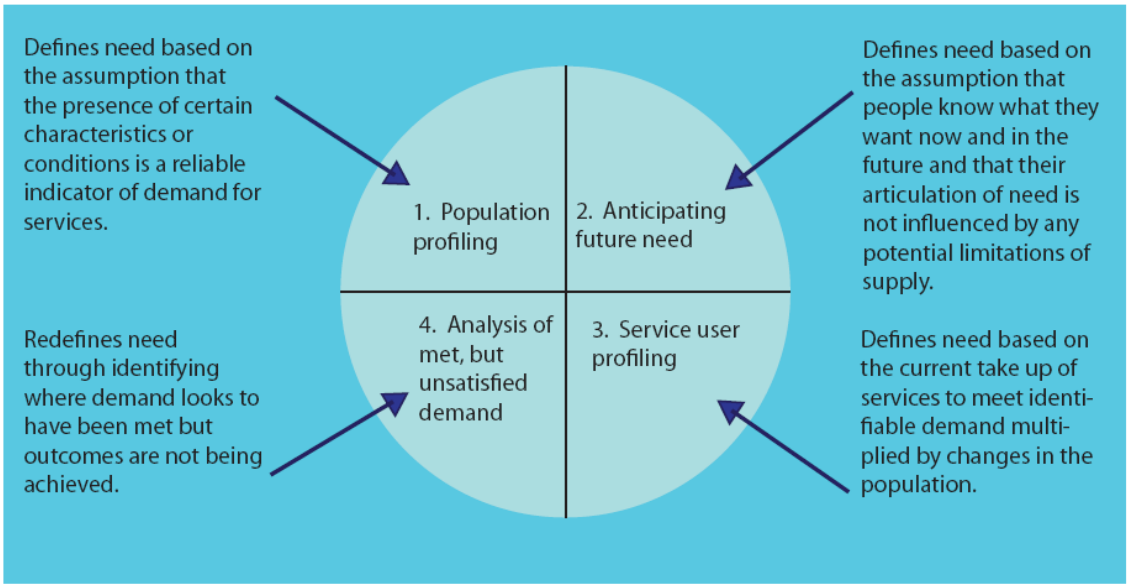
So, if services are to be purchased successfully and achieve outcomes desired by agencies and individuals, the key to success lies in the quality of 'the jam' or the knowledge available to us and our analysis of that information. This entails shifting commissioning away from changing existing service provision to a better understanding of demand and supply and how that knowledge gets used to develop appropriateness and quality within the market.

Understanding demand

The importance of predicting demand is heavily emphasised by the *Commissioning Framework for Health and Well-Being* (DoH 2007) which sees Strategic Needs Assessment as involving three main activities:

- *A joint analysis of current and predicted health and well-being outcomes;*
- *An account of what people in the local community want from their services;*
- *A view of the future, predicting and anticipating potential new or unmet need.* (p. 28)

Figure 2 The four activities of Strategic Needs Assessment



Some of the prediction of strategic needs can be delivered through effective analysis of population-based data. However, this does not translate into who comes to a Social Services Department (SSD) or a GP surgery. Predicting future demand requires a range of activities including assessing the views of current service users, carers and the wider population. There is also a benefit in reviewing the relationship between demand, service supplied and outcomes in those instances where it looks as if needs are being met and a service supplied but where, for a variety of reasons, the outcomes for the service user remain poor. Figure 2 illustrates these four elements of demand forecasting.

Population profiling

As indicated above, population profiling does not necessarily tell commissioners who will come forward for a service, but it does form a valuable backdrop for:

- Indicating the prevalence of conditions which may inevitably predict a social care response, e.g., dementia in people aged over 85;
- Understanding changing patterns of prevalence within a known population, e.g. adults with a learning disability living longer and being subject to early onset of a number of old age conditions;
- Understanding strike rate, i.e. the numbers of people in particular circumstances or with particular conditions encountered by social care/health care/housing as compared to their prevalence within the population;
- Identifying general pressures that may exist in the future if current service provision is extrapolated based on population change;
- Exploring the relationship between where populations are located as compared to services and community facilities, e.g. drop kerbs for wheelchairs, shops, banks, etc;
- Helping to identify how many people there may be within particular target populations that a LA should contact if it is attempting to move from a reactive to a proactive service, e.g. number of carers, offering more than 50 hours care per week, where the carer is aged over 75.

To identify the above data requires the undertaking of five activities (re. older people, see CSIP, 2007):

- Identifying the current baseline population;
- Projecting that population forward;
- Identifying key characteristics within the population now and their potential prevalence in the future, where those characteristics may have a bearing on the likelihood of people requiring social care services, e.g. number of people who live alone aged over 85;
- Using estimates of prevalence from research studies and surveys to estimate the likely numbers of people within a population who may have a particular condition, e.g. dementia;
- Comparing populations to known service users and other performance data.

Anticipating future need

If the population data provides the baseline for Strategic Needs Assessment, then understanding current and future expectations amongst relevant groups provides definition or colour to that population data. However, engaging wider populations in making a contribution towards strategic commissioning is an activity often fraught with difficulties. In the past, for many authorities, consultation has centred on organisations or individuals with whom there is regular discussion about service provision. This has not always given a true picture of future need. Notwithstanding this problem, there is a wide range of potentially useful sources of information that may help in developing a picture of future need such as:

- General estimates of demand, e.g. housing needs surveys;
- MORI polls and other national surveys which explore attitudes towards health and social care;
- Research which looks at general population perspectives on services or future provision.

Ideally commissioners use a twin approach, supplementing findings from national research with locally-based work.

The Care Services Efficiency Delivery Programme (forthcoming on CSED Website) takes the above material a step forward and suggests a specific approach utilising focus group techniques for consulting with wider populations of older people. This approach was based on populations immediately prior to statutory retirement age and used two hour group sessions divided into four topics for discussion:

- To ask people to think fifteen to twenty years ahead and consider where they might be living, what financial resources they might have and what contact they may have with family, friends and neighbours;
- To ask the same questions but after people had been read a description of physical incapacity that might happen to them;
- To ask the same questions but after people had been read a description of moderate dementia that might happen to them;
- Finally, to ask people to reflect on the different perspectives of their future lives that had been talked about and consider what kinds of services they might need to assist them in the above situations regardless of who paid for that provision.

Service user profiling

Profiling current service users entails three potential activities:

- Quantitative profiling – who do we know, when do we know them, what

did they need and what did they receive, at what cost;
- Mapping – can we numerically assemble who is known along a care pathway exploring the relationship between initial contact and who then goes on to receive more intensive provision (care homes, hospital, etc.), who leaves the pathway or who remains at the initial point of entry;
- Qualitative profiling – what do current service users genuinely think of the service provided to them, did the service match their expectations, and what impact does it have on their quality of life.

Each of these three activities potentially poses problems. For example:

- Social Services Departments and Primary Care Trusts have a wealth of data about their service users/patients and yet most is in a format where extracting and analysing that data in order to help plan future commissioning is virtually impossible;
- Whilst mapping care pathways may be possible, identifying key points where decisions are made that change the course of the pathway may be much harder;
- Getting genuine feedback on service provision is not easy. For example, some people may be anxious that if they are critical of service provision then it may influence the way in which that service is delivered to them or limit its availability; some older people who have suffered falls or strokes may limit their own expectations of making a full recovery and consequently have lower perceptions of the volume or type of service required. Finally, users and carers are often aware of what services are around and consequently there may be a tendency to concentrate on quantitative demand and 'cut to the chase' of discussing services, rather than genuinely measuring need.

Analysis of met, but unsatisfied demand

This final element of demand forecasting is the most complex to describe yet, perversely, it may give rise to the biggest potentiality for change through improved commissioning leading to a reconfiguration of provision. It represents not just unmet need, i.e. where a need has been identified but a service has either not been provided or does not fully meet what is required, but a wider perspective of where need looks to have been met (indeed all parties may have been satisfied with what was provided) but it did not alter the outcome for the service user or carer or fully meet their potential for recovery or rehabilitation. To uncover this less overt need involves questioning whether people's existing needs really are being met, or whether the volume, nature and type of current service is achieving the outcomes which a service user might desire or should expect. For example:

- Are there needs being presented where targeted interventions could prevent worse outcomes but where this is not occurring, e.g. people coming into care homes where the provision of an alternative, community-based service could prevent this happening?
- Is the intensity of the service provided sufficient to achieve the outcomes desired, e.g. in stroke services do we know what intensity of rehabilitation is required for a particular individual to achieve maximum potential recovery?
- Are there unintended consequences to current service provision, e.g. does the provision of mobility aids, through encouraging dependency, actually acerbate diminishing immobility?
- Is the point at which intervention occurs the point at which it is most likely to deliver the best outcomes, e.g. are eligibility criteria effective

rationing devices or do they debar people from provision at a time when it may have the greatest preventative impact.

Answering the above questions is a crucial part of the analysis that needs to be undertaken in developing a commissioning strategy. It may involve challenging professional barriers and stereotypes, it is time consuming and often there is not the data against which such questions can be definitively answered. It may also have considerable inter-agency implications. For example, low levels of health service physiotherapy provision may negatively impact on a person's capacity to recover from a stroke which, in turn, may lead to diminished mobility, which may eventually require considerably increased social care provision. Equally, the absence of an early social care intervention may impact on health services in requiring a costly hospital admission. Effective joint commissioning requires a strong evidence base and the capacity to track back through systems to establish cause and effect across organisational boundaries.

Using the data

So far, Demand Forecasting or Strategic Needs Assessment has been discussed in terms of the information to be captured. Its aim is essentially to discern three distinct populations:

- Given populations - people the LA or the PCT are bound to know because those individuals and/or their carers require assistance either because of the nature of their condition or through their frailty;
- Target populations - those populations an organisation should know now because they are at high risk and poorer outcomes could be prevented if interventions were to take place in the immediate future;
- Vulnerable populations – populations where intervention now may be beneficial either in terms of future prevention or in terms of significantly improving the quality of an individual's life.

As has been illustrated by the range of activities, distinguishing between these three populations clearly takes time and effort by commissioners. Not all of the research necessary can be undertaken at one go and, in some instances, effectively recording and monitoring demand may require new processes for capturing and recording data.

Understanding supply

Commissioners and the market

In recent years the phrase 'Managing the Market' has been much used although increasingly recognised as redundant. Opposition has come from those who suggest that if a market is managed then '*ipso facto*' it cannot be a true market, through to providers who argue with considerable vehemence, that they have no intention of being managed by the public sector especially as, in the case of older people, a large part of their income comes from those who fund their own care. As a consequence, increasingly, the phrase used has moved from 'market management' to 'market influencing or facilitating' in order to describe the relationship that commissioners have with providers. The Department of Communities and Local Government (DCLG, 2006) goes one step further and describes three distinct areas of activity for modern commissioners:

- *Market intelligence refers to the accessibility at a local, regional and national level of market data covering areas such as current market activity, current and potential suppliers, and future opportunities, to inform strategic planning on both the supply*

and demand sides, as well as market research for individual transactions;

- *Market dialogue refers specifically to the quality and frequency of interactions between stakeholders on the supply and demand sides, in interpreting and discussing this data, to better inform individual transactions and the medium and long term development of supply markets for local government services;*
- *Market shaping refers to collaborative action by public sector organisations and the supply market as a whole to develop markets in ways that support the delivery of key policy objectives at both local and national level.* (p. 97)

Whatever terminology is used, clearly future commissioning is moving beyond 'what do we buy, at what price?' Figure 3 below suggests that market intelligence entails covering four areas; conducting a quantitative and qualitative analysis of what is available now, mapping out what best practice would look like and evaluating what resources are currently available as a benchmark against which to judge future costs and charges. Although normally included within considerations of demand, it may also be useful to consider carers on the supply side, given those instances where if carers were not providing a service it would require a response from the LA or the health service.

Quantitative analysis

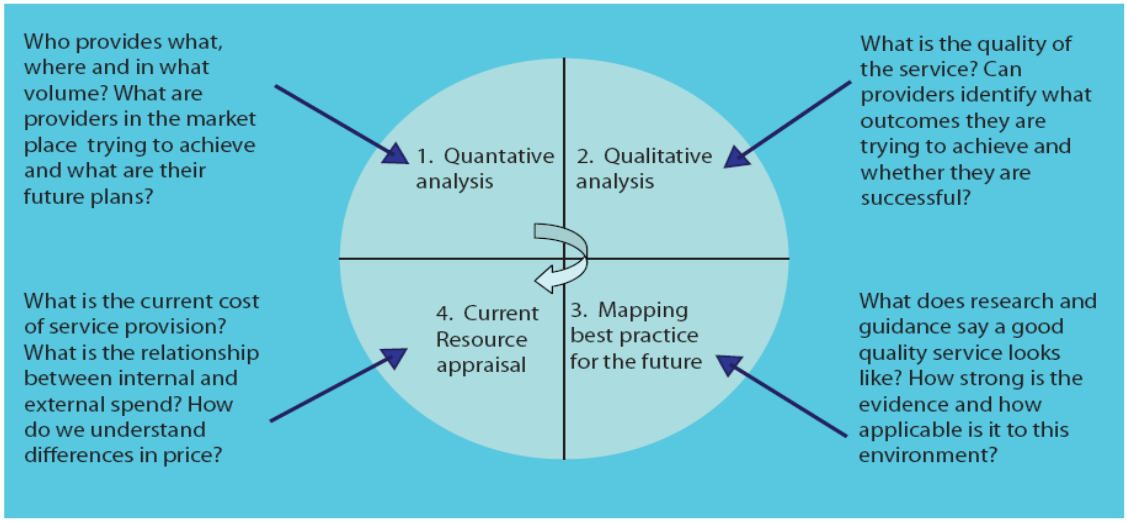
Nationally, the social care market is large and diverse. As the Audit Commission (2005) notes:

> *In 2004, an estimated 410,000 older people lived in residential and nursing homes across the UK. There are about 15,700 private, voluntary and LA care homes in the UK, providing care at an estimated annual value of more than £8 billion per annum.* (p. 1)

The above is equally true of the third sector (IFF Research, 2007):

> *An estimated 35,000 third sector organisations currently provide health and/or social care in England and a further 1600 plan to do so in the next three to five years. The total funding for these services amounts to £12bn over the last year. This is a sizeable amount compared to the government's £87bn budget for health and social care in England in 2005/06.* (p. 1)

Figure 3 Mapping market intelligence



Although the above two reports describe the national volume of provision, the starting point for analysing local markets is about simply knowing what is available and where across the whole market, i.e. in-house services, voluntary and private sectors. It needs to identify shortfalls in provision and potential additional capacity. The data derived from this kind of review may be brought together and displayed in a number of ways. It may simply involve describing the name of providers or companies, what services they offer and how many places are available. Alternatively, the analysis could also provide type and size of service mapped geographically, like with like, services compared by price, levels of demand, comparison to what future types of service provision may be required.

Building on the supply map, commissioners need to have a clear view of what are the future plans of provider organisations and avoid making statements about the private and voluntary sector that are based on supposition rather than evidence. Sometimes this can include assumptions about future capacity to undertake tasks, both in terms of a lack of capacity or in terms of misjudging the direction that those organisations may be working towards. Finally, it is important in mapping the volume of supply to identify those areas where there is an over-supply of provision, either through vacancies, or through premises being used for a wider purpose than was intended. Judgements need to be made about pressure points, caused through potentially higher demand now or in the future (using the demand forecasting material), too high a price, or declining supply.

Qualitative analysis

If building the quantitative picture of the market is time consuming, building a qualitative view is both time consuming and difficult. Whilst qualitative views and opinions abound, little of that information is assembled systematically or benchmarked against a set of standard criteria. Obvious sources for beginning this analysis are:

- CSCI inspections;
- Best value reviews;
- Complaints and letters of support about individual services;
- Anecdotal accounts from service users, carers and members of staff;
- Local and national consultative research.

Overall, the end product from this exercise should be a clear view of the qualitative aspects of current supply and on what this view is based. For each service this may mean making clear statements about what quality is to be expected, how has this quality standard been determined and how it is/was to be tested. Are there divergent views between commissioners, users/carers and providers? Are factors affecting quality temporary or permanent? Is there clarity about what the service is trying to achieve and is this based on outcomes or outputs? Both the quantitative and qualitative data could form part of the material that commissioners need to make available to the wider community as suggested by the *Commissioning Framework for Health and Well-Being* (DoH, 2007). It states that commissioners should enable:

> *any citizen – whether self funding or paid for by the state - to obtain good information and advice about local health, social care and well-being services. This should include information about whether services meet a minimum level of quality, how services compare to others in the area and whether they deliver value for money.* (p. 19)

Mapping best practice for the future

Few commissioners in compiling their strategic approach appear to conduct a rational review of the research and best practice literature in order to help determine

what portfolio of services may be offered in the future. Consequently, change tends to be incremental or driven by factors that are not necessarily synonymous with best practice. In addition, there seem to be few attempts to engage with providers in a way that they could safely reveal their long-term plans and intentions. The emphasis, in many areas, on an arms length engagement with suppliers, does not always help this. Therefore, the end product from this activity should be:

- A model of good practice built on research and best practice examples, with a rationale as to how this provision would be better than that currently available;
- The start of a match between provision and the needs of users and carers.

Resource appraisal

Underpinning market intelligence is the need to gain a good picture of the current allocation of resources and to estimate the costs and benefits of current provision. Again, for most commissioners, whilst it is possible to identify what is paid for externally provided services and some unit costs of internal provision it is much harder to determine whether those services offer value for money or whether alternative forms of provision or re-configurations might offer a better service at a lower price. Some of the information that commissioners might wish to pull together at this stage includes:

- What is the financial range and mean for contracts for different service types?
- What is the distribution of resources as against service recipients?
- What are the cost differentials where services are commissioned as compared to being provided internally through a service level agreement? What is the explanation for these differences and does this deliver value for money?
- Are there any identifiable links between funding and outcomes?
- Are there providers that are financially vulnerable or markets that are under threat?

Some of the above material will be snapshots at a given date. However, this is an area where there is a strong need to understand trends in the market place, such as in contract values and turnover of suppliers. The end product from this exercise should be a succinct statement of costs of provision, both purchased externally and provided internally, together with the costs of commissioning and contracting as an activity. The statement should include an assessment of market strengths and weaknesses, trends or patterns amongst supply and areas of financial performance that could be targets for improvement.

Using the data

The above material suggests how commissioners gain market intelligence in order to inform their market dialogue. Bringing this knowledge of the supply side together with that on demand will entail answering further questions:

- What is the overview of the market in terms of who provides what and who pays or funds the use of that provision (remember this is the whole market not just that sector within which the LA or the PCT commissions)?
- Is there an over- or under-supply of certain services and on what is this based?
- What are the numerical trends in terms of volume and in terms of market share by key providers?
- Are services located in the right place now and in the future?
- What is the comparison between what is provided and what we know (from demand) about what people want?

- What are the costs, what are the trends in expenditure?

The starting point for analysis is always to focus on 'what is the data telling us?' For example, it is fairly straightforward to complete a visual map of current services but the key questions could be, "why has this pattern of services emerged and are there any shortfalls in current provision as a result of this type of evolution? Is there a danger of monopolistic supply? Is the availability of provision equitable across the authority?" In conducting the supply side analysis, the intention is to get as close to being able to link cost with activity with outcome. In most authorities, this is notoriously difficult given that data is often held in different systems and stored under differing categorisation. Tackling this may become part of the change agenda the strategy outlines.

Tackling the issues

The previous sections suggest activities to be undertaken by commissioners in order to map demand and supply in the social care market place. Mapping is not a one-off activity but a range of continuous knowledge acquisition tasks which, over time, build to inform commissioners' understanding. The aim is to acquire the detailed knowledge necessary to influence the market to the benefit of actual and potential groups of users. Some of this will require commissioners developing new skills. This view has been recognised by the Department of Communities and Local Government (2006). They argue that:

> *…developing staff capacity in procurement will clearly be an important factor in driving improvement in the operation of local government services markets. However, as the demands on local government change, alongside the changing aspirations for its role, improvements in procurement capacity and capability alone may not be sufficient to meet these demands. Other capacity constraints may also play a role, including:*
>
> - *The capacity for strategic commissioning as a core leadership discipline within local government;*
> - *The need for improvements in capacity in understanding, analysing and influencing supply chains and markets to secure local and national priorities;*
> - *The need for new ways of working and innovative strategy and delivery vehicles to support a strategic commissioning perspective.* (p. 97)

Examples of the kinds of skills that may be useful to future public care commissioners include:

- How to use local planning controls and mechanisms to influence access to land to promote or discourage the development of services;
- Developing a range of techniques, e.g. focus groups, polls, sampling methods, consultation events in order to better understand demand from a wide range of perspectives;
- The ability to develop local indicators of performance and the data sets that will provide commissioners with knowledge in the future that goes beyond who received what service, for how long, at what price;
- How to use seed-corn funding as an investor in order to influence the development of new services or to protect vital but vulnerable providers.

However, there are some dissenting views about the future role of commissioners and contractors. There is a suggestion that self-directed care, via direct payments and individual budgets, will in effect, abolish the local authority contracting task. Individual needs will be assessed from which, if eligibility thresholds are crossed, people will be offered an actual or a notional budget to purchase services from whomever

they wish. Roles of assessment, advocacy and brokerage remain but the contracting role at an individual and at a collective level will go. In this environment, even the strategic role of commissioning as envisaged in the guidance, may gradually vanish if the view is taken that the market will itself regulate supply to meet demand.

In reality, such a scenario seems unlikely. For example, many older people and carers want quality and choice but not additional responsibility on their part to achieve it, albeit that the scope of the service they receive is framed within a notional budget. Whilst some financial gains may be made through service users bringing new people to assist with care who were not previously in a carer role, such financial benefit is likely to be swiftly offset by higher costs through the inability of commissioners to block purchase services. Finally, whilst market forces may work well in other sectors in driving down costs, this may not be true in social care. For example, in the residential care of older people, where a private market has existed for a long time, there is little evidence that, through individuals purchasing their own care, the price has either been driven down or that the quality of care has been driven up.

The greatest likelihood is for a continued mix of contracting, with a higher proportion of service users directly purchasing their care but, at the same time, joint contracting continuing for those who do not opt for, or who cannot manage, alternative arrangements. This twin approach to purchasing would then be set in a context where the commissioner's task is to ensure that there are sufficient volumes of provision available at a high quality standard, whether individually or collectively purchased, and where such services deliver the outcomes that both users and commissioners desire.

Given the above, this positions commissioning managers in the future as 'investors' on behalf of the public. To achieve this, they will need to have authority to intervene at a senior level within organisations, to be able to negotiate with a wide range of providers, service users and carers, to have good analytical skills and to have a vision of the future, based on sound evidence, that they can drive forwards with a wide range of individuals and organisations.

References

Audit Commission (2005) *Care Homes for Older People in the UK: A Market Analysis*, London: Audit Commission.

Care Services Improvement Partnership (2007) *POPPI (Projecting Older People Population Information)* - CSIP Care Services Efficiency Delivery Programme, (www.poppi.org.uk).

Commission for Social Care Inspection (2006) *State of Social Care in England 2005-2006*, London: CSCI.

Department of Communities and Local Government (2006) *Developing the Local Government Services Market to Support a Long-Term Strategy for Local Government*, London: DCLG.

Department of Health (2006) *Our Health, Our Care, Our Say: A New Direction for Community Services,* London: Department of Health.

Department of Health (2007) *Commissioning Framework for Health and Well-Being*, London: Department of Health.

Health Policy Forum (2006) *Making Commissioning Effective in the Reformed NHS in England*, London: HPF.

IFF Research Ltd. (2007) *Third Sector Market Mapping*, Research Report prepared for Department of Health, London: Department of Health.

Notes on Contributor:

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