Research report for external body :
Cornes, M., Manthorpe, J., Waddington, P., Huxley, P., Evans, S. & Maegusuku-Hewett, T. (2008). *Commissioning eBook Impact Study: Report of Preliminary Findings from Phase 2 of the Evaluation of the Care Services Improvement Partnership (CSIP).*(pp. 1-104). King's College London.

Commissioning eBook Impact Study: Report of Preliminary Findings from Phase 2 of the Evaluation of the Care Services Improvement Partnership (CSIP)

March 2008

Michelle Cornes

Jill Manthorpe

Martin Stevens

Paul Waddington

And

Peter Huxley

Sherrill Evans

Tracey Maegusuku-Hewett.

Correspondence to:

Dr Michelle Cornes

Social Care Workforce Research Unit

Melbourne House (5th Floor)

King's College London,

Strand

London WC2R 2LS

Tel 01768 486462

Email: michellecornes@aol.com

CONTENTS

List of Tables

Acknowledgements

Executive Summary

1: INTRODUCTION

1:1 Overview **8**
1:2 Purpose and scope of CSIP's Commissioning Programme **11**
1:3 CSIP Commissioning Programme achievements for 2006/7 **17**
1:4 CSIP Commissioning tools and guidance – a review **18**

2: COMMISSIONERS' VIEWS AND PERSPECTIVES ON CSIP & THE eBOOK

2:1 Introduction **26**
2:2 Method **26**
2:3 Job roles **29**
2:4 Career Background **35**
2:5 Training and induction **36**
2:6 Using CSIP and the eBook **32**
2:7 Use of other service improvement agencies **42**
2:8 Valuing CSIP and the eBook **44**
2:9 Credibility and evidence-based practice **51**
2:10 Overall impact and value for money **54**
2:11 Summary **54**

3: CONCLUSIONS AND RECOMMENDATIONS **56**

References
Appendices

LIST OF TABLES

Table 1:	**Commissioning Competencies and Steps**	**14**
Table 2:	**Participants Geographical Location and Field**	**27**
Table 3:	**An Analysis of Participants' Job Content**	**30**

Acknowledgements

The research team would like to thank all the Commissioners who participated in this study; and also members of the Social Care Workforce Research Unit Service User and Carer Advisory Group for sharing their views; especially Wes and John for undertaking reviews of the eBook. Thanks also to Nigel Walker and Janet Crampton for all their practical help and support. The research was funded by the Department of Health Policy Research Programme. The views in this report are those of the authors and do not necessarily those of the Department of Health.

EXECUTIVE SUMMARY

1: INTRODUCTION

This summary presents key findings from the second phase of the evaluation of the Care Services Improvement Partnership (CSIP). Phase Two was carried out by researchers from King's College London and the University of Swansea between December 2007 and February 2008. This study was commissioned by the Department of Health and comprised: (1) a knowledge review of the evidence base underpinning the care commissioning tools and guidance produced by CSIP and; (2) qualitative interviews with 25 commissioners working in local councils and Primary Care Trusts (PCTs).

The overall aim was to explore how CSIP's Commissioning Programme supports change across delivery agencies, focussing on one product in particular, the 'Commissioning eBook'. The 'Commissioning eBook' is described as a resource to improve commissioning of community services and it is expected that commissioners will shape and contribute to it.

2: METHOD

The overall objective of the review stage was to test CSIP's claim that its approach to service improvement is 'evidence-based'. We reviewed eight commissioning tools in total, including the 'Commissioning eBook', and broadly followed the method for knowledge review advocated by Pawson and colleagues (2003).

In addition to knowledge review, interviews were carried out with twenty-five (n=25) commissioners working in different locations across the country (at least one per CSIP Region). Participants were working as commissioners in a wide range of different fields (children and families, adults, housing and so on) and were employed by either a local council (n=18), a Primary Care Trust (PCT) (n=5) or through a 'joint arrangement' (n=2). The interviews followed a 'topic guide' which was designed to

explore the impact of the Commissioning Programme and the Commissioning eBook on ‘job role’. The issues considered were: career background; induction and training; how CSIP and the full range of service improvement agencies were used in day to day practice; what commissioners valued most about CSIP; and how judgements were made about the reliability and trustworthiness of the information and advice that are given.

3: KEY FINDINGS

(Review Findings)

- CSIP’s approach is best described as ‘evidence-informed’ rather than ‘evidence-based’. CSIP documents do not always acknowledge this. As a result, recommendations sometimes go beyond the evidence.
- There is a need for greater overall ‘quality control’ in the material produced especially as regard methodological rigor and bibliographic referencing.
- CSIP material was praised highly in the interviews for its clarity of style and practicability. It was considered to be the antithesis of ‘academic writing’ which is perceived to be inaccessible and impracticable. This suggests that there is considerable scope for ‘skill sharing’ between the service improvement and academic communities (vis-à-vis basic research ‘know how’ and how to present and disseminate research findings).

(Commissioners’ Views)

- On becoming a ‘commissioner’ few participants reported receiving any employer-led training and induction. CSIP was identified as playing an important role in filling the gap. Participants used CSIP in a wide variety of ways, ‘mix and matching’ different products and services to build bespoke packages of developmental support which could be ‘fitted in’ around the day to day pressures of the job.
- Few participants seemed aware of the totality of support available through CSIP and CSIP could do more to advertise its products and services.
- CSIP was felt to cater more for those working with adults than to those working with children and families.

- Support provided by CSIP was most appreciated where it was identified as ‘practical’ – that is, where it facilitates networking between commissioners and those who know what is ‘working well’. Credibility and reliability were often judged on the basis of proximity to practice.
- Most participants did not use the eBook on a regular basis. The chief criticism was that it was out of date. Because it was not used regularly most participants felt that it had limited impact on their day to day commissioning practices. The implication was that the preference was for core CSIP services (newsletters, Learning and Improvement Networks (LINS), regional support) rather than specially commissioned tools and products such as the ‘Commissioning eBook’
- Overall, we would conclude that CSIP plays a vital important role in supporting commissioners in their ‘job role’. CSIP was perceived to provide ‘good value for money’ and many commented that they would like to see it continue.

1: INTRODUCTION

1:1 Overview

The Social Care Workforce Research Unit at King's College London was funded by the Department of Health to undertake an evaluation of the Care Services Improvement Partnership (CSIP). Commissioned by the Department of Health and other agencies CSIP was launched in 2005 and aims to support the development of services to help improve people's lives. CSIP's objectives are to:

- promote the improvement of services to lead to better performance and higher quality care for the people who use them;
- support people to live more independently, by promoting more choice, improved access, and greater control for people in their dealings with care providers; and
- facilitate system change (for example, the reconfiguration of health and social care organisations and the improving relationships between statutory and non-statutory sectors).

CSIP works with communities, systems and organisations that are engaged with the health and social care needs of:

- people with mental health problems
- people with learning disabilities
- older people
- children, young people and families
- people in the criminal justice system; and
- families, carers and supporters of these groups.

The evaluation of CSIP began in November 2005 and will report in full at the end of October 2008. The evaluation comprises three phases.[1] Phase one of the evaluation explored CSIP's early organisational development in terms of the integration of nine previously independent service improvement programmes (Cornes et al 2007). These were:

[1] Plans for Phase Three are currently under discussion.

- National Support Service for Child & Adolescent Mental Health Services (CAMHS)
- Integrated Care Network
- Integrating Community Equipment Support Team
- National Institute for Mental Health in England (NIMHE)
- Health and Social Care Change Agent Team
- Valuing People Support Team
- Change for Children
- Health in Criminal Justice.
- Care Services Efficiency Team.

Phase one revealed that many of CSIP's early activities were not explicitly evidence-based according to lead managers, and while this was often said to be understandable, there did not appear to be widespread or conscious use of theoretical models. Service improvement methodologies were not used consistently; while some approaches were evidence based others relied upon interpersonal approaches and tacit or intuitive change methodologies (Cornes et al 2007, p 32). This was an interesting emerging finding and one, which it was agreed with commissioners of the CSIP evaluation, should be usefully explored further. In order to develop a coherent and manageable proposal for phase two, it was decided to focus on the development of products and services around a single cross cutting theme (commissioning) to which all nine previously independent programmes are expected to contribute. This was identified by the Department of Health as timely and policy relevant. It is acknowledged that while there is a wide range of development initiatives and resources nationwide to support the development of commissioning they are of varying quality and appropriateness and lack effective co-ordination (DH, 2007b, p60).

The second phase of the evaluation, the subject of this report, was carried out between December 2007 and February 2008 and comprises: (1) a review of the evidence base underpinning the care commissioning tools and guidance produced

by CSIP[2] and (2) qualitative interviews with 25 commissioners working in local councils and Primary Care Trusts (PCTs) exploring how they are supported in their 'job role' through CSIP's Commissioning Programme. We focused on one product in particular, the 'Commissioning eBook' (CSIP, 2006). Of the commissioning tools and products produced by CSIP in 2006/7 (see Appendix 1) the 'Commissioning eBook' was the flag-ship product developed with a budget of £20,000:

> 'The Commissioning eBook is a resource to improve commissioning of community services: it describes itself as a site that commissioners can shape and contribute to.'
>
> (CSIP, 2006)

The overall aim of phase two is to inform CSIP about its own next steps and to provide complementary information to the 'Health Reform Evaluation Programme' (DH, 2007a). This is concerned with identifying the key factors for effective health care commissioning; including how Primary Care Trusts (PCTs) are building their commissioning capacity and capability; and what use is being made of opportunities to acquire the necessary skills and competencies.

Objectives of Phase Two

1. To provide the DH with a review of the evidence base underpinning the care commissioning tools and guidance produced by CSIP.
2. To evaluate in more detail one method (the 'Commissioning eBook') used by CSIP to support change across delivery agencies from the perspective of its key stakeholders.

[2] Before the end of the 2006/7 business planning period.

The scoping review was led by the Centre for Social Carework Research at the University of Swansea, under the overall project management of Professor Huxley (with the assistance of Dr Sherrill Evans, and Tracey Maegusuku-Hewett). The impact study of the 'Commissioning eBook' was undertaken by Dr Michelle Cornes, Professor Paul Waddington, Professor Jill Manthorpe and Dr Martin Stevens of the Social Care Workforce Research Unit at King's College London. The two strands have worked together throughout the study and the involvement of a number of researchers has provided a wide and useful range of perspectives and insights to the study.

In the remainder of this Chapter, we present an overview of the purpose and scope of CSIP's Commissioning Programme, linking these to relevant policy developments. We consider CSIP's main achievements from its own perspective and against the findings of the review of commissioning tools and guidance. In Chapter 2 we explore how commissioners use of CSIP and their views on the eBook and other tools and resources. Finally, in Chapter 3 we present our overall conclusions as to the nature and effectiveness of the support provided by CSIP in developing commissioning capability and competence at the interface between health and social care.

1:2 Purpose and scope of CSIP's Commissioning Programme

CSIP's Better Commissioning Programme specialises in supporting commissioners working at the interface between health and care (http://www.csip.org.uk/our-initiatives/csip-networks/better-commissioning-programme.html [checked 25.02.08]). Working nationally through a full time 'Programme Lead', and regionally through eight (half time) Regional Development Centre Commissioning Leads, the Programme:

- provides learning opportunities for commissioners at regional and national level to develop skills and capabilities;
- co-ordinates the Better Commissioning Learning and Improvement Network (LIN); an electronic network of commissioners across the country to help keep them in contact and learn from each other;

- delivers programmes of work at regional and national level (recent projects include: direct payments; recruitment and retention; end of life care; a service development guide for older people's mental health and wellbeing; and management development);[3] and
- develops tools and resources to support policy implementation and best practice in commissioning.

In its business plan for 2006/7 (Appendix 1), the stated aim of the Programme is to develop practice that will realise the commissioning position expressed in the White Paper 'Our Health, Our Care, Our Say' (DH, 2006a).[4] In support of this, CSIP led the consultation process and worked with the Department of Health's Policy and Commercial Directorate to establish the commissioning principles contained within the 'Commissioning Framework for Health and Well-being' (DH, 2007b). This aims to shift the focus of commissioning away from volume and price toward quality and outcomes. It seeks to broaden the focus from those who are in ill health to all citizens; looking further than physical health problems to promote well-being, which includes social care, work, housing and all the other elements that build a sustainable community:

> 'Local authorities have taken an historical lead securing this portfolio across communities. PCTs and practice based commissioners should work with local authorities in partnership and across communities.'
>
> (DH, 2007b)

More recently, CSIP's Commissioning Programme has become involved with supporting the vision for 'World Class Commissioning' (DH 2007c, 2007d). World class commissioning is defined as a means of shifting away from traditional models

[3] For more information see www.integratedcarenetwrok.gov.uk/betterCommissioining/index.cfm?pid=653 [Checked 22/02/08])

[4] For 2006/7, secondary objectives of CSIP's Commissioning Programme were: supporting the Commission for Social Care Inspection (CSCI) and the Healthcare Commission (HC) to develop inspections of commissioners; creating links across Government Departments and external organisations (such as IDeA, Association of Directors of Social Services (ADSS) and the Local Government Association (LGA); supporting the development of Children's Trusts; working on the Third Sector; and supporting the work of CSIP's Care Services Efficiency Delivery Team (CSED).

of commissioning and creating world class clinical services and a world class NHS (DH, 2007e). In commissioning terms it is about investing in high-quality personalised services that improve health and well-being for the local population. It aims to achieve partnership working, demonstrating better outcomes, narrowing health inequalities and 'adding life to years and years to life'. Drawing upon negotiating, contracting, financial and performance management skills, world class commissioners are expected to shape local services and drive continuous improvement in quality, safety and choice. To become world class, commissioners are required to take an evidence-based approach. They are said to need advanced knowledge management, analytical and forecasting skills, as well as an ability to listen to and communicate with the local community;

> 'Commissioners ([defined as] PCTs working with practice based commissioners) will be expected to take the lead on behalf of their population; to seek out their views as well as assess their needs; and to act as the catalyst for service transformation and health improvement locally.'
>
> (DH, 2007e p26)

While the 'Commissioning Framework for Health and Well-being' (DH, 2007b) defines eight steps to effective commissioning, 'World Class Commissioning' (DH, 2007d) identifies eleven headline competencies. These are summarised comparatively in Figure 1 below.

Table 1: Commissioning Competencies and Steps

	Commissioning Framework for Health and Well-being - Eight Steps to More Effective Commissioning (DH, 2007b)	World Class Commissioning - Headline Competencies (DH, 2007d)
Engaging the population	Put People at the Centre of Commissioning – Give people greater choice and control (including self-care). Develop mechanisms to help the public get involved in shaping services, with advocacy to support groups who find it hard to express views (1)	Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health (3)
Needs Assessment & Knowledge Management	Understand the needs of populations and individuals. Undertake Joint Strategic Needs Assessments, use recognised assessment and care planning processes, mitigate risk to the health and well-being of individuals (2)	Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements (5)
	Share and use information more effectively. Clarify what information can be shared; join up the IT systems of front line practitioners and encourage individuals and communities to be co-producers of information (3)	
Stakeholder Engagement	Recognise the interdependence between work, health and well-being. Facilitate collaborative approaches with business (5)	Lead continuous and meaningful engagement with clinicians to inform strategy and drive quality, service design and resource utilization (4)
Prioritisation		Prioritise investment according to local needs, services requirements and the values of the NHS (6)
Process Partnership Finance & Outcomes	Develop incentives for commissioning for health and well-being. Bring together local partners to promote health and well-being and independence by using contracts, pooled budgets, direct payments and practice based commissioning (6)	Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities (2)

		Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes (7)
		Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration (8)
		Secure procurement skills that ensure robust and viable contracts (9).
	Assure high quality providers for all services. Develop effective strong partnerships with providers and engage them in needs assessments. Ensure fair and transparent procurement. Focus on outcomes, leading to more innovative provision, tailored to the needs of individuals and supplied by a wider range of providers (4)	Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes (10)
		Make sound financial investments to ensure sustainable delivery of priority outcomes (11)
Leadership & Accountability	Make it happen – be locally accountable (7)	
	Make it happen – capability and leadership. The DH and other stakeholders will provide support to all commissioners to address their capability gaps. This support will be tailored to different commissioners – PCTs, practice based commissioners and local authorities (8)	Be recognised as the local leaders of the NHS (1)

*** Numbers in brackets denote the priority given to the 'competence'/'step' in the original documents.**

The strategic positioning of CSIP's Commissioning Programme at the interface between health and care is particularly important as, according to the King's Fund (2006), many of the aspirations of the White Paper will falter unless Primary Care Trusts (PCTs) and local authorities can both deliver better commissioning more effectively. It concludes that much remains to be done to build joint commissioning skills between health and social care. In terms of the spur for joint working, the Local Government and Public Involvement Health Act 2007 places a statutory duty on upper tier local authorities and PCTs to produce a Joint Strategic Needs Assessment (JSNA). Joint Strategic Needs Assessment describes a process that identifies current and future health well-being needs in light of existing services, and informs future service planning, taking into account evidence of effectiveness (DH, 2007f):

> 'By identifying current needs and anticipating future trend, PCTs will be able to ensure that current and future commissioned services address and respond to the needs of the whole population… The JSNA will form one part of this assessment, but when operated at world class levels will require more and richer data, knowledge and intelligence than the minimum laid out within the proposed duty of a JSNA.'
>
> (DH, 2007d)

To achieve the required competency level, 'World Class Commissioning' (DH, 2007d) states that there is a role for educational establishments, improvement agencies and established commissioners from other public, private and voluntary sector organisations in the teaching, training and development process and that commissioners will need to engage with them to improve capability by agreeing and securing what is needed at an organisational and individual level:

> 'Commissioning competencies should feature in the personal development goals of individuals so that collectively individuals and organisations in which they work cover the full spectrum required.'
>
> (DH, 2007d p4)

The 'Commissioning Framework for Health and Well-being' (DH, 2007b) asks PCTs to prepare development plans which will be inspected by the Healthcare Commission in 2007/8 to assess progress in building commissioning capability (DH, 2007b). Particular attention is drawn to the *'wealth'* of resources provided by CSIP and it is suggested that PCTs may wish to work together with local authorities[5] and practice based commissioners to commission learning sets, peer-to-peer support, and other local initiatives.

1:3 CSIP Commissioning Programme achievements for 2006/7

In supporting the development of commissioning capability and competence in 2006/7, CSIP describes its main achievements as follows:

- Introduction of regional commissioning development programmes to build local commissioning competency.
- Management of a range of conferences, networks and other regional groups to address commissioning development issues.
- Support for the design and joint delivery of a commissioning management development programme for teams from local authorities/health/third sector (accredited by the University of Teeside).
- Work with Primary Care Trust (PCT) commissioners in London to increase investment in telecare for people with long term conditions.
- Support for the development of 'Joint Strategic Needs Assessment Plans' (JSNA).
- Provision of a range of tools and guidance to assist commissioners in strengthening the link between policy and practice, including (as part of the eBook) the development of on-line *podcasts* as training and awareness raising products. It is reported elsewhere on the website[6] that *'In the last six*

[5] The DH (2007b) anticipates that commissioners of social care should be able to access support through each Primary Care Trust's *'Framework for Procuring External Support for Commissioners'*.'

[6] http://www.integratedcarenetwork.gov.uk/betterCommissioning/index.cfm?pid=184 [checked 29.02.08]

months, an average of over 3,000 articles have been downloaded per month by our readers.'

http://www.csip.org.uk/about-us/about-us/commissioining.html

[Checked 28.02.08].

1:4 CSIP Commissioning tools and guidance - review findings

Based on a review of the literature on health care commissioning, Woodin and Wade (2007) caution that defining and validating commissioning competency are incredibly challenging tasks because there are no definite answers to questions such as: What are commissioners required to do? What knowledge, skills and attitudes and behaviours are required to do it well? Who (either within or beyond the NHS) is most likely to possess these attributes? How should these capabilities be developed? They conclude that while numerous toolkits, frameworks and models have been developed to describe effective commissioning, a common understanding of what competent commissioning really looks and feels like has remained elusive. In this section, we present overview findings from a review of the evidence base underpinning CSIP's Commissioning Programme and the eBook, testing the claim;

'We use an extensive range of evidence-based approaches and methods. An online directory of service improvement is available for use across our organisation and is regularly updated to share the latest tools, techniques and experiences.'

CSIP Marketing Brochure

www.csip.org.uk/about-us.html

[Checked 15.2.08]

To identify tools and guidance developed by CSIP to support the development of commissioning practice we used the cross CSIP website search facility (www.csip.org.uk [checked 27.11.07]) to find all references to 'commissioning' (n=20).This initial search acted as a gateway to a vast library of resources. In addition to the tools developed by CSIP, we also included products developed by the former constituent parts of CSIP (e.g. the Change Agent Team) where those

products were now being taken forward and further developed by CSIP (e.g. the Commissioning eBook). Primarily to ensure that the task was manageable given the three month time frame for the review, we excluded a number of products to be found on the CSIP web site but refer to them in the text where appropriate. The excluded products include:

- 'Think tank'[7] discussion documents;
- On line Video Podcasts (which are filmed discussion groups)[8];
- Documents in draft;
- Non-CSIP tools and guidance such as those produced by the Centre of Public Innovation and the Audit Commission;
- Resources which CSIP had commissioned but did not then subsequently appear as the main author;
- Resources linked to CSIP's health care commissioning web page (http://www.integraedcarenetwrok.gov.uk/betterCommissisioning/index.c.f.m?pid= 309) [Checked 27.11.07].
- Resources which provide specialised advice (e.g. guidance on condition specific care pathways) or very general advice (e.g. guidance on developing domiciliary care);
- Materials produced after the end of the business planning period 2006/2007 which determined the timeframe for the review (e.g. the new 'Readiness Tools' (http://www.readiness-tools.com/ [Checked 29.2.08]).

In total we identified eight CSIP tools for review (see Appendix 3 for the reviews of each individual tool):

- Commissioning eBook (see Appendix 3a)
- Catalyst for Change & Catalyst II (see Appendix 3b)
- Getting to grips with the money; including commissioning for people with learning difficulties (see Appendix 3c)

[7] Think Tanks are discussion groups convened by CSIP around a topical theme.

[8] We did however ask the Service User and Carer Advisory Group at the SCWRU to review one of the podcasts (see Appendix 2).

- Key activities in commissioning social care (2nd edition, 2007) (see Appendix 3d)
- A guide to fairer contracting part 1 (see Appendix 3e)
- A guide to fairer contracting part 2 (see Appendix 3f)
- From segregation to inclusion: commissioning guidance on mental health day services (see Appendix 3g)
- Fair Commissioning – The Four Tests of Fairness Checklist (CSIP produces a range of checklists and we selected this particular one as being illustrative of the overall product style) (see Appendix 3h)

We emailed the list of the tools to the CSIP commissioning lead to check if any significant tools were missing in her view. We read all of the tools and guidance to identify the underpinning evidence base, and where we found references to evidence in the text we obtained and read the originals (where available) and subjected a sample of them to detailed review, to assess the robustness of the evidence and the extent to which we believe it could be relied upon. In doing so, we broadly follow the model advocated by Pawson and colleagues (2003) in a SCIE Knowledge Review. According to Pawson et al in judging the quality of sources of knowledge, the basic questions to ask are: **transparency** (are the reasons for it clear?); **accuracy** (is it honestly based on relevant evidence?); **purposivity** (is the method used suitable for the aims of the work?), **utility** (does it provide answers to the questions it set?); **propriety** (is it legal and ethical?); **accessibility** (can you understand it?); and **specificity** (does it meet the quality standards already used for this type of knowledge?).

Using this approach also enabled us to take a broad view of what may be meant by 'evidence-based practice' since this model challenges the stereotypical medical model of the 'gold standard' of the Randomised Control Trial – promoting the view that a wider range of evidence should be considered valid. This point was echoed by Research in Practice (RIP, 2006, p 12) which describes its preference for the term 'evidence-informed practice':

> ‘Although few people would dispute that decision-making should be informed by the best available research evidence, there is still vigorous debate about what constitutes credible and robust research in the social science context’.

The findings of the review suggest that CSIP’s work is underpinned by a range of approaches and methods and that the overall approach is perhaps more closely aligned with the concept of ‘evidence-informed practice’ rather than ‘evidence-based practice’ (RIP, 2006). This reflects that CSIP often draws on ‘experiential’ (practice wisdom and user views[9]) as well as ‘empirical’ (research) evidence. Indeed, the use of ‘experiential evidence’ in this specific context needs to be situated in a wider review of the literature (Woodin and Wade, 2007). This suggests that the existing evidence base tells us little about the specific mechanisms through which commissioning competency does, or does not, lead to improved outcomes. As Woodin and Wade (2007, p1) point out, the lack of evidence should not undermine attempts to articulate and develop commissioning competency, however this complexity and ambiguity should be clearly acknowledged. Briner (2006) captures the essence of this when writing about Human Resource Management:

> ‘Actually, there is always evidence. It may be scant, poor quality, not very relevant, indirect, anecdotal, old, sketchy, but it will be there. A common misunderstanding of evidence-based practice is that it means acting only on the basis of ‘good’ evidence. However, as indicated earlier, this is just not the case. Rather, it is about combining the best available evidence with practitioner expertise in order to make decisions about what to do’ (Briner, 2006, p5).

Usefully, Briner then goes on to suggest that the original, somewhat narrow, focus on the question ‘what works?’ has started to broaden in the following ways:

> ‘First, is the issue of what particular kinds of practices and in what combinations of practices affect what sort of outcomes (eg, Cappelli and

[9] While CSIP advocates user involvement in the ‘Commissioning eBook’ we did not see any evidence (methodologically described) of any actual involvement in the design of tools and products (see Appendix 2 for comment).

> Neumark, 2001). Second, better designed longitudinal studies which are more able to explore cause and effect can help address and unpack whether it is HRM (Human resource management) that drives outcomes such as financial performance or whether, in fact, it is financial performance that drives HR practices (eg, Wright et al., 2005). Third, are the relatively recent attempts to alert practitioners to the dangers of fads and fashions in management, and advocate the importance of evidence based practice (Pfeffer and Sutton, 2006). Fourth, are the more comprehensive and rigorous attempts to address the question of whether HR works, by conducting semi-systematic reviews. One such review (Wall and Wood, 2005) reinforces the point that asking simply whether in general HR works is the wrong sort of question. In addition, it concludes: '… although consultants are acting in good faith, and their views are seemingly reinforced by the presumption on the part of academics that HRM systems actually do promote organizational performance, the empirical evidence is as yet not strong enough to justify that conclusion' (Wall and Wood, 2005, p. 454).

There are some signs that social care and the integration agenda may be beginning the same attempt to broaden the 'what works' question as Briner believes HRM is doing. For instance, within and without CSIP there is a growing emphasis on outcomes driven services, there are increasing attempts by a range of research commissioning agencies to address the research capacity problems in social care and there is a growing recognition that more longitudinal studies are needed in social care.

Turning our attention to the review of the individual tools and documents, on the whole most were accessible and often well written in our view. However, there is much evidence of a lack of transparency concerning: methods used (insufficiently described); sources of data described either too briefly or not at all; no indication of how samples of either agencies or individuals have been selected; inadequate reports of the methods of analysis of information. This is not to say that the information is not there - simply that it is not presented. Where citations are made they are frequently inaccurate, leading to a failure to be able to trace the original

source. This applies in particular to web-site citations, where no date of access is given. Because organisations change and documents sometimes are taken off websites or moved, this makes it difficult to follow up information. The review also raises the question of how case examples and good practice examples exert their influence, if they do, on the commissioning process and service outcomes. This is by no means a straightforward matter. Surveys of good practice or illustrative practice may benefit from being clearer about their inclusion criteria and if they are descriptive then a method for gaining data might help.[10] While some CSIP documents are more technically robust more than others, it does appear that there is a need for greater overall 'quality control'.

Arguably what really weakens the impact of some CSIP documents is the over-reliance on what Pawson et al (2003) refer to as 'infrastructural knowledge' (documents that underpin the basic role and operation of social care including policy, guidance, legislation, inquiries, regulation and standards). On a number of occasions, for example, the evidence that has been gathered provides very limited support for the matter under investigation yet because the subject is a policy goal the authors seemingly advocate the roll-out of the particular programme on the basis of, at best, small or inconclusive evidence (see Appendix 3c). As touched upon above, the reliance on 'best guess' or 'best evidence' is not in itself problematic so long as it is acknowledged as such.

Often the style of influence and transmission of ideas seems to be similar in CSIP and in the work of management consultants, and both seem to be removed from the generation of knowledge systematically using a predetermined design, as personified by SCIE (Social Care Institute of Excellence) and NICE (National Institute of Clinical Excellence).[11] The transmission of ideas seems to owe more to the social status and influence of the knowledge producer, and the extent to which this person influences

[10] SCIE, for example, has used a Practice Survey method over the years that may be worth considering (www.scie.org.uk [checked 10.11.07])

[11] For more information see www.scie.org.uk and www.nice.org.uk

or holds sway over others. This is a process known as ‘social proof’ and has been described in ‘The Game’ (Strauss, 2005):

> ‘One means we use to determine what is correct is to find out what other people think is correct...We view a behaviour as more correct in a given situation to the degree that we see others performing it. As with the other "weapons of influence," social proof is a shortcut that usually works well for us: if we conform to the behaviour we see around us, we are less likely to make a social faux pas’ (p116).

Cialdini (1993) reports that the tendency for people to follow suit trades on the ‘bandwagon fallacy’ and appeals especially to the psychographic profile known as ‘believers’, those who are motivated by ideals and respond well to such tag lines as ‘fastest growing’ or ‘4 out of 5 doctors recommend...’ Cialdini suggests that:

> ‘We are likely to use these cues when we don't have the inclination, time, energy, or cognitive resources to undertake a complete analysis of the situation. When we are rushed, stressed, uncertain, indifferent, distracted or fatigued, we tend to focus less on the information available to us. When making decisions under these circumstances, we often revert to the rather primitive but necessary single-piece-of-good-evidence approach.’ (p235)

Unfortunately, he also argues, the evidence suggests that the ever-accelerating pace and informational crush of modern life will make this particular form of unthinking compliance (shortcuts and the quick fix) more and more prevalent in the future. Indeed, even Pawson et al (2003) argue for more detail in journal abstracts so that whole articles do not have to be read in order to save abstractors’ or indexers’ time. The problem with this approach is that we risk being misled unless we can be sure of the robustness of the approach that is being advocated. As Pirsig (2005) maintains in ‘Zen and the Art of Motorcycle Maintenance’:

> ‘The real purpose of scientific method is to make sure Nature hasn't misled you into thinking you know something you don't actually know. There's not a

> mechanic or scientist or technician alive who hasn't suffered from that one so much that he's not instinctively on guard. That's the main reason why so much scientific and mechanical information sounds so dull and so cautious. If you get careless or go romanticizing scientific information, giving it a flourish here and there, Nature will soon make a complete fool out of you. It does it often enough anyway even when you don't give it opportunities. One must be finely careful and rigidly logical when dealing with Nature: one logical slip and an entire scientific edifice comes tumbling down. One false deduction about the machine and you can get hung up indefinitely.'

Or, as Briner (2006) puts it:

> 'From fortune-tellers to football managers and from homeopaths to home secretaries, all practitioners tend to believe quite strongly that what they do is based on evidence. To challenge this belief is likely to provoke a reaction somewhere between mild puzzlement and deep offence in most (people)' (p1).

However, it is the readers of the eBook who are best placed to say if CSIP's current orientation is useful and it is to their views and perspectives that we now turn our attention.

KEY POINTS

- CSIP's approach is best described as 'evidence-informed practice' rather than 'evidence-based' practice.
- There is a need for greater 'quality control' to ensure consistency in reporting of methods and citations.
- The evidence base for developing commissioning is weak. It is important to acknowledge where advice and guidance is based on 'best guess' or 'best available evidence' and to make recommendations accordingly.

2: COMMISSIONERS' VIEWS AND PERSPECTIVES ON CSIP AND THE eBOOK

2:1 Introduction

In this chapter we explore the perspectives of twenty-five (n=25) commissioners on CSIP and, in particular views on the Commissioning eBook. We begin with some contextual information on 'job role', career background and the induction and training provided by employers. We explore how CSIP and the full range of service improvement agencies are used in day to day practice; what commissioners value most about CSIP products and services; and how judgements are made about the reliability and trustworthiness of the information and advice that is given. Finally, we consider the overall impact of CSIP and the eBook on commissioning practices.

2:2 Method

We carried out in-depth face to face interviews with twenty-two commissioners. Where it was not possible to arrange a face to face meeting we carried out a telephone interview (n=2). We also received one written submission following a request to see the interview questions prior to interview (n=1). In recruiting commissioners to the study we aimed to gather a sample spilt between those who were familiar or regular uses of CSIP and those who were less familiar with CSIP (perhaps never having heard of CSIP or having made a previous decision not to use CSIP). To recruit participants familiar with CSIP we asked CSIP's 'Better Commissioning Learning and Information Network' (LIN) to send out an email out to its members informing them of the study and asking them to get in touch if they were interested in participating. This yielded a response of over forty emails from which we subsequently approached thirteen commissioners for interview (n=13). Selection was on the basis of first come first come served ensuring that we had secured broad representation across the different CSIP regions and commissioning fields (see Table 2).

Table 2: Participants (n=25) Geographical Location and Commissioning Field

CSIP REGION								Commissioning Field								
NE	**NW**	**EM**	**WM**	**E**	**L**	**SE**	**SW**	**CF**	**CJ**	**LD**	**MH**	**OP**	**PD**	**SI**	**SM**	**other**
					LC							X				
		LC										X				
	LC												X	X		
PC											X					
							LC					X				
							LC									A
PC																P
						LC										A
	PC											X				
	PC											X				
	LC											X				A
			LC													A
			LC					X								
			LC					X								
			PC													P
			LC													A
					LC							X				
				JA						X	X				X	
LC																H/CS
	JA								X		X					
					LC							X				
					LC			X								
					LC											H/CS
							LC			X						
					LC							X				

KEY

NE = North East, Yorkshire and Humberside
NW= North West
EM = East Midlands
WM = West Midland
E = Eastern
L = London
SE = South East
SW = South West
CF = Children and Families
CJ = Criminal Justice
LD = Learning Disability
MH = Mental Health
OP = Older People
PD = Physical Disability
SI = Sensory Impairment
SM = Substance Misuse
A = Adult Social Care
H/CS = Housing and Community Services
P = PCT Population
LC = Local Council Employee
PC = PCT Employee
JA = Joint Appointment

*Note that to protect the anonymity of participants, the list running order does not link to transcript numbers in the text.

To recruit participants who may be unfamiliar or less familiar with CSIP we approached another email network which also provided information to commissioners working in health and social care; explaining why we wanted to hear their views even if they had no previous awareness or contact with CSIP or its products This yielded no responses. As a result, we used our own informal networks to find a sample of commissioners who were not registered with CSIP's Better Commissioning LIN (n=7). We could not find any commissioners who had never heard of CSIP and, barring two commissioners, most in the second sample turned out to be regular users of CSIP products; with views and perspectives not markedly different to those recruited through the LIN.

When inviting participation, we did not give a fixed definition of what we meant by the term 'commissioner' allowing participants to self-select on the basis that that was how they identified themselves. Eighteen participants were employed by local councils, five were employed by PCTs and two were employed on the basis of a joint appointment between the local council and the PCT.[12] It is important to acknowledge then that there is bias in the sample towards the views of commissioners working in local councils. Two participants worked close to front line practice[13] (n=2) while the rest were evenly split between those working at middle management or director or assistant director level. Some participants described themselves as experienced commissioners while others acknowledged that they were relatively new to commissioning and inexperienced. Participants were given assurances that they would remain anonymous in any reports.

Prior to the interview all participants were asked to re/familiarise themselves with CSIP and Commissioning eBook. The interview followed a topic guide (Appendix 4) covering a range of issues including discussion of: (i) career history, training to become a commissioner and current job role; (ii) use of CSIP and other service improvement agencies; (iii) views on the full range of products developed by CSIP,

[12] Participants are identified in the text as local council (LC), Primary Care Trust (PC) or Joint Appointments (JA) reflecting their employment status followed b their transcript number (e.g. (LC1) (PC2) (JA3).
[13] One commissioner was the team manager of a hospital social work team and one commissioner was responsible for managing a service contract in a local council 'Commissioning Team'.

including the Commissioning eBook; (iv) overall impact on working practices. Twenty face to face interviews were digitally recorded and transcribed.[14]

The data was analysed thematically (by hand). Transcripts were read by four different members of the research team. Information on commissioning was subject to a content analysis using the steps and competencies framework outlined in the previous chapter (more details are given below in the section on job content). Analysis of data on the 'Commissioning eBook' was broadly informed using Strother's (2002) framework for understanding e-learning in training in corporate settings. This explores: (*Level I: Reaction*) learners' reactions to the course/learning object; (*Level II: Learning*) what was learned; (*Level III: Transfer*) changes in behavior on returning to the job after the e-learning/training; and (*Level IV: Results)* the business outcomes flowing from learners doing their jobs differently.

Finally, a draft of the report was circulated to all participants, to 'reality check' the findings.

2:3 Job role

In the interviews, participants were asked to give a description of their role as a commissioner and what constituted a typical day for them. Based on a content analysis which matched key phrases in the interview transcripts to those found in the commissioning steps and competencies framework (highlighted in bold below), Table 3 presents an insight into participants' 'job role'. This would seem to suggest that for most participants, the principle emphasis in commissioning is on: involvement and engagement; needs assessment, partnership working; procurement and contract compliance, with less emphasis currently on; sharing information; investing in priority outcomes; clinical engagement; leadership and public accountability:

[14] Telephone interviews were not recorded and the meeting space for two of the interviews was not conducive to recording.

Table 3: An Analysis of Participants' Job Content Based on the Commissioning Steps and Competencies Frameworks

	Commissioning Framework for Health and Well-being - Eight Steps to More Effective Commissioning (DH, 2007b)	**World Class Commissioning - Headline Competencies (DH, 2007d)**
Engaging the population	Put People at the Centre of Commissioning – Give people greater **choice and control** (including **self-care**). Develop mechanisms to help **the public get involved in shaping services,** with **advocacy** to **support groups who find it hard to express views** LC1 LC3 LC6 LC12 LC15 LC17 PC18 PC19	Proactively seek and build continuous and meaningful **engagement** with the public and patients, to **shape services** and **improve health** LC1 LC3 LC6 PC18 PC19
Needs Assessment & Knowledge Management	**Understand the needs of populations and individuals.** Undertake **Joint Strategic Needs Assessments**, use recognised assessment and care planning processes, mitigate risk to the health and well-being of individuals JA2 LC3 LC6 LC10 LC11 LC15 PC16 LC17	**Manage knowledge** and undertake robust and regular **needs assessments** that establish a full understanding of current and future **local health needs** and requirements LC1 JA2 JA4 PC18 PC19
	Share and use information more effectively. Clarify what information can be shared; **join up the IT systems** of front line practitioners and encourage individuals and communities to be **co-producers of information**	
Stakeholder Engagement	Recognise **the interdependence between work, health and well-being**. Facilitate **collaborative approaches with business**	**Lead continuous and meaningful engagement with clinicians** to inform strategy and drive quality, service design and resource utilization
Prioritisation		**Prioritise** investment according to local needs, services requirements

		and the values of the NHS LC6
Process **Partnership** **Finance** **& Outcomes**	Develop incentives for **commissioning for health and well-being**. **Bring together local partners** to promote health and well-being and independence by using **contracts, pooled budgets, direct payments and practice based commissioning** LC1 JA 2 LC10 LC11 LC12 LC14 LC15 LC17 LC20 LC23 LC25	**Work collaboratively** with community partners to commission services that **optimise health gains and reduce health inequalities** JA4 LC17 PC18 PC19 PC24
		Effectively **stimulate the market** to meet demand and secure required clinical and health and well-being outcomes LC12 LC17
		Promote and **specify continuous improvements** in quality and outcomes **through clinical and provider innovation and configuration** JA2 PC16
		Secure **procurement skills that ensure robust and viable contracts** LC1 JA2 LC3 LC5 LC11 LC12 PC16 PC18 PC19 LC20 LC23 PC24
	Assure high quality providers for all services. **Develop effective strong partnerships with providers** and engage them in needs assessments. Ensure fair and transparent procurement.	Effectively manage systems and work in partnership with providers to ensure **contract compliance** and continuous **improvements in quality and outcomes** LC1

	Focus on outcomes, leading to more innovative provision, tailored to the needs of individuals and supplied by a wider range of providers LC1 JA2 LC3 JA4 LC12 LC17 PC18 PC19 LC20 LC25	JA2 LC3 JA4 LC12 LC17 PC18 PC19 LC20 LC25
		Make sound **financial investments** to ensure sustainable delivery of priority outcomes LC1 PC18 PC19
Leadership & Accountability	Make it happen – be **locally accountable** LC1 JA4 LC6	
	Make it happen – **capability** and leadership. The DH and other stakeholders will **provide support** to all commissioners to address their capability gaps. This support will be tailored to different commissioners – PCTs, practice based commissioners and local authorities LC6 PC24 LC25	Be recognised as the **local leaders** of the NHS LC1 JA4 LC6

*Some participants were excluded for the following reasons: PC9 = written response which did not give sufficient information about job role; LA21/LC7 = Telephone interviews not transcribed; PC13/LA8 = Tape failed - no transcript.

> ‘When I looked at the [world class commissioning] competencies I was quite delighted to see that actually I could tick the boxes and that if someone is going to examine it then at least I would be able to say I was up to speed.’ (LC1)

No participants in the study described their job role in terms of *‘working at the interface between health and care’* (which is how CSIP’s commissioning programme conceptualises its target audience). Participants tended to position themselves in either the local council, the Primary Care Trust or in an integrated arrangement:

> ‘In [this area] we have very integrated joint commissioning arrangements so we have formal joint commissioning partnership which is responsible for commissioning Mental Health, Adult Learning Disabilities and Substance Misuse Services for both the local authority and the NHS, so it is a partnership with 250 million pounds a year on expenditure… We specify an integrated mental health service not a health or social care service.’ (JA2)

A recurrent theme in the interviews was the difficulties associated with facilitating ‘joint working’ and ‘joint commissioning’:

> ‘We had a big event a few months ago and no one from the council turned up even though they had been invited… There is without question a need for greater integration and that comes through personal relationships and the need for us to have an understanding of what councils plans are and what they are trying to do, and for them to have an understanding of ours. I do think if we are to be successful we need to have greater integration.’ (PC16)

> ‘I also manage a joint commissioning team which is based in the PCT, now that is not an ideal relationship I will be honest. Because they are based at the PCT they are seen as PCT staff … and one of my concerns is at the moment that the council views aren’t represented by that team of people.’ (LC3)

There was a perception among a number of participants that there were significant differences between local council and PCT commissioning. The former was perceived to be rooted in the broader principles of service development, while the latter was assumed to be more contract and procurement based:

> *'*One of my PCT colleagues recently said I do "pure commissioning", and I thought okay… you mean you go out and say we need ten beds somewhere. That's not commissioning that is just contractual procurement of ten beds, it is not about why do you want ten beds, and will you need ten beds next week…' (LC1)

> 'The SHA (Strategic Health Authority) has driven the establishment of a Commissioning Business Support Agency and that is a region wide contractual body. It offers hope that it can free us from the detailed transactional end of contracting by doing things like the data crunching for us… The theory is that this should free us up to develop very clear strategies… but there is still so much more to do.' (PC24)

A number of participants felt that recent government policy could have done more to bridge the divide:

> 'I was very disappointed that competencies were only laid down for the NHS and when I asked Ivan Lewis at the recent conference why - he said well because we feel that actually local authorities' commissioners are ahead.' (LC1)

2:4 Career background

Participants had varied career backgrounds, with most having worked in front line health or social care before progressing into management then into commissioning:

> 'I worked in mental health services as a nursing assistant, in a psychiatric hospital… and just carried on through social care… starting right at the bottom'. (LA3)

Other career pathways were through NHS management training or through the administrative side of local authority procurement and contracts management. One participant highlighted the uncertainty as to what is the most suitable career pathway for commissioner:

> 'When I started on the commissioning side here the job descriptions for commissioners were very much around people who had a clinical background and expert knowledge of service areas, as being the main requisite. I changed that fairly rapidly. It was my view that people with a clinical background - particularly a managerial background in practice - would only rarely have the level of business planning skills that I felt that were required. To me if I had to have one or the other I would rather have somebody who had good business planning skills, knew the care business sector but didn't necessarily have a clinical background.' (JA2)

Indeed, a recurrent theme was 'falling into' commissioning rather than pursuing it as a specific career pathway:

> 'I picked up commissioning because no one else was doing it.' (LC6)

> 'An awful lot of people are finding themselves in a commissioning role…People have been shifted into jobs that they know nothing about and that is one of the problems.' (LC1)

‘Last year [following a reorganisation] people went into very different jobs and all of us struggled thinking I can’t do this and all of a sudden there is the realisation that we are not thick, that what we were being asked to do is meaningful.’ (JA4)

2:5 Training and induction to the role of commissioner

On becoming a commissioner very few participants reported receiving any formal, in-house training to develop their commissioning skills and competencies. In some areas employers were reported to be generally supportive, recommending and encouraging staff to undertake formal training and qualifications while in other areas this was not the case.

‘I think what the big gap is, and I know that CSIP have been quite instrumental in pushing this… is skilling up the workforce - we have employed people who are called commissioners and actually they are not - we have never really skilled them up to do this.’ (LC25)

‘I do think they are beginning to do stuff for middle managers and I think in ten years time it might be quite different…I am really keen for my own commissioning managers to have a much more structured approach to what commissioning is. At the moment in my own team of people I see a bag of excellent skills which aren’t always in the right combination. That’s a typical situation in commissioning teams I think.’ (PC24)

‘We are looking actually at putting on training for our frontline commissioners and for us in strategic commissioning, but that is as far as we have got because we have no money.’ (LC6)

‘The message seems to be that world class commissioning be put in our objectives but I am not aware that the PCT has any plans for developing staff to become world class commissioners… however our Chief Exec is adamant

> that we will be world class commissioners in the next year and that we will be a first class PCT, so we will have to wait and see won't we?.' (PC16)

Most participants in the study were educated to degree level or above. Many had undertaken additional university courses fairly recently which were perceived to be supportive of their professional development as commissioners:

> 'I only actually came into formal commissioning about three and a half years ago, but having done a Business Management MBA and that sort of stuff I found commissioning brought it all together.' (JA2)

When discussing training or the need to develop training opportunities the conversation often turned to CSIP:

> 'We worked quite closely with CSIP to establish a commissioning course which is a post graduate certificate that ran last year, at [the] University. CSIP had to do an awful lot to make that happen and keep it going.' (JA2)

> 'I would like to see how the world class commissioning competencies are going to pan out… It doesn't matter where we are on our journey as commissioners, training is critical and accredited training, and I see CSIP being the driving force of that.' (LC1)

To summarise so far, few participants reported then receiving any employer led training and induction. This was despite the fact that there were few reports of clearly structured pathways into commissioning. In turn, CSIP was often identified as playing an important role in potentially filling the gap.

2:6 Using CSIP and the eBook

Participants use CSIP in a wide variety of different ways, often developing a highly personalised pattern of use, mix and matching different products and services to

meet their own specific needs and requirements. Most participants in this study could be described as regular users; especially as regards internet use and sign-up to the various email newsletters:

> ‘I get stuff from the Housing LIN, the Telecare LIN and I have asked for the workforce one.’ (JA4)

> ‘I would look at the [CSIP] site maybe once a week - depends what I am doing but if there is something new then probably more than that. And I would have expectations that people that I work with use it and are familiar with it. I think we start from scratch too often when we don’t need to.’ (LC15)

> ‘I have used CSIP on and off. I dip in and out when I need it…If I was talking to a colleague… then I’d say let’s go and have a look at what CSIP actually says.’ (JA6)

> ‘You do form relationships with people [from CSIP], even if it is an email relationship, which is good when you are in a very busy role… I have never found anyone unapproachable at CSIP, when I have telephoned or e-mailed.’ (LA1)

> ‘[Researcher: So how much in your everyday working life do you use CSIP?] ‘Regularly, I use the eBook all the time. I have just used it to put together a commissioning framework… I also use CSED [Care Services Efficiency Delivery Team]. We have had CSED in here and going through all our processes like a dose of salts which is fantastic’. [Researcher: And have you looked at the podcasts?] Yes, but they are not my kind of thing.’(LA3)

Other than reference to the eBook and one mention of ‘Catalyst for Change’, very few direct references were made to any of the other ‘branded’ commissioning tools and products discussed in the previous chapter. Indeed, while some participants did use the eBook regularly, most used it much less frequently and some had not used it all prior to the interview:

> ‘The idea of [the eBook] was great and I thought it was brilliant but I haven’t looked at it for a long time… I looked at it when it first came out and thought I can go back to it…I haven’t probably looked at it for six months plus, so I don’t use it routinely.’ (JA2)

> ‘I am less familiar with the eBook. I have to own-up that it’s not something that I log onto on a regular basis.’ (LC25)

> ‘I know there is the commissioning eBook and I do want to have a look at it, but I haven’t had time. I have been locked into a piece of work for the last nine months that I have never had a moment’s time to do anything else about and I kind of feel that the commissioning eBook will not help me in the review of residential care home provision. I might be wrong but I just feel that it won’t have what I need in it, because that is not the purpose of it. I might be wrong.’ (L20)

Significantly, there were practical issues around accessing the podcasts[15] (attached to the eBook); in some workplaces the technology was configured to prohibit their use. A couple of participants also worried about whether watching a podcast was an appropriate use of ‘work time’:

> ‘I like the idea of a podcast. There are times in the day when you think I really don’t want to write that, or fiddle with that contract. I am going to have some legitimate time for me. At least it feels like down time to be able to watch a discussion. It feels a bit guilty doing it in work time but it is a learning experience…I am in a shared office so I try to do it when it is fairly quiet, but I will occasionally say to my boss come and look at this what do you think of it and he will pull his chair round.’ (LC12)

[15] One participant with a hearing impairment commented that the podcast volume could not be turned-up high enough.

While some participants were heavily involved with their CSIP Regional Office and were in receipt of a direct consultancy service others did not use it at all or were not aware that it even existed:

> '[Discussing the consultancy provided by a Regional CSIP consultant] He has been working with us around the whole issue of developing an outcome focus, so how do you identify an outcome and how do we measure outcomes, how do we actually shape, reshape our thinking… Actually taking it right back to basics… making sure we do things that have the most impact on people's lives. '(LC25)

> 'I have been here a year, a year and a few months, and I don't even know about our CSIP regional rep. It would be great if they came in to talk to us, and support us… It needs to be advertised wider.' (LC6)

Indeed, a number of participants spoke about the need to be proactive in drawing in improvement support:

> 'At first, it was like for goodness sake stop wasting our money, give us the money and we will deliver it ourselves… However, I think as a region we have made sure that we have got what we needed out of [service improvement agencies]…If you keep them out you won't get any value from them… Whatever stage of our performance, we all want to be better and we are not afraid of saying that we need to improve.' (LA25)

In terms of getting involved with CSIP beyond the internet, personally knowing CSIP staff seemed particularly important:

> 'I know about [CSIP] from two or three people that went into it [as staff].' (JA4)

However this could work both ways:

> ‘[The CSIP Regional Office] tried to set up a meeting… We had a conversation over lunch… I came away with two impressions, one was I would do this very differently, and secondly I have this feeling that there is a kind of existing network in the group. I was the only person who went from anywhere west of [the city] and I felt like they were helping each other and that they wouldn’t want me to slow down the boat too much and jump on.’ (JA4)

Overall, very few participants seemed to have a clear understanding of the totality of CSIP in terms of its many different component parts and the full range of products and services that was available. As a result, participants sometimes seemed to be ‘missing out’ on things that were potentially of relevance to their work. Two comments were particularly telling as regards finding the Commissioning eBook:

> ‘I think once you find [the eBook], it is very user friendly… but I think access to it is not so user friendly because it is kind of buried within the CSIP site… it has moved around different web sites and that has proved difficult, so access I think is something which requires further attention. Once you get into it the content is perfectly accessible.’ (LA11)

> ‘I only came across it by good luck.’ (JA2)

While some participants did find it frustrating navigating between the different chapters of the eBook and would have liked the option of downloading the whole content with one click, most people did feel that it was easy to use. However, the concept of an eBook was defeated somewhat as most participants did resort to paper copies:

> ‘In general terms and about all their work I want them to be down-loadable. I go through the paper copy and highlight things and I can’t do this on screen. I know I could use it electronically but I want to browse. I take things home. If I have a paper copy I can stick it in my bag and leaf through it to find bits’. (PC13)

2:7 Use of other service improvement agencies

Among participants there was widespread support for the concept of the 'service improvement agency' and, in addition to CSIP, most participants were connected into a wide range of improvement support:

> 'I look at papers from LGA, IDeA and Sainsbury and King's Fund mainly, as a matter of routine… I get the *HSJ* (*Health Service Journal*) and email alerts on MH (mental health) and look at NACRO (National Association for the Care and Resettlement of Offenders) and Prison mental health, there is such a lot… I do a broad trawl. It's part of my job.' (PC13)

Acknowledging the potential bias in the study sample, CSIP was the 'preferred provider' for many of the participants:

> 'CSIP is still the main source of information… It doesn't have to be CSIP and I am not saying CSIP delivers brilliantly… but there ain't anyone better out there… CSIP is the main brand, especially for commissioning mental health.' (JA2)

In addition to CSIP, the most frequently mentioned other sources of 'improvement support' were CSCI (the Commission for Social Care Inspection - a regulatory body), and IDeA. CSED was also mentioned frequently and many participants were surprised to learn that it was part of CSIP.

Where CSIP was not the 'preferred provider', two participants commented that CSIP was of more relevance to those working in local authorities and of less relevance to those working in PCTs. While all those working with children and families all felt CSIP catered more for those working with adults:[16]

> '[Researcher: When you go and search all these websites, which ones do you start with?] The first one I start with is Every Child Matters, because that links

[16] This bias was also thought to be reflected in the content of the eBook. A number of participants also commented that CSIP and the eBook were perhaps more relevant to those working with older people rather than other adult groups.

> in with what we are doing here obviously, and then I would look at IDeA. They have a lot on commissioning which is quite useful again, and then CSIP to look at what commissioning is about, and then just general Google… The weakness [with CSIP] is that it is so adult orientated and to me every time I look through it seems to hang things on adult social care or health, which kind of puts me off looking there.' (LC6)

In explaining different patterns of use, the 'style' of improvement support was said to vary considerably between the different improvement agencies:

> [Researcher: Do the different improvement agencies have different styles?] Yes, everything is in different styles, it varies completely, you have some people that you can tell are project managers, and they go through every single step of the management cycle; you have others that you can tell have legal background because they are very procurement focused; and then you have the social workers who don't go into any detail.' (LC6)

While CSIP's style 'clicked switches' for some participants, it also put others off:

> 'Immensely valuable, really spot on… [CSIP] are talking the right language.' (JA2)

> 'The thing I know most about is the 'Ten High Impact Changes in Mental Health' which was steered by CSIP. Theirs is a language and culture of service improvement and I know that I am not part of that you can see especially the influence of Prince 2, there are core things that are said – it's like a catechisms. When you are in minority a common language allows you to identify each other like in areas of PPI [Patient and Public Involvement]. People invent their own language and customs as a defence, some publications from CSIP feel quite a long way from front line experiences and experiences with users. At times the language needs translation.' (PC13)

In terms of the products and services produced by the different service improvement agencies, some duplication was picked up, for example in one area, it was noted that another improvement agency had developed a product very similar to the commissioning eBook. A number of participants also commented that improvement agencies should work together more closely:

> 'I think we would all benefit from real clarity about the future [of CSIP] and of the whole mix really – of the interface between all of the improvement agencies… So that when we set out our priorities we know where we can draw resources in from. Some will be from CSIP or maybe from IDeA and some of it from CSED or whatever, but at the minute there is too much confusion.' (LC25)

2:8 Valuing CSIP and the eBook

On the whole, participants were very positive about the improvement support provided by CSIP and, indeed, the other service improvement agencies. CSIP was perceived to support participants in their 'job role' in a wide variety of different ways. In the first part of this section, we focus on CSIP networks and consultancy services. In the second part, we turn our attention to the value placed on written information, including newsletters and the eBook.

i) *CSIP Networks and consultancy - Leading the way in uncharted territory/helping practitioners translate new policy into workable strategy and practice*

The face to face consultancy support services provided by CSIP either through the regions or the national work programmes were very highly rated by most of the participants who had used them. The support was perceived to have a distinctive developmental role at the level of 'working with' commissioners to translate new government policy into workable strategy and practice. What was particularly rated about CSIP's developmental approach was that it was perceived to be 'practical' –

that is, facilitating networking between commissioners to find answers rather than imposing or importing answers from elsewhere:

> ‘I have to create a vision and interpret the white paper… CSIP are the only friends I know of who are trying to help us make sense of it together… I mean CSIP did this regional conference… and there were people from PCTs, local authorities, prisons, probation, mental health services… Now if there was no CSIP I wonder who would have organised that? They are familiar with bringing lots of different parties together. You go to something that is organised by the Local Government Association, for example, and you won’t get health there…A request went out recently for information and they got something like 200 replies …and I just thought brilliant. I thought where else would this happen - there’s a network out there. I don’t know anywhere other than CSIP that has built something like that.’ (JA4)

> ‘Well the CSIP guidance is a more practical. They have worked with local authorities - they go out to see what is going on and they develop pilots, they take information back from the pilots and they disseminate good practice and they disseminate new ideas and they disseminate ways of doing new things, so that other people can see what different options are when they are developing a new service. So their stuff is not written by a Tefal headed boffin who may not have much contact with the real world. CSIP has contact with the real world and turns the policy into something which works.’ (L20)

In terms of enabling both personal and organisational development participants had firm views about which kinds of external support were most helpful. A key message was that CSIP needed to distinguish it role clearly from that of regulation and performance management:

> ‘I don’t think the Department of Health helps us to deliver what the Government want us to deliver, some of the policy stuff is well framed now, but in terms of performance let me give you an example… [Discussing the

recent Mental Capacity Act] There is a framework which the Department produced which is helpful, but then they started to produce these incredible mechanistic tools about implementation… I think there needs to be some performance aspect, don't get me wrong, but the way they go about it you know just sort of check lists and traffic lights… it's not really developmental. Whereas CSIP says … "Right well, you need to develop, you have identified how are going about it, what are you going to do? Have you heard these people are doing this way?"' (JA2)

'The idea of inspection is meant to be for improvement and change… Yes it does focus minds but in a very sort of crude mechanistic way, I am not convinced that is the best way of moving organisations on, particularly as it is so targeting. Whereas I think there is a need for agencies [like CSIP] that really try to get into the spirit of things and try and help you develop your understanding and correct you.' (JA2)

Indeed, where CSIP consultancy was said to be at its best was where it was provided some sort of 'local challenge'. This reflects that participants were often prepared to reveal themselves to CSIP in a way that they were not to other external agents:

'[CSIP staff] need to be different from your inspectors - you dread them coming in and you wouldn't be open with them and listen to them.' (LC6)

'I think maybe if [CSIP] could have a bit more of a critical function it might help, but in a way that is not as threatening as the inspectorates.' (JA2)

'[CSIP] are there to help us but I also think they need to challenge us as well. [Service improvement is] about challenge… About an honest broker facilitating change… They come in at our request, which is right, but when they do come in they walk a tightrope about what side are we on? Can we afford to say this? We may get thrown out, or not invited back. (LC15)

Where CSIP was perceived to have fallen off the tightrope and to have blurred its boundaries with regulation and performance management, then the support provided was valued much less:

> 'Over the last 2 years I feel that CSIP have become less relevant to me and less helpful. In some ways this is because CSIP's role has been confused with whether they are service improvement or performance management. They are often good people but there is a narrow line between wanting to give advice and wanting to enforce accountability. It is a combination of CSIP's lack of clarity about its role and… certain individuals' own characters... [In this area] the SHA (Strategic Health Authority) and the service improvement agency have started to blur and we have started to get things from CSIP [which look like a] commandment… The SHA is getting away from its responsibilities, but we are supposed to be accountable to them.' (PC13)

ii) Newsletters, written information and the eBook - keeping up to date

> 'I don't get to go the LIN meetings anymore [because of pressures of work], so the newsletters keep you up to date with all that is going on without you having to go and search for it on the internet… I think that is just about the most useful thing CSIP does.' (LC20)

In discussing why participants liked or disliked the written information produced by CSIP (both in terms of electronic media and hard copy) a number of factors were important. First, the information needed to be perceived as 'current' and in a format which was readily accessible and digestible - as one participant put it, 'It needs to be quick and positive' (PC13):

> 'You can skim read a [CSIP] document, pick out important sections or interesting things to do with new ideas, new approaches, changes in the way local authorities should commission services and things like that and the

> CSIP newsletter is good for that because that has got a whole range of summaries.' (LC20)

If the information was perceived as unwieldy, then it was considered much less useful for service improvement:

> 'We each haven't got enough head room or spare capacity here… so when they produce their Top Ten High Impact Changes I know everyone does look at them and we take them on board and discuss it, there is no question about it… I find that by and large if a document is well explained with five or ten simple steps then we can follow them, but if it is an academic article about how one might do x,y,z and they are not written in a certain way - too abstract – then we won't use it. But something as simple as ten changes we can actually go away and really do something with it.'(PC16)

While there was unanimous support for the newsletters produced by CSIP, opinions on the value of the eBook were mixed. The chief criticism of the eBook was that it was out of date:

> 'When it started which is about three years ago, the articles going in were on some fairly hot topics at the time… I know it has kept up to date in some areas, for example it has had an article on Joint Strategic Needs Assessment, which is brand new and the guidance hasn't even come out yet… But I think in other areas it hasn't kept up with cutting edge change… It needs to keep-up if it's going to be people's first choice for information.' (LA11)

> 'It has gone a bit off the boil and needs to pick itself up and re-launch itself.' (LC25)

In terms of content, while some participants felt the balance of material contained in the eBook was helpful and 'just right', others were disappointed. Views were often contradictory and there was very little consensus around what constituted positive

and negatives. Indeed, it often seemed to be a matter of personal taste as to whether the eBook was loved or loathed. There were for example, contradictory views on different chapters:

> ‘I had dipped into the eBook about six months ago, read one very good chapter in it called ‘Strategies are not Worth the Paper they are Written On’ – and it got you thinking’ (JA4)

> ‘[The eBook] may be really good but I haven’t looked at it, I see a section there on commissioning strategies and then I see something called ‘Strategies Not Worth the Paper they are Written On’, which is an interesting thing to get you going on, but actually that isn’t what I want to hear.’ (JA2)

And contradictory views about whether the eBook was sufficiently critical and reflexive:

> ‘The eBook wasn’t quite what I thought it was going to be… I think the big issue [is how the different commissioning frameworks will fit together]. The [eBook] seems like another agency trying to tell you what commissioning should be… I thought it would walk you through the basics of commissioning then allow you to drill down.’ (JA2)

> ‘I think there are some really good personal viewpoint discussion papers in there. One I read more recently was something about strategies - are they worth the paper they are written on? That didn’t help me in terms of writing a strategy but it kind of made you think about making them effective, so it has got a balance between theoretical and discursive papers and case studies, and the mix is right.’ (LA11)

For some participants, that the main strength of the eBook is that it provides a much needed manual or ‘cook-book’ on how to do commissioning. In this context, the eBook was considered to be an especially useful resource for training and induction:

> ‘The development of the eBook was just fantastic. We had to come-up with a new kind of strategy and it felt like we were sinking in a sea of mud. At least there was something written down [in the eBook] so that we could refer to it… It felt like in my computer I had some help.’ (LA1)

> ‘‘When I first started and they said you are doing commissioning strategy, I said “What the hell is a commissioning strategy?” I kind of knew bits from my old job but the [eBook] gave examples.’ (LC6)

> ‘I have a team of commissioning officers and when I have seen an article [in the eBook] which I think they ought to read I will “print it off” which kind of defeats the purpose slightly but I give it to them.’ (LA11)

Other participants were of exactly the opposite view, disputing the ‘practical’ value of the eBook:

> ‘I thought it was written by academics and very useful for academics.’ (LC22)

> ‘Well I think it’s academic… They are fairly easy to read articles but I am not sure about accessible in terms of allowing me to move from the articles to doing things.’ (LC23)

> ‘If we talk about the eBook, I found it was quite academic – at a basic level - and not reflective of how things happen in practice… The way things happen in practice is you get three weeks to come up with a plan worth over a million pounds, or you get three weeks or a little bit longer to come up with a plan to commission a brand new service… I don’t think anyone sits down and looks at models… We know how things work and they actually get pushed through anyway whether you have [followed the model for needs analysis/public involvement] or not.’ (PC16)

In making sense of the difference of opinion surrounding the eBook, one comment is particularly telling about the possible influence of different organisational cultures:

> ‘To be dead honest I haven’t used [the eBook] more than a little bit, and the reason for that is in the last twelve months when I went to work in the health authority there was a major change in my life. It was like I hit a rock in the road, bumped my head and woke up speaking a different language.’ (JA4)

2:9 Credibility and evidence-based practice

When asked about how they assessed the reliability and validity of the information and advice provided by service improvement agencies, most participants described a commonsensical or intuitive process:

> ‘I look at and I think does this make sense to me from what I know about commissioning? Have I heard about this from other people? Are they doing some weird stuff? Is it legal? Does it worry me? …I get a broad idea of what people are doing, pick out the bits that I like and I think that’s what we need to do hear and that’s what fits in here.’ (LC6)

Often the CSIP brand itself was taken for granted as a ‘quality mark’ and it was assumed that there was some kind of rigour or ‘quality control’ (LA11) underpinning CSIP:

> ‘[CSIP] are rooted in practice. They are practical because they are looking at the academic stuff and making sense of it for you.’ (LA3)

However, there was a clear difference of opinion among participants as to which type of evidence should underpin CSIP’s work. In the minority camp, where those who argued that CSIP should make more use of empirical research evidence:

> ‘CSIP set out with the ambition to collect the evidence base with rigour but ended up collecting anecdotes. It throws up the paucity of evidence… and we end up with spectacularly weak service improvements.’ (PC13)

> ‘[Discussing the eBook] I think it is a bit light on numbers. There’s not much about unit costing, not much about bench marking and so we use PSSRU [Personal Social Services Research Unit]. That’s okay but it is a bit academic.’ (LC15)

> ‘I don’t want different people’s versions of commissioning I want consensus. I realise that there will be slightly different versions but there must be a starting point... I don’t want a case history of how one area went about it.’ (JA2)

In the other camp, were those who felt that CSIP should remain rooted in experiential evidence:

> ‘[Discussing the eBook] I think some of it isn’t academically or research rigorous. You know it isn’t backed up with evidence and statistics and quotes and references, but actually we don’t want that. You can go to the library and get that. What people like me want is a practical examination with the theory and legislation behind it. I don’t mind a bit of discussion, I don’t mind a bit of assertion, even if it is not fully backed up because I can edit that for myself.’ (LA11)

> ‘I think Good Practice guides are a bit like mother’s milk and apple pie, it is good to have but I probably wouldn’t go out of my way for it. What really interests me is: Has anybody done this before? How did they get on with it and what did they learn? What wouldn’t they do next time? What I want from CSIP is “come and give me your experiences in other authorities”.’ (LC12)

> ‘I would like to see is a resources library, pulling together actual strategies from each local authority.’ (LC6)

> ‘I think one of the things [CSIP] didn’t do so well was they put together a course on commissioning. It was a lot of theory. Lots of academia - you know… [This author] says this [that author] says that... I can understand critical analysis fine, but actually what I wanted was someone to tell me how

> to commission? What do I need to do to become a really good commissioner? It's when they focus on that practical stuff that they are top notch and we need to see more of that.' (LA3)

In making judgements about the quality of experiential evidence, actual proximity to practice was recognised as particularly important. One participant described how, in his view CSIP had recently suffered a 'credibility blip':

> 'I think it's the personal link that makes me use [CSIP]. Because you have worked with them, you know and trust them. I also know which individuals to go to. Some of the regional CSIP people I wouldn't approach to be truthful, but I know that I can go to [name of staff member] and I am going to get a sensible answer…I think the problem with CSIP now is that they have got people who have been working for the Department of Health for donkey's years and haven't been near practice for ages... The world has moved on and I think they need a better balance between the theory and practice. If you are going to have people going out there telling organisations how to do it, then they have to have done it recently themselves.' (LA3)

For another participant, the close proximity of CSIP staff to the Department of Health was seen as an advantage:

> 'Because CSIP have got ears to the minister or are working directly with the Department of Health… Their knowledge and understanding is far deeper than anyone else that we would have contact with.' (LA1)

Underpinning the eBook and much of CSIP's practice is the notion of a two way relationship between CSIP and commissioners working out in the field. As noted earlier, the Commissioning eBook is promoted as a resource that commissioners can shape and contribute to. However, none of the participants had contributed to the eBook themselves. The main reasons were lack of time to write things up or lack of confidence in knowing how to write things up:

> ‘I must admit it has crossed my mind that maybe I should put something in but I haven’t practically encouraged that in my team this year because we have been so busy...’ (LC17)

2:10 Overall impact and value for money

> ‘I have had more than my money’s worth out of CSIP. I think it’s brilliant’. (LA3)

The majority of participants in the study were of the view that they got ‘good value’ out of CSIP and that overall it impacted positively at the level of both organisational and personal development. However, only a relatively small number of practical examples were given as to where CSIP achieved tangible change, for example, in one area reducing the waiting list for blue badges (exemptions from car parking restrictions for people with disabilities). More commonly, the impact of CSIP was felt to be more influential at the level of inspiring commissioners to go out and achieve positive change for themselves. CSIP was often described as being about ‘visionary stuff’ (LC10). However, as noted earlier, the flip side was that for some participants this equated with CSIP being out of touch with the realities of how commissioning ‘really worked’. As might be anticipated, views on the overall impact of the eBook were disparate. For most participants the eBook was said to have had either no impact or to have had some limited impact when it was first launched. For others, where the eBook was being used as their ‘cook book’ or manual of commissioning practice then it did have direct impact, acting as the template on which local strategies were being honed and developed.

2:11 Summary

On becoming a ‘commissioner’ very few participants reported receiving any employer-led training and induction. CSIP was identified as playing an important role in filling the gap. Participants used CSIP in a wide variety of ways; ‘mix and matching’ different products and services to build bespoke packages of developmental support to fit in with the pressures of the job. CSIP was felt to cater

more for those working with adults than to those working with children and families. Few participants seemed aware of the totality of support available through CSIP and thought CSIP could do more to advertise its wares. Support provided by CSIP was most appreciated where it was identified as 'practical' – that is, where it facilitates networking between commissioners and those who know what is 'working well'. The preference was for experiential knowledge and learning and there was little appetite for information identified as 'academic'. Information and advice were often assumed to be credible if it was 'branded' by CSIP. Credibility and reliability were often judged on the basis of proximity to practice. The Commissioning eBook was either loved or left unread but most participants did not use it on a regular basis. The chief criticism was that it was out of date. The preference seemed to be for easily digestible and up to date information (e.g. news letters). Because it was not being used regularly most participants felt that the eBook had limited impact on their day to day commissioning practices. For those who did use it more regularly it was often used as a 'cook book' or manual of practice. Here, the impact was more tangible as a template on which local strategies were being fine tuned and developed. Overall, participants were positive about the improvement support provided by CSIP which seemed most influential at the level of inspiring them with 'visionary thinking'. CSIP was perceived to provide 'good value for money'. Many commented that they would like to see it continue.

KEY POINTS

- CSIP plays a vital role in supporting commissioners in their 'job role'.
- Support is most appreciated where it is identified as 'practical' – that is, where it facilitates networking between commissioners and those who are perceived to know what is 'working well' elsewhere.
- The overall implication is that there is a preference for core CSIP services (newsletters, LINS, regional support) rather than specially commissioned tools and products such as the 'Commissioning eBook'

3: CONCLUSION

> '[Discussing the ideal service improvement support] what would really work for me is somebody that physically wasn't too far away - that actually knew me personally - because if you don't know what I am good at and what I am hopeless at you can't really offer me the tailor made assistance I need to move things forward…Because CSIP are not "management" they would be well placed to offer this kind of coaching resource… Like clinical supervision at its best'.' (JA4)

Our research brief was two-fold. Firstly, to provide the Department of Health with a review of the evidence base underpinning the care commissioning tools and guidance produced by CSIP. Secondly, to evaluate in more detail, one method (the Commissioning eBook) used by CSIP to support change across service delivery agencies from the perspectives of its key stakeholders. The study was limited in that the participants were all volunteers and most employed by local councils and this may have biased the sample.

In relation to the first requirement, it is acknowledged that CSIP's work is underpinned by a range of approaches and methods. However, within CSIP knowledge production would appear to be more closely aligned with the concept of 'evidence-informed practice' rather than 'evidence-based practice' (RIP, 2006). This reflects that CSIP draws on 'experiential' (practitioner wisdom and user views) as well as 'empirical' (research) evidence. The use of 'experiential evidence' in this context needs to be set firmly in the context of the wider review of the literature (Woodin and Wade, 2007) which suggests that the empirical evidence for what works in commissioning is relatively weak. In this respect, CSIP's advice and guidance can be seen to fill a void with 'best guesses' or 'best available' evidence. However, one criticism to emerge from the review is that this is not always made explicit. The review demonstrated that some documents rely overly on what is termed 'infrastructural evidence' (for example, circular referencing to other CSIP documents rather than drawing-in external evidence). This weakens the credibility and usefulness of some of the information and advice produced by CSIP. For

example, there was a tendency to recommend the roll out of programmes and practices – just because they were advocated in policy documents – even though the evidence from other sources should have set alarm bells ringing. Another problem detected in CSIP material was that 'experiential evidence' was often gathered and presented in an unsystematic way. For example, case studies would often approach the status of sites of 'good practice' but beyond the commitment of the person selecting the site it was often hard to see on what grounds this judgement had been made. In many CSIP documents we detected what might be termed a lack of basic research 'know how', for example how to cite references properly and how to describe methods of data collection. However, CSIP material was praised highly in the interviews with commissioners for its great clarity of style and practicability. Indeed, CSIP documents were often perceived by commissioners to be the antithesis of 'academic papers' which were frequently identified as inaccessible and impracticable. There is a strong message then, emanating from the study about the need for 'skill sharing' between the service improvement and academic communities (vis-à-vis basic research 'know how' and how to present and disseminate findings).

Turning our attention to the eBook, its story would seem to encapsulate some important learning for CSIP. Given the limited nature of employer-led training and induction around commissioning skills and competencies, CSIP (working alongside other service improvement agencies) is without doubt fulfilling an important role in supporting commissioners in their 'job role'. Inevitability people did prefer some tools and resources above others but the key message is around the importance of having as wide a menu as possible. This enabled commissioners to build bespoke packages of developmental support which could be 'fitted in' around the day to day pressures of the job. Overall, CSIP was thought to be most influential at the level of inspiring commissioners with 'visionary thinking'.

However, like all organisations, CSIP is constrained by resource limitations and there is a need to undertake some business planning around product and service development. In 2006/7, the Commissioning Programme prioritised the development of the eBook and a number of other 'branded' tools and products. However, feedback from commissioners in this study would suggest a preference for 'more

hands on support' and the prioritisation of core CSIP services (newsletters, Learning and Information Networks [LINS], events and direct consultancy). The implication was that the eBook had a relatively short shelf-life and was soon to be found gathering dust beyond the initial launch. The other branded 'tools' were hardly mentioned in the interviews and did not seem routinely used. Some participants did recognise the need for a 'step by step' guide or practical manual of commissioning and were using the eBook as such, ironically printing it out to make a traditional book. The idea of a living, breathing virtual entity did not appear to be working well as none of the participants in this study had contributed to it. Overall, the eBook was felt to have little or no impact on commissioning practices although it was used by some participants as a template around which local commissioning strategies could be developed.

Reflections on the use of the eBook also provide a unique insight into the organisational cultures in which commissioners work. It might be suggested, for example, that concerns about whether it is appropriate to watch a 'podcast' in work time coupled with the need for information which is always 'quick and positive', reflects that employers may not be providing enough organisational support to facilitate reflection and learning and ultimately, commissioning practice which is evidence-informed (Research in Practice, 2006). As the Social Care Institute of Excellence (SCIE) points out in relation to social care there is little point in simply turning up the rate at which research flows to the workforce as little research is in fact has direct applicability. What is needed is a better understanding of the relationship between research and the work of practitioners, including what organisational structures are needed to realise the aim of using research to improve practice (reported in RIP, 2006 p. 19). A key issue for CSIP is then, whether to continue to meet the demand for 'fast food' evidence or whether to take purposeful action to overcome barriers and create incentives which will make world class commissioning genuinely possible. In reflecting on the challenge ahead, Briner (2006, p1) poses the following insightful question:

> 'What determines what anyone does [when faced with a particular problem]? The more palatable answer goes like this: [He or she] evaluates or diagnoses

the problem through collecting valid data; they identify a range of possible solutions or interventions; carefully consider the merits and drawbacks of each; implement one or more of these solutions; and then evaluate what happens. The… more realistic answer is something like: Drawing on very limited resources, using the little time available to them, and working with restricted knowledge about the nature of the problem, the [he or she] identifies the small number of options… and then implements one in the hope that the problem might… at least go away for long enough for them to deal with all the other things they have to do. Which sounds more like your job?'

REFERENCES

Audit Commission (1997) *Take Your Choice: a commissioning framework for community care'; the 2004 Department of Health Workbook.* London: Audit commission.

Audit Commission and Social Services Inspectorate (2003) *Making Ends Meet.* Online resource cited at*:* http://www.joint-reviews.gov.uk/money/homepage.html (Checked 04.02.08).

Bowling, A. (2005) *Adding Quality to Quantity: Older People's Views on their Quality of Life and its enhancement*. Reading: ESRC.

Briner, R. B. (2006) *Is HRM practice evidence based and does it matter? Les Opinion.* Online resource: http://www.employment-studies.co.uk/pdflibrary/op6.pdf (Checked 22.01.08).

Cappelli, P. and Neumark, D. (2001) 'Do "high performance" work practices improve establishment level outcomes?' *Industrial and Labor Relations Review*, 54, 737-775.

Care Services Improvement Partnership (2006) *The Commissioning eBook: A Resource to improve commissioning of community services.* Online resource: http://www.integratedcarenetwork.gov.uk/betterCommissioning/index.cfm?pid=184 (Checked: 22.01.08).

Care Services Improvement Partnership (2007a) *Getting to Grips with the Money.* Online resource: http://www.socialcare.csip.org.uk/index.cfm?pid=80 (Checked 22.01.08)

Care Services Improvement Partnership (2007b) *Getting to Grips with Commissioning for People with Learning Difficulties.* Online resource: http://www.socialcare.csip.org.uk/_library/Getting_to_grips_with_commissioning_for_people_with_learning_disabilities.txt.pdf (Checked 22.01.08).

Care Services Improvement Partnership and Care and Health and (2007c) *London Pilot of Fair Pricing Tool for Residential and Supported Living.* Online resource: http://www.socialcare.csip.org.uk/_library/CSIP_Report_v4.doc (Checked 22.01.08)

Care Services Improvement Partnership (2007d) *Commissioning for adults with learning disabilities: A tale of two nations.* Online resource: http://www.socialcare.csip.org.uk/_library/Two_nations.pdf (Checked 22.01.08)

Care Services Improvement Partnership (2007e) *Key activities in commissioning social care: lessons from the Care Services Improvement Partnership Commissioning Exemplar Project* (2nd Edition). Online resource: http://www.icn.csip.org.uk/_library/Key_Activities.pdf (Checked 22.01.08).

Care Services Improvement Partnership (2007f) *A Guide to Fairer Contracting Part Two: Service Specifications.* Online resource: http://www.integratedcarenetwork.gov.uk/_library/Part_2_-_Service_Specifications.doc (Checked 22.01.08).

Care Services Improvement Partnership (2007g) *From segregation to inclusion: Commissioning guidance on day services for people with mental health problems*. Online resource: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131061 (Checked 22.01.08)

Carr, S. (2004) *Has service user participation made a difference to social care services?* London: SCIE. Online resource: http://www.scie.org.uk/publications/positionpapers/pp03.pdf (Checked 2.11.07)

Cialdini, R. (1993) *Influence: Science and practice* (3rd ed). New York: HarperCollins

Cornes, M., Evans, S., Huxley, P., Manthorpe, J., Stevens, M., and Waddington, P. (2007) *Turbulent Times : Report of Preliminary Findings from Year 1 of the Evaluation of the Care Services Improvement Partnership*, London : Social Care Workforce Research Unit, King's College London.

Crampton, J. and Rickets, S. (2003) *A Catalyst for Change: Driving Change in the Strategic Commissioning of non-Acute Services for Older People.* London: Warwick Insight and the DH. CSIP Online resource: http://www.changeagentteam.org.uk/_library/docs/GoodPracticeGuides/Catalystforchange2.pdf (Checked 22.01.08).

Crampton, J. and Rickets, S. (2007) *A Catalyst for Change II. Tackling the long ascent of improving commissioning.* London: Warwick Insight and the DH. CSIP Online resource: http://www.changeagentteam.org.uk/_library/Catalyst%20II%20-%20version%206%20release%201%20Final%201.02.pdf [Checked 22.01.08]

Crawford, M., Rutter, D. and Thelwall, S. (2003) *User involvement in change management: a review of the literature.* London: National Co-ordinating Centre for NHS Delivery and Organisation. Online resource: http://www.sdo.lshtm.ac.uk/files/project/18-final-report.pdf (Checked 4.12.07).

Davies, C., Finlay,L. and Bullman, A. (eds) (2000) *Changing practice in health and social care.* London: Sage.

Department of Health (2004) *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08.* London: Department of Health.

Department of Health (2005) *Desk guide to Procurement.* London: Department of Health.

Department of Health (2006a) *Our Health, Our Care, Our Say: A new direction for community services*. London: DH.

Department of Health (2006b) *Health Reform in England: update and commissioning framework*. London: DH.

Department of Health (2007a) *Health Reform Evaluation programme: PCT and Practice Based Commissioning - Research Brief.* London: DH.

Department of Health (2007b) *Commissioning Framework for Health and Well-being.* London: DH.

Department of Health (2007c) *World Class Commissioning: Vision Summary*. London: DH.

Department of Health (2007d) NHS *World Class Commissioning - Competencies.* London: DH.

Department of Health (2007e) *The NHS in England: the Operating Framework for 2008/09.* London: DH.

Department of Health (2007f) *Guidance on Joint Strategic Needs Assessment.* London: DH.

Duffy, S. (2003) *Keys to citizenship a guide to getting good support services for people with learning difficulties.* Birkenhead: Paradigm Consultancy and Development Agency Ltd.

Evans, S. (2007) *High Impact Changes in Social Care. Report to CSIP*. Centre for Social Work and Social Care Research, Swansea University

Garwood, S. (2006) The process of commissioning an Extra Care Housing Scheme from a social services perspective. In CSIP *'Commissioning eBook'*. Online resource: *http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap4SueGarwood.pdf* (Checked 22.01.08).

Goodwin, N. (2006) Developing effective joint commissioning for adult services: Lessons from history and future prospects. In CSIP *'Commissioning eBook'*. Online resource: http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap1NGoodwin.pdf (Checked 22.01.08).

Gosling, D. (2006) Monitoring and improvement: monitoring contracts in adult social services. In CSIP *'Commissioning eBook'.* Online resource: http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap10DGosling2.pdf (Checked 22.01.08).

Gosling, D. (2007) Planning4Care - A strategic planning tool. In CSIP *'Commissioning eBook'.* Online: http://www.integratedcarenetwork.gov.uk/_library/C5_Planning_for_Care.pdf (Checked 22.01.08).

Health and Social Care Change Agent Team (2004) *Fair Commissioning – The Four Tests of Fairness Checklist,* London: CAT and DH. CSIP online resource: http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/S

upport_materials/Fair_Commissioning_-_A_good_practice_check_list.pdf (Checked 22.01.08).

Health and Social Care Change Agent Team (2005) *A Guide to Fairer Contracting Part One*. Online resource: http://www.changeagentteam.org.uk/_library/docs/CATReports/Fairer_contracting_guide.pdf (Checked 22.01.08).

Help the Aged (2006) *My Home Life: Quality of life in care homes*, London: Help the Aged and the National Care Home Research and Development Forum.

Henwood, M., Lewis, H. & Waddington, E. (1998) *Listening to Users of Domiciliary Care Services*. Leeds: Nuffield Institute for Health, University of Leeds.

Her Majesty's Government (2007) '*Local Government and Public Involvement Health Act'*

Kane, R., Degenholz, H. and Kane, R. (1999). 'Adding values: An experiment in systematic attention to values and preferences of community long-term care clients' *Journal of Gerontology*: Social Sciences 54B (2) S109–S119

King's Fund (2006) Briefing*: Our Health, Our Care, Our Say: A New Direction for Community Services.* London: King's Fund.

National Institute for Mental Health in England (2004) Cases for Change: User Involvement. Online resource: www.nimhe.org.uk (Checked 22.11.07)

NERA Economic Consulting (2005) *Commissioning in the NHS: challenges and opportunities*. London: NERA Economic Consulting.

NHS Service Delivery and Organisation (2004) *User Involvement in Change Management: A Review of the Literature*. London: SDO.

Nuffield Institute (2003) *Nuffield Partnership Assessment Tool*, Leeds: University of Leeds.

ODPM (2004) *Mental Health and Social Exclusion.* London: Office of the Deputy Prime Minister.

Patmore, C. (2002) *Towards flexible, person-centred home care services: a guide to some useful literature for planning, managing or evaluating services for older people.* York: Social Policy Research Unit, University of York.

Patmore, C. and McNulty, A. (2005) *Caring for the Whole Person: home care for older people which promotes well-being and choice.* York: Well-being and Choice Publications.

Patmore, C. (2006) Commissioning with Service Users and Carers: Well-being and choice for older people - how can commissioners promote this? In CSIP *'Commissioning eBook',* Online http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap3CPatmore.pdf (Checked 22.01.08)

Pawson, R., Boaz, A., Grayson, L., Long, A. and Barnes, C. (2003) *Types and quality of knowledge in social care*. Bristol: SCIE and The Policy Press. Online resource http://www.scie.org.uk/publications/knowledgereviews/kr03.asp (checked 12.2.08)

Pfeffer, J. and Sutton, R.I. (2006) *Hard Facts, Dangerous Half-Truths, and Total Nonsense: Profiting from Evidence Based Management.* Boston: Harvard Business School Press.

Pirsig, R. M. (2005) *Zen and the art of motorcycle maintenance: an inquiry into values.* NewYork : Harper Perennial Modern Classics.

Poll, C., Duffy, S., Hatton, C., Sanderson, H., Routledge, M. (2006) *A report on in Control's first phase 2003- 2005,* London: in Control Publications.

Raynes, N., Temple, B., Glenister, C. and Coulthard, L. (2001). *Quality at home for older people: involving service users in designing home care specifications.* Bristol: Policy Press.

Research in Practice (2006) *Firm Foundations: A Practical Guide to Organisational Support for the Use of Research Evidence.* Online resource: www.rip.org.uk (Checked 3.3.07)

Richardson, F. (2006) Introduction: The Commissioning Context. In CSIP *'Commissioning eBook'.* Online resource: http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap1FRichardson.pdf (Checked 22.01.08).

Sekerka, L., and McCraty, R. (2004) 'The psychophysiology of appreciation in the workplace.' In D.L. Cooperrider & M. Avital (eds.), *Constructive discourse and human organization,* (pp. 217– 240). Boston: Elsevier Ltd.

Shapiro, J. (2003) 'Lessons for the NHS from Kaiser Permanente', *BMJ*, 327, 1242-1243.

Singh, D. (2005) *Transforming Chronic Care. Evidence about improving care for people with long term conditions*, Birmingham: Health Services Management Centre, University of Birmingham.

Smith, J. and Goodwin, N. (2006). *Towards Managed Primary Care: The Role and Experience of Primary Care Organizations*, Aldershot: Ashgate.

South West Centre of Excellence (2006) *Showcasing Good Practice: Adult Services Fair Pricing Tool - Wiltshire County Council.* Wiltshire County Council and South West Centre for Excellence.

South West Centre of Excellence (2007) *Showcasing Good Practice: Adult Services Fair Pricing Tool. Gloucestershire* County Council and South West Centre for Excellence.

South West Centre of Excellence - Lift SW Partnership (2008) I Learning Disabilities Fair Pricing Tool and Provider and Placement Database. Online resource: http://www.swce.gov.uk/workstreams/adultservices/fairpricingtool.htm (Checked 22.01.08)

Starfield, B. (1994). 'Is Primary Care Essential?', *The Lancet*, 344, (8930), 1129-1133.

Starfield, B. (1998). *Primary Care: Balancing Health Needs, Services and Technology*, Oxford: Oxford University Press.

Strauss, N. (2005) *The Game*. Edinburgh: Canongate.

Strother, J. (2002) An Assessment of the Effectiveness of e-learning in Corporate Training Programs, *The International Review of Research in Open and Distance Learning,* 3(1) http://www.irrodl.org/index.php/irrodl/article/viewArticle/83/160

Turner, M. and Beresford, P. (2004) *Contributing on equal terms: service user involvement and the benefits system.* London: SCIE Online resource: http://www.scie.org.uk/publications/reports/rep08.asp (Checked 11.11.07)

Wall, T.D. and Wood, S.J. (2005) 'The romance of human resource management and business performance, and the case for big science', *Human Relations*, 58, 429-462.

Walker, N. (2006) Service user involvement: Involving people who use services in the commissioning process. In CSIP *'Commissioning eBook'*. Online resource: http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap3NWalker2.pdf (Checked 22.01.08).

Wanless, D. (2006) *Securing Good Care for Older People: Taking a long term view.* London: King's Fund.

Williams, B. (2004) Book Review in *Management Learning* 35(3): 359-361.

Woodin, J. and Wade, E. (2007) *Towards World Class Commissioning Competency: A Report produced for West Midlands Strategic Health Authority.* Birmingham: Health Services Management Centre, School of Public Policy, University of Birmingham.

Woodruff, L. & Applebaum, R. (1996) 'Assuring the quality of in-home supportive services: a consumer perspective' *Journal of Aging Studies,* 10(2),157–169.

Wright, P.M, Gardner, T.M, Moynihan, L.M and Allen, M.R (2005), 'The relationship between HR practices and firm performance: Examining causal order', *Personnel Psychology*, 58, 409–446.

APPENIDIX 1

2006/07 Headline Management Plan National Commissioning Programme

Purpose and scope

This paper develops the national commissioning programme outlined to CSIP Management Team in February 2006. It outlines examples (though not a definitive list) of existing work and developing products across CSIP and suggests ways forward that will embed the commissioning programme within and across CSIP's RDC's and national work programmes.

This is a timely programme that will support DH Policy and Commercial Directorate colleagues as they establish commissioning principles within their own new and developing commissioning framework as well as developing practices in PBC and PbR. It will also resonate with the development of Children's Trusts and Local Area Agreements as well as work that is progressing on Third Sector development. Further it will support the efficiency programme of CSED, assist CSCI and the Healthcare Commission in their inspections of commissioners by working with them to support and inform their thinking and create links across Government Departments (ODPM, OGC, DfES etc) and external organisations (such as IDeA, ADSS and LGA). Some of these may become formalised during the life of the programme. It covers interests that are both general and specific in all work programmes. The initial programme should run for one year with a review in October 2006 to establish a longer term programme alongside currently developing government agendas. The aim of the programme is to define specific products that will support policy initiatives and developments.

Governance

The programme should form a part of the core agreement with DH and Policy colleagues as a key element of implementation of developing commissioning practice that supports the commissioning position expressed in the White Paper "Our Health, Our Care, Our Say".

An RDC will report to Management Team and a person will be identified as the Programme Lead to co-ordinate the programme across the RDC's and CSIP Programmes as well as undertaking day to day negotiations over development with all related partners. This role should rest initially with the lead of the Better Commissioning Network who has undertaken the drawing up of existing planning for commissioning. Several programme products already rest within this central function and the postholder has contact with most key partners.

The programme lead will need to ensure that they meet regularly (bi-monthly?) with representatives from each RDC who are established as official links between the RDC and the Commissioning Programme on a Programme Board. These representatives should also act as programme links and therefore some co-ordination of the formation of this group will be required to ensure that all programmes are represented through the RDC reps.

DH will be approached about links to the Commissioning Programme and representation on the Programme Board.

The programme should cover all work areas represented within CSIP and other programme areas (such as NOMS or Drug and Alcohol initiatives) may be later considered through the DH commissioning arrangements.

Posts that will be created

Posts	F/T or P/T	If substantive, what are plans for pick up of cost?
• Programme Lead – Commissioning Secondment of existing post which should be no direct cost but would involve backfill of the Lead for ICN and Better Commissioning Networks • RDC Commissioning Leads	Full time fixed term 0.5wte x 8 fixed term	Not substantive but period of term to be agreed, probably two years April 2006-2008

Specific products in this financial year

Prod No	Product	How outcome is measured	Delivery Date
1	**Launch and development of Commissioning E-book –** a web-based facility for Commissioners bringing together informed articles and examples of good practice on existing and developing commissioning issues. Initially aimed at adult services but with a recognised need to move into linking to further areas as part of development plan.	Measurement through monitoring of website visits, users' comments and suggestions for development, responsiveness to policy development	Initial launch late March 2006 with ongoing development planned throughout the year.
2	**Exemplar Long-term Commissioning Strategies –** Three long term whole systems commissioning strategies (up to ten years in length) will be available together with process information of how they were developed and interviews with key participants in the programme. This is part of a drive to encourage commissioners to consider whole systems commissioning over much longer periods of time. Launch via conference .	Response to conference and take up of information. Follow up work take up via IPC and possible formation of network. Evidence of local application	October 2006. Work ongoing since July 2005.

3	**Publication : "Guide to Fairer Contracting Part II**". Follows from December publication and looks at the development of clear and fair specifications to support contracts. Aimed largely at residential and domiciliary care services for older people	Take up from web publication. Review of comments invited from website and document. Invitations to be involved in ongoing work with commissioners as a result of publication.	September 2006
4	**Publication: "Guide to Fairer Contracting Part III".** This work will report on market development and market management within the context of tender and contracting practice, specifically within the current legal and practice framework of competition, contestability and best value.	See 3 above	March 2007
5	**Availability of Demand Forecasting tools for Commissioners.** A joint programme with CSED will bring together basic demand forecasting tools by summer 2006. A more detailed programme will then assist pilot authorities to develop more complex tools for nation-wide use in an ongoing development programme.	Working directly with a number of commissioners to agree basic tools. Feedback from this group plus others as to usability of tools following roll-out via specific follow up. Efficiency gains.	June 2006 for basic toolkit. Ongoing beyond that with new targets agreed.
6	**Offender Health partnership toolkit.** This is an emerging and joint piece of work between CSIP, DH NOMS policy and the Home Office to ensure a comprehensive approach to offender health and social care.	To be agreed	By March 2007
7	**Getting to grips with the money.** VPST will be running a national programme to improve commissioning for people with learning disabilities in response to ADSS concerns relating to value for money and outcomes. The programme is national in scope and will work across Social care and Health boundaries.		Programme starts April 2006 via CSIP Social Care Programme
8	**Mental Health Commissioning Series.** National programme of publications (via NIMHE) inc Guide to PbC, Long term Conditions & Toolkit on out of sector treatment	Through usage and feedback	Spring – Summer 2006

9	**Regional Programmes to support improved local commissioning** Programmes established in partnership with local stakeholders (ADSS, LAs, SHAs, PCTs,	Evaluation of programmes by stakeholders	Programmes delivered in 2006/07

Budget

Prod No	Financial Resources	Budget
1	Commissioning e-book. (requires additional funding to widen scope and fully exploit and develop programme reach and write up "good ideas")	£20K (BC Network funding) (DN need to clarify what is existing resource in other programmes and what needs new monies.)
2	Exemplar strategies	£20K (BC Network funding)
3	Publication: "Guide to Fairer Contracting: Part II – Specifications"	£20K (BC Network funding)
4	Publication: "Guide to Fairer Contracting: Part III – Market development and management "	30K (BC Network funding)
5	Availability of Demand Forecasting Tools	funding via CSED
6	Offender health partnership toolkit**..**	To be finalised (via Prison Health, NOMS and Home Office)
7	Getting to grips with the money	To be finalised. Mixed funding from CSED, Social Care Programme, Regional Centres of Excellence and ADSS
8	Mental Health Commissioning Series	£30K (NIMHE)
9	Programme Manager (backfill) – additional funding required	£60k
10	RDC Commissioning Leads (0.5 wte x 8) plus regional events – salary costs need to be identified from existing commitments	£320k

Evaluation

No plans have yet been made for any consistent evaluation of this programme. However it is recognised that this is an issue that would need consideration following acceptance of the programme and discussion with funding colleagues.

The Lead Manager would be expected to be able to answer this question fully by the time of the suggested programme review in October 2006.

Major Risks

That the existing programme does not meet the policy requirements of the developing DH programme.

That duplication of commissioning in other CSIP programmes is not addressed.

That the programme (or elements of it) is insufficiently funded and may not have the impact that is expected or required; this would include programme areas of work not yet identified as a part of this programme and new work streams that may be required (eg Outcomes commissioning)

That the programme is not sufficiently understood or joined up across both CSIP, relevant Government Departments (including DfES, ODPM, OGC etc) and other partners.

The biggest risk may be to have no identified work programme for commissioning.

APPENDIX 2

SERVICE USER AND CARERS VIEWS ON A CSIP COMMISSIOINING PODCAST

User and carer involvement is central to the aims of CSIP so one part of the evaluation explored how CSIP is experienced from the perspectives of people who use services and carers. There are many ways in which users' experiences of services or of professional activity are gathered in qualitative and quantitative research but few studies have looked at electronic products. In light of the timescale and resources of this evaluation, the research team consulted with the Social care Workforce Research Unit's Service User and Carer Advisory Group and agreed that viewing an illustrative podcast, on the subject of 'outcomes', followed by a group discussion would be one potentially productive way of considering the value of a specific podcasts as to its usefulness and the extent to which it may reflect values of the organisation as a whole.

Podcasts are one example of techniques and media that assist in publishing messages from an organisation to recipients. While many are used by commercial organisations they can be used for a range of communicative functions, such as training or staff development. While they are increasingly available thought the general media, for some lay people they are not familiar. Some members of the group pointed to this in their initial reactions to the podcast and one later reflected on this in a written follow up to the meeting:

'*Being an older person I am often baffled by modern gadgets and one of my latest problems is how to make use of podcasts which organisations mainly the BBC, are constantly are suggesting we make use of…I quote "A podcast is simply an audio recording that has been compressed into an MP3 audio file; this makes it smaller and easier to send over the internet. Once you have downloaded the file you can listen to it on your PC or transfer it to a personal digital audio player even a digital radio, providing it can read MP3 files and has a suitable PC connection or a USB/memory card socket. 'It's as simple as that!' Although I downloaded and watched the full list of available podcasts from CSIP I felt that there was no*

advantage or improved ease of learning or understanding that could not have been absorbed either by reading a report or listening to the report on the radio'.

However, another older person talked with enthusiasm of having recently made a podcast that had been circulated to the Department of Health, broadcast at a regional conference and was on a website. Another member of the group was keen to see that service improvement agencies such as CSIP were using every means possible to get messages across: '*you have to use every method of information available don't you? There is no point in saying people aren't going to look at podcasts'*

Turning to the content of the podcast, members of the group felt that it did fulfil an expressed purpose in providing a 'taster' and 'sparked debate' about the subject of commissioning. However, while the subject was user outcomes members of the group queried the lack of attention to and lack of user engagement.

When asked to think about potential improvements, members of the group raised the following suggestions:

- '*Inclusion of the views of people working at the frontline might have helped to provide more concrete examples of outcomes'*

- '*The length of the podcast was quite long in being 17 minutes that could have been edited to achieve a more interesting presentation*'.

- '*The use of jargon and use of initials like LIN and so on was a little annoying and people might have to search the site to understand some abbreviations'*. While many were familiar to some, generally they were used as if the audience would know each and every one'.

This consultation was an innovative approach and one that the research team consider has raised some useful observations that have been woven into the main part of this report.

APPENDIX 3

Review of Commissioning Tools and Guidance

APPENDIX 3A: The Commissioning eBook: A Resource to improve commissioning of community services (CSIP, 2006)[17]

http://www.integratedcarenetwork.gov.uk/betterCommissioning/index.cfm?pid=184 (Checked: 22.01.08).

The 'Commissioning eBook' is a resource to improve commissioning of community services. It is stated that the eBook is continually being refined and added to. Our review of the content took place at a single time point in late 2007. At this point the eBook comprised Ten Chapters and forty-five articles. The time limits imposed on the study and the size of the eBook (800+ pages) precluded in-depth review of the whole document. In what follows, we concentrate on a sample of papers and case studies which we judge reflect the overall content and style of the document as a whole.

It is useful to begin where the eBook begins with a consideration of what it means by commissioning. The eBook is certainly a potentially valuable resource in this sense, and we have been able to probe further in the interviews to determine the extent to which it is useful and makes a difference in practice.

> **Chapter 1: The Commissioning Context (Richardson, 2006).**
> http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap1FRichardson.pdf (Checked 22.01.08).
>
> As Fiona Richardson argues in the introductory paper, it is important to understand what is meant by commissioning, because the term is often used

[17] It should be noted that there are two on line versions of the 'Commissioning eBook'. The Change Agent Team web site (http://www.changeagentteam.org.uk/index.cfm?pid=359) [checked 29.2.08] provides access to an earlier version which has not uploaded some of the more recent additional content.

interchangeably with contracting, purchasing or procurement. There are many definitions of commissioning, but she favours that developed by the Audit Commission:

> 'Commissioning is the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the private and voluntary sectors.' (1997, pg 2)

Richardson suggests that this definition has certain strengths, which includes an emphasis on commissioning as not a one-off event; that it relates to whole groups of people or populations and not simply individuals, and its importance in meeting users' needs, irrespective of the sector to which the service provider belongs. She underlines the fact that the eBook focuses on the strategic nature of commissioning and not micro-commissioning.

Richardson usefully reviews a number of other documents and models of commissioning, including: the Audit Commission (1997) handbook 'Take Your Choice; the CSIP workbook 'A Catalyst for Change: driving change in the strategic commissioning of non-acute services for older people' (Crampton and Rickets, 2003); the Audit Commission and the Social Services Inspectorate (2003) 'Making Ends Meet'. The latter has six modules drawing on: the NERA Economic Consulting report for Norwich Union Healthcare (2005) 'Commissioning in the NHS: challenges and opportunities' which presents a model of commissioning health care services and debates the role of strategic commissioning in the NHS in the future; the Department of Health (2005) 'Desk Guide to Procurement'; and the Care Services Improvement Partnership (2005) 'A Guide to Fairer Contracting, Part One.'

In reviewing the commissioning landscape, Richardson refers mostly to policy documents and statements, and not to empirical research evidence - perhaps reflecting (although not stating explicitly) Woodin and Wade's (2007) review findings which suggest such evidence is thin on the ground. She cites

independent evidence from the Audit Commission and the Gershon review, and all other references are from the DH, CSIP or other government departments.

Chapter 1: The Commissioning Context - Developing effective joint commissioning for adult services: Lessons from history and future prospects (Goodwin, 2006)
http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap1NGoodwin.pdf (Checked 22.01.08).

The central argument in Goodwin's paper is that commissioning, especially joint-commissioning, has historically been relatively ineffective due to a range of inhibiting factors. Indeed, making a reality of the commissioning function has been one of the key 'unmet challenges' of recent reforms, especially in the NHS. He suggests that, given the emphasis placed on commissioning to deliver the new agenda, the lessons of past mistakes 'must be heeded and policy-makers should seek ways to support and facilitate commissioners in their activities as a matter of urgency.'

Goodwin's presentation of the evidence base for the chronic care model, for instance, refers only to health or health-system outcomes and not to social outcomes or social care services:

> 'Research supports the effectiveness of the chronic care model in improving health outcomes and reducing system costs. The extensive international studies of Barbara Starfield (1994, 1998), for example, demonstrate clearly the benefits of primary/community-based orientations to health outcomes in those health systems that employ a higher degree of co-ordination in care delivery between sectors. Similarly, examination of managed care organisations – such as Kaiser Permanente – in the USA has shown that a focus on the

> chronic disease model of care can both improve the quality of care for people with many different long-term conditions as well dramatically reduce hospital utilisation rates (Singh, 2005; Smith and Goodwin, 2006).' (p4)

Again, the integration of care referred to by these models, is not specifically health and social care, but rather primary and secondary, or hospital and community. The outcomes in question are health systems outcomes and not social care outcomes specifically, so there must be some doubt about the extent to which the model improves social care outcomes, until further research is undertaken. Goodwin goes on to suggest that the use of the care pathways model contributes to successful health outcomes:

> 'An important reason why chronic models can achieve such beneficial outcomes is the presence of strong clinical leadership of the commissioning process that enables the development of care pathways that reduce unnecessary referrals and promote care integration (Shapiro, 2003; Smith and Goodwin, 2006). However, in the UK, commissioning arrangements have not been as effective in enabling such approaches to flourish and have been hampered by a history in which health and social care commissioning arrangements have generally remained disparate.' (p5)

There are reasons to doubt whether the care pathway model is generally applicable, and some evidence (Huby, personal communication) that it does not operate well in mental health settings where social care is integrated. Goodwin argues that the current state of commissioning in social and health care is essentially 'reactive' rather than 'pro-active' and this leads to the continuance of existing service models rather than a change in service delivery models. Among the reasons for this, Goodwin cites a lack of strategic direction; resource pressures; competing demands between agencies; and conflicts with the choice agenda. Importantly, he also stresses the lack of commissioning skills and experience, and a lack of useful data. To this we

might add the lack of robust research and other forms of evidence about the effectiveness of commissioning activity in relation to final, user outcomes. Goodwin concludes, largely, it has to be said, in relation to health and joint commissioning:

> 'This long and rather worrying list of perceived problems shows the need for the urgent development of the commissioning function if it is to fulfill the agenda that has been created for it.' (p10)

There are significant professional and structural barriers to the development of effective joint commissioning processes and:

> 'There is no evidence, as yet, to show that any model has been particularly successful in this regard.' (p11)

Chapter 3: Commissioning with Service Users and Carers - Involving people who use services in the commissioning process (Walker, 2006). http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap3NWalker2.pdf [Checked 22.1.08].

This chapter on service user involvement quotes the white paper 'Our Health, Our Care, Our Say' (DH 2006a) view of user involvement as being:

> 'Systematically and rigorously finding out what people want and need from their services is a fundamental duty of both the commissioners and the providers of services.' (p2)

It also cites the view of Davies et al (2000) who maintain that:

> 'Service user involvement is not an end in itself, but a means of effecting change, both in the outcomes of services and the behaviour of workers.' (p3)

However, no supporting evidence is offered to support this statement. There are a number of works cited that either review the literature, offer guidance on good practice (not defined and possibly better termed illustrative) or both. The other references are largely to DH or NHS policy related advice. We examined the main works cited by the author, and these included an NHS Service Delivery and Organisation Review (Crawford et al, 2003); two SCIE papers (Carr 2004, Turner and Beresford, 2005) and one paper from NIMHE (2004). We also examined, for a separate exercise on the 10 high impact changes in social care (Evans, 2007), the extent to which there is evidence that user involvement does lead to improved service outcomes. Overall, the evidence would seem to suggest that it is too early for major impact to be detected, and that more research is needed to assess the impact of user involvement.

Chapter 3: Commissioning with Service Users and Carers - Well-being and choice for older people - how can commissioners promote this? (Patmore, 2006).
http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap3CPatmore.pdf [Checked 22.01.08].

Patmore's paper advises how purchasers can develop home care services for older people which promote 'well-being and choice'. Although presented as another case study this guidance derives from a small research study into factors which underpin this style of care. The author conducted the original research and refers to six papers published by himself and colleagues and to several other well-known published papers and reports, a few of which are US studies.

Patmore's (2002) research was conducted in three stages, an international literature review, telephone interviews with provider managers in 12 locations, of which 6 were selected for more in-depth interviews with selected staff and

homecare users. An overriding objective was to assess how home care services can be organised and how older people's services can be customised to the values of individual service users. We have therefore gone back to those citations most relevant to this objective and to address the question, 'to what extent do these studies and reports provide an adequate evidence base for the benefits of customising home care service to users' preferences'? The Raynes et al work (2006) is based on a slightly less than 50% response rate (n=143) from a survey of recipients of home care purchased by local authorities (a 10% random sample of 3000 over 65s, n=300) and on consultation with three local groups. The Henwood report (1998) for Nuffield was a qualitative methodology in three places where 46 people in six groups provided information, and a further 16 individuals, whose selection was not described. Patmore's article in *Community Care* (6-12 October, 34-35) did not provide any methodological details. The Help the Aged report (2006) was not actually about quality of life as conventionally measured. Woodruff and Applebaum (1996) is a US based study that examined service users' concepts and perceptions of quality in-home care. Their methodology encompassed a telephone survey with 270 randomly sampled service users (60% response rate from a 10% sample of 451 service users across four areas). There is insufficient methodological detail, however it appears the survey was qualitative and quantitative, given some descriptive statistics are presented. A further six in–depth case studies were undertaken with six home service users. The sample was conveniently selected and the case study entailed an ethnographic approach in which the researcher spent a period of time engaging in activities with the respondents for the purposes of participant observation and unstructured interviews. Kane et al (1999) was a study from the United States of America.

Chapter 4: Working with Service Providers - The Process of commissioning an Extra Care Housing Scheme from a Social Services perspective (Garwood, 2006).

http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap4SueGarwood.pdf [Checked 21.01.08].

Garwood's paper is a case study that examines the process of commissioning Extra Care housing from a social services perspective. In March 2005, Leicester City Council, in partnership with Hanover Housing Association, was successful in obtaining joint funding from the Department of Health and Housing Corporation to develop an Extra Care Housing scheme for older people. This case study describes the process that Leicester City Council and its partner, Hanover Housing Association, went through to achieve success in its bid to the Department of Health Extra Care Fund and the Housing Corporation for capital grants. Garwood suggests that it can provide useful guidance and advice for any commissioners or providers currently drawing up a bid for funding, or developing an Extra Care Housing scheme locally. The study is written with summaries of the lessons learned at various points in the text. Some of these may be obvious to the experienced service planner, but could prove useful to those in need of further support and guidance.

The case made for resources had many strengths (identified by the funders), and made use of existing data sources (none were referenced in the paper). These included, the Office for National Statistics census data and 2003 based population projections; Supporting People (SP) supply mapping; the 2002 City Council Housing Needs Survey; sheltered housing stock review; cognitive impairment prevalence rates; local and national health statistics; crime data; and departmental social care data. In our experience it is not always easy to make use of, or combine, data from different data sets, due to the different timescales covered, different coding conventions, and different geographical coverage. It might have been useful for more of this part of the process to be outlined, and what lessons if any were learned in the process.

As with some of the other case studies, this one made use of existing relevant local and national data, but made no use of or reference to any other sources of evidence, whether this was published research, government or local authority reports. Like other case studies, this makes it appear as if it is developed in a vacuum, perhaps necessarily a local vacuum to meet local circumstances. This raises the question about how others can learn lessons that can be applied in a different context, and how to separate out the impact of the case study from the various other influences on the commissioning process.

Chapter 5: Commissioning Strategies - Planning4Care - A Strategic Planning Tool (Gosling, 2007)

http://www.integratedcarenetwork.gov.uk/_library/C5_Planning_for_Care.pdf (Checked 22.01.08)

Gosling's paper is a case study which describes a web-based strategic planning tool, Planning4care, which enables authorities to profile the social care needs of their over 65 population and understand projected changes over the next 20 years in terms of needs, service requirements and cost of meeting need. The tool also models the effects of possible changes – 'what if' scenarios – on the whole health and social care system. It is said to have the potential to provide vital analysis for the social care element of the Joint Strategic Needs Assessment (JSNA), and to be able to support joint working through providing a shared information base. The tool was developed by the two consultancies Care Equation and Oxford Consultants for Social Inclusion (OCSI) in collaboration with Brighton & Hove local authority and PCT. The project received support from CSIP and built on the national long-term care finance model developed by the Personal Social Services Research Unit (PSSRU) and used for the national Wanless Review of Social Care (2006).

This web-based tool provides graphical and tabular information about six core aspects relevant to strategic planning: the current needs of the over 65 population, broken down by level of need, age band, gender, type of support

(informal and formal care) and source of funding (publicly funded and self-funded); the geographical distribution of people with care needs shown on maps using Middle-layer Super Output Areas (MSOA) boundaries (MSOAs are an Office for National Statistics unit of population of about 7,000 people); population projections, by age; projections of care needs, by needs group, type of support (informal and formal care) and source of funding (publicly funded and self-funded); projections of service requirements, by type of service; projections showing expected service requirements for the whole population (including self-funders, but excluding those fully supported by informal care) and for services commissioned by the Local Authority; projections in service costs, globally and by type of service, and by whether LA funded or for the whole population (including self-funders).

The tool makes use of established available technologies and models, such as the PSSRU long term care model, and ONS data categories, and in this sense is based on existing empirical evidence. However, the background and supporting arguments for the tool are entirely policy related and there is no reference to similar work elsewhere in the world, or to other health and social care settings in the UK. Its usefulness can only be determined by its users.

Chapter 10: Monitoring and Improvement - Monitoring Contracts in Adult Social Services (Gosling, 2006)
http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap10DGosling2.pdf (Checked 22.01.08).

Another paper by Gosling looks at contract monitoring in adult social care services. Although described as one of the eBook case studies it is in fact based on an empirical study undertaken by CSIP in 15 local authorities, funded by the CSIP 'Better Commissioning Learning and Improvement Network'.

Gosling points out that contract monitoring can:

> ‘change the nature of provision and quality of service for users and carers, but it can also improve value for money and identify areas of poor performance which require additional monitoring and support.’ (p 2)

There is no background included and no reference to any other forms of evidence, however, an internet search was undertaken (methods not given), to identify existing projects, or sources of information about the monitoring of contracts in social care. The search highlighted the lack of existing information or research. Therefore one of the initial broad aims of the project was to gather some empirical evidence about how local authorities monitored contracts for adult services.

A questionnaire was developed with input from 12 authorities from the North West region. Gosling points out that:

> ‘A lack of monetary resources and tight timescales meant that despite it being one of the objectives of the project, it was not possible to involve service user organisations in developing the questionnaire. However, in order to ensure relevance to and understanding by the intended recipients, the questionnaire was piloted by two authorities, and their feedback was incorporated into the final questionnaire prior to distribution.’ (p4)

In June 2006, the questionnaire was sent to 38 authorities in the North West, West Midlands, and Yorkshire and Humberside regions, and 15 completed questionnaires were returned, a response rate of 40%. They were completed by a range of different people in these authorities, but no further details are given.

This is a bold attempt to gather some supporting evidence, and while the response rate is good for this type of exercise it is limited in the sense that

the number of returns would prevent anything other than the most simple descriptive statistical analysis, and it is not clear what the differences might be between those returning the questionnaire and those authorities that did not. The extent to which the data provided are valid and reliable rather depends on the status and expertise of the person completing the questionnaire, and we have to assume that the most competent person actually completed it. To be fair, Gosling includes this factor as a limitation of the study.

In spite of his arguments about the importance of contract monitoring the responses showed that one of the main findings was that 13 of the 15 authorities said they felt that they did not have sufficient levels of dedicated staff to monitor contracts effectively. Questionnaire returns showed that the responding authorities expressed an opinion (but without any further supporting evidence) that contract monitoring enabled in some cases improved quality of service, acceptable standards of care, better provider procedures and practices, better value for money and improved compliance with the contract.

In fact, as the results indicated, contract monitoring was rarely thought to change the content of the contract, content of the commissioning strategy, policies and procedures for care managers, suspension or termination of a contract. Furthermore, responses indicated that there was little evidence that contract monitoring consistently changed commissioning plans or practice, or that it changed the content of contract or specifications. There was also little evidence that authorities shared the results and implications of contract monitoring with service users, or with one another.

In these circumstances, it is rather difficult, not to say premature, to move to the development of a good practice model, when the evidence, such as it is, suggests that there is little in the way of good practice to build upon, other than the conviction of the respondents that monitoring is a good thing. The aim to distil the elements of best practice to develop a model of effective

contract monitoring was not met and ‘will be the subject of a separate case study’. It will be interesting to see whether good practice guidance was in fact developed and disseminated and found to be helpful.

***

In summary, Table I below presents an overview of the different types of evidence referenced in the selected eBook Chapters we have reviewed. This would seem to suggest that taken as ‘whole document’, the eBook is underpinned by a broad range of different evidence types, including empirical research published in peer review journals. However, this cannot be said for all papers when they are examined in isolation which perhaps suggests the need for greater consistency and ‘quality control’.

Table I: Evidence Cited in Selected eBook Chapters	**Ch1 [Rich]**	**Ch1 [God]**	**Ch3 [Wa l**	**Ch3 [Pat]**	**Ch4 [Gar]**	**Ch5 [Gos]**	**Ch1 0 [Gos]**	**Total**
DH Commissioning Guidance	3	0	1	0	X	1	X	**5**
Other DH Documents	8	3	2	1	X	0	X	**14**
Other government departments	5	2	1	0	X	0	X	**8**
Other guidance/work books/ tools/ frameworks (from think tanks; business consultancies; and other independent/private companies	1	3	2	1	X	0	X	**7**
Case study examples	0	0	0	0	0	0	0	**0**
Local authority strategies& action plans	0	0	0	0	0	0	0	**0**
Independent Agency research	2	7	3	0	X	0	X	**12**
Peer reviewed Research papers	0	6	1	6	X	0	X	**13**
Book	0	9	0	6	X	0	X	**15**
CSIP documents	1	0	0	0	X	0	X	**1**
CSCI documents	2	0	0	0	X	0	X	**2**
Ministerial speeches& parliamentary papers/ Bills/ Acts	0	4	0	1	X	0	X	**5**

X = Indicates that no bibliography was presented in the paper.

Appendix 3b: A Catalyst for Change: Driving Change in the Strategic Commissioning of non- Acute Services for Older People (Crampton and Rickets, 2003).

http://www.changeagentteam.org.uk/_library/docs/GoodPracticeGuides/Catalystforchange2.pdf (Checked 22.01.07).

'A Catalyst for Change: Driving Change in the Strategic Commissioning of Non-Acute Services for Older People' is a sixty-two page workbook produced by the Department of Health Change Agent Team and Warwick Insight Ltd (a private business and change management consultancy) in collaboration with the Social Services Inspectorates in London and the South East, the London Older People's Services Commissioning Project and DH policy branches. It consists of a dozen or more chapters, which can be added to over time, and commented upon by users. The workbook has been produced:

> 'As a practical aid to those in health, social care or independent sectors who have responsibilities for ensuring the delivery of a range of non-acute services principally for older people. It is intended to be used alongside other guides and advice from the Department of Health… it may also be used as a self-audit tool of the health of working relationships and practices, and it makes some suggestions on how these can be optimized.' (p5)

The workbook is aimed at senior managers and advocates a whole systems approach in which partnerships from all sectors are involved in purchasing and provision of services with service users and families at the centre. The workbook activities centre on 'six key drivers' said to 'create the experience in which user experience is central.' (p8) These are:

- Building partnerships
- Encouraging innovation
- Maximising use of resources

- Understanding the market
- Creating viable market conditions
- Commissioning and contracting.

Each one of these drivers are broken down into performance criteria at four levels, along with indicators of how agencies and partnerships can gauge the level they are at. It aims to 'provide a framework for identifying what must be done to move from one level to the next. At each of the four levels for each performance criterion, statements of evidence and best practice indicate the kinds of things that need to be rated at each level' (p 9). In working through each key driver, performance is ranked against a score and the intention is that agencies work together to prioritise areas of action in order to 'achieve sustainable, consistent and strategic change' (p.9).

There is a methodology section. This however, is confined to a discussion that acknowledges that although a sample of eight health and social care sites in London, the South East and South West was sought in order 'to find and share established examples of innovative thinking and best practice; it was found that many sites were unable to demonstrate innovative ideas, were not sufficiently well developed or mature to serve as exemplars that other sites may adopt' (p. 57). The authors extend the discussion by way of outlining further pressures upon services. There is no detail as to how the different sources of information served in the formulation of the workbook, although from the acknowledgement section there is some indication that the authors made use of user-provider focused organisations, and "50 or so" health and social care economies appear to have had input into piloting the various scoring methods.

The authors claim that the workbook is based upon robust information from a diverse range of publications, reports and research findings, including DH and Audit Commission documents as well as consultation of experts involved in developing a wider range of commissioned services, for instance, drawing upon the expertise of organisations such as the Nuffield Institute (2003) self-audit as set out in its Partnership Assessment Tool. The authors also visited and gathered information from several local authorities that they consider to be 'forward-looking sites' (p5). It

may have been useful to have provided the citations underpinning certain drivers, indicators and suggestions of best practice; there was only one explicit reference within the text and this was the loose reference, as mentioned above, to a comparison between the workbook and one developed by the Nuffield Partnership Assessment Tool. Instead the authors acknowledge the information that contributed to the workbook in a bibliography at the end.

Catalyst II: Tackling the long ascent of improving commissioning (Crampton and Rickets, 2007).
http://www.changeagentteam.org.uk/_library/Catalyst%20II%20-%20version%206%20release%201%20Final%201.02.pdf (Checked 22.01.08]

Catalyst II is a revised version of the earlier workbook developed by the Change Agent Team. The workbook has the same aims as the first edition and is centred on five key areas, referred to as "the key routes". These are identical to the Key Drivers outlined in Catalyst I, excluding the key driver 'encouraging innovation'. Indicator levels aim to help managers work towards change, but the sources of these are not explicitly referenced (save three references cited as "DfES Processing of Commissioning", "CAP/JAR self assessment frameworks" and "Massachusetts Institute of Technology". None of these were in the bibliography.

The methodology and approach section of the document is limited. It sets out the reasons why there was a need for the amended version (i.e. based upon change within social care and health systems and what "people told us they need") There is an acknowledgement of drawing upon good practice examples and best practice, but no specific information about these and how they contributed to the formulation of the workbook. Table II is a comparative table of the sources contained in Catalyst version I and II.

Table II: Evidence cited in Catalyst I & II	Catalyst I.	Catalyst II
DH Commissioning Guidance	1	10
Other agency guidance/ workbooks/ tools/frameworks	4	7
Case study examples	2	1
Other DH documents	9	6
Other government department documents	6	7
Local authority strategies& action plans	3	
Agency research e.g. Audit Commission, private consultancies, National Audit Office, Academic, King's Fund.	6	2
Agency Research- Scotland	1(not peer review)	
Research Paper (not peer reviewed)	1	
Legislative references	2	2
Total (excludes references which were not accessible)	**35**	**35**

In summary, there were 50 sources in the bibliography of Catalyst I. Of these 15 were not found due to either insufficient bibliographic detail or their withdrawal from publication. Excluding these sources, there were 35 sources in each edition of Catalyst. In both, the majority derived from the Department of Health. This included eleven commissioning guides and fourteen reports. Catalyst I indicates use of a wide range of sources. For example, seven sources were local authority strategies and action plans and eight were commissioning tools and case examples. Finally, six of the sources were research based, 4 English reports, one Scottish based report and one research article in a non peer reviewed National Statistics Bulletin. Catalyst II draws heavily on DH and other government documents and makes only two references to research evidence.

Appendix 3C: Getting to Grips with the Money (CSIP, 2007a)

http://www.socialcare.csip.org.uk/index.cfm?pid=80 (22.01.08)

'Getting to Grips with the Money' is a programme of work which forms part of CSIP's Personalisation Programme.[18] The Programme aims to help councils and the NHS to respond to the challenges of spending and service provision with an emphasis upon better commissioning of flexible and individual support. A wide range of products and tools has been produced as part of the Programme. Below we review a sample of these.

(a) Getting to Grips with Commissioning for People with Learning Difficulties. (CSIP, 2007b)
http://www.socialcare.csip.org.uk/_library/Getting_to_grips_with_commissioning_for_people_with_learning_disabilities.txt.pdf (Checked 22.01.08)

This is an eight-page document that outlines the background to the impetus behind 'Getting to Grips with the Money' and argues that the current system of commissioning social care services for adults with learning disabilities is resulting in a high spend on relatively few people with the highest needs. The main message of the report is: 'a shift towards self-directed support on a large scale offers the best chance for councils to meet increasing needs and get better value for money' (p.1).

Several pieces of work are then highlighted as examples of the benefits of this including reference to the learning from the 'In-control' pilots. In Control's evaluation work is well known and began in 2003 to test Self-Directed Support as a viable model of social care in six local authority pilot sites. In Control acknowledges that it set out to implement a new system and learn from the experience, rather than to formally evaluate an intervention. It notes

[18] Throughout 06/07 CSIP worked closely with Department of Health colleagues to set up networking opportunities for Local Authorities to share learning around implementing a number of programmes that foster personalisation, choice and control.

that in terms of traditional research design, 'this means that we have to be cautious about interpreting the questionnaire results, particularly in terms of assuming that the in Control pilot project caused the changes reported here'. Moreover, the researchers note that due to the sample size 'we cannot be certain that we would see the same changes if information could have been gathered from everyone who participated in the project' (page 42).Nevertheless, in spite of these limitations, the researchers go on to claim that 'having taken these cautions into account, …in Control pilot project has been associated with important improvements in people's lives' (p42).

The report goes on to consider scope for improving efficiency. There are several strategies listed and these include tightening eligibility criteria, transferring in house services to the private and voluntary sectors, developing block contracts of residential care placements, developing shared contracting and accreditation arrangements between councils, and investigating and benchmarking costs for residential care. The report claims that some of the above activity may result in immediate savings, however each of these strategies, is merely listed and has no follow up references or elaboration. That said, the report does mention (but not cite or expand upon in any depth) an example of work undertaken by councils in South West England and the Regional Centre of Excellence to develop a fair pricing tool. The report states that this pricing tool has resulted in savings of 5% in residential care and states that other regions have done similar work, but the report fails to elaborate which regions and what work. Although it became apparent that the fair pricing tool pilots are expanded upon elsewhere the reader could have been usefully signposted to this.

In respect of the fair pricing tool in use in the South West of England, further information was subsequently found at the South West Centre of Excellence (www.swce.gov.uk [checked 28.12.07]). The fair pricing toolkit is summarised as 'having been developed to help social workers plan a learning disabilities residential care package and provides an indicative cost determined by a service user's specific needs. This can then be used to inform negotiations

with providers.' It is asserted that the tool has been refined through piloting and costs have been benchmarked against figures from various research units (although such research is not cited), as well as against local South West prices. The partnership also made use of a Provider Reference Group as part of a consultation exercise in May 2006. With regards to implementation, over 300 care workers across 13 authorities are reported to have been trained to use the tool.

The website also provides links, information and case studies concerning the fair pricing tool in Gloucester (SWCE 2007) and Wiltshire (SWCE 2006). These cases are described in brief and encompass a background to the projects, the objectives, benefits, critical success factors, lessons learned and risks. It appears that the Wiltshire case study (August 2005-March 2006) utilised an existing Fair Pricing Tool from Gloucestershire Council; yet, Gloucestershire Council does not appear to have piloted this tool until 2006-2007.

(b) London Pilot of Fair Pricing Tool for Residential and Supported Living (CSIP, 2007c) http://www.socialcare.csip.org.uk/_library/CSIP_Report_v4.doc (Checked 22.01.08)

This is a 26 page document, developed by CSIP working with 'Care and Health'. The report describes work carried out in London between March and July 2007 to pilot a tool designed to assist Adult Social Services Departments to assess the needs of people with learning disabilities, and the costs of residential care or supported living to meet those needs. It was intended that five councils would take part in the pilot with each contributing twenty completed versions of the tool for evaluation. Data was to be analyzed qualitatively and quantitatively, however the details of such analysis are not divulged in the report. The report concludes that 'It would appear appropriate for all London authorities to implement this approach' but to some extent this would appear to be going beyond the data and avoiding the conclusion that more robust work is needed before widespread implementation:

> ‘The size of the pilot was limited so it is not possible to draw robust conclusions on the approach most likely to deliver the best cost control for each authority. There is probably no one approach that will achieve this in all circumstances. To some degree each authority will need to develop the approach that is right in their case, while using the experiences of what has worked elsewhere.’

(c) Commissioning for people with learning disabilities - a tale of two nations (CSIP, 2007d) http://www.socialcare.csip.org.uk/_library/Two_nations.pdf (Checked 22.01.08)

This six page discussion paper compares spending on services for adults with learning disabilities and the differing results achieved amongst two groups of English councils with different approaches to commissioning. The groups are referred to as ‘two nations’ - ‘Careland’ and ‘Communityland’. Although acknowledged as tentative, the resulting guidance is somewhat ambiguous. On the one hand, it is suggested that ‘the evidence appears to support the case for a big shift in spending away from residential and nursing care’. On the other hand it is suggested that:

> ‘There is very little information available on outcomes, quality of life, or satisfaction. In particular it is not possible to assess from national data whether people living in supported accommodation have better lives than those living in residential care… There are no grounds for assuming that the type of accommodation is itself linked to better outcomes’.

Appendix 3d: Key activities in commissioning social care: lessons from the Care Services Improvement Partnership Commissioning Exemplar Project (2nd Edition)

(CSIP, 2007e) http://www.icn.csip.org.uk/_library/Key_Activities.pdf (Checked 22.01.08)]

This 88 page document launched in Bournemouth in 2007 is the result of work by CSIP and the Institute of Public Care (IPC) working together with three local authorities in what was called the 'Commissioning Exemplar Project'. The aim of the project was to explore practical issues and approaches in commissioning social care, to inform the development of a set of commissioning strategies and to draw lessons from that work which could be of benefit to others. The project focused on activities involved in developing a strategy and the learning that can be gained from those activities rather than simply offering a 'model product'. Two out of the three authorities in the project concentrated their efforts on a commissioning strategy for older people and therefore many of the examples concentrate on older people. The authors argue that the examples and materials presented are of relevance to other areas of practice, and are equally applicable to children's services. They say that the document is based on the findings from the exemplar project, but also on policy guidance and research; however the results from the exemplar project take up only 4 of 57 pages of the text. The appendices (31 pages) contain a range of tools and examples which commissioners may find helpful in developing their strategic thinking.

The Key Activities report cites a number of relevant documents; guidance and research, using a numbering footnote system. There are 48 of these notes, and the evidence to which they refer is categorised in Table III.

Table III: Evidence cited in Key Activities	N	%
DH Commissioning Guidance	10	22.7
Other DH documents	5	11.4
Other government departments	6	13.6
Agency research	9	20.5
Research papers	4	9.1
CSIP documents	7	15.9
CSCI documents	2	4.5
Ministerial speeches	1	2.3
Explanatory footnotes = 4		
Total	**44**	**100.0**

We omitted the explanatory footnotes from the total. Government documents account for almost half of the citations (47.7%) and CSIP and CSCI documents for a further 20.5%. None of these CSIP and CSCI references is to research evidence *per se*; they usually refer to other forms of commissioning guidance, some in the health service, making about 70% of citations somewhat circular.

The 'agency research' category contains materials produced by a range of organisations, including IDeA, SOLACE, the Audit Commission, the UKHCA, FFRES, NERA and ESRC. We have examined all of these materials to assess their evidence base. Altogether less than 10% of the citations were traditional academic peer-reviewed papers.[19] This is in spite of the fact that, throughout the document, there are numerous assertions that commissioning itself needs to be based on sound evidence. For example, reference to 'evidential route to planning' (p16), 'knowledge about what may or may not be achievable outputs and processes need to be tempered first of all by our knowledge of what works' (p16), researching future provision needs to become 'better researched' (p26), 'no authorities within the exemplar projects and few outside appear to conduct a rational review of the research and best practice literature' (p30), 'the task is to review a range of national

[19] The academic papers referenced in the agency research category were generally of good quality. See for example, Bowling (2005) *'Adding Quality to Quantity: Older People's Views on Their Quality of Life and its enhancement',* ESRC.

and international research' (p35), and 'there is ample research available exploring what outcomes older people are looking for' (p49) – but none is actually cited.

Appendix 3e: A guide to fairer contracting Part 1 (HSCCAT, 2005)

http://www.changeagentteam.org.uk/_library/docs/CATReports/Fairer_contracting_guide.pdf
(Checked 22.01.08)

The fairer contracting guide was produced by the Health and Social Care Change Agent Team (HSCCAT), prior to the creation of CSIP, and relates to contracting rather than commissioning. The guide was developed for the use of local authorities and Joint Commissioning bodies in purchasing care placements and domiciliary care services and for those who contract to provide such services. It was developed through extensive consultation with providers, local authorities and representatives of central government departments. There is no reference to previously published empirical work. It was designed to explore a range of issues concerning how contracts for placements and services are constructed and to provide helpful examples of how clauses in contracts may be amended or enhanced to provide a fairer approach to contracting. It did not provide a commissioning model, nor address the nursing element in care homes, or the needs of different groups of service users. All these items were to be covered in the Part 2 (2006).

Appendix 3f: A Guide to Fairer Contracting Part Two: Service Specifications (CSIP, 2007f)

http://www.integratedcarenetwork.gov.uk/_library/Part_2_-_Service_Specifications.doc (Checked 22.01.08).

This guide describes models of good practice concerning; contract terms, service specifications, and tendering/market development (building on an earlier guide developed by the Change Agent Team prior to the launch of CSIP). The guidance is for both providers and employees but excludes NHS care, although the authors argue that the principles behind the guidance are transferable. The methods used to

gather the intelligence on which the guidance is based included: a search of national legislation, policy and guidance, and of research and best practice literature (no further details are given about the search methodology); a review of a sample of current contracts and specifications in use; and consultation via a number of reference groups.

As in some other documents a numbered footnote system is used to refer to the supporting evidence, and an untitled list of references or sources used for the document is given at the end. Although the guidance states that a review of the research literature has been undertaken, only five out of 34 references relate to empirical research studies (and only one is a reference to a peer review journal article].

Appendix 3g: From segregation to inclusion: Commissioning guidance on day services for people with mental health problems (CSIP, 2007g)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131061 (Checked 22.01.08)

This guidance is designed to assist commissioners of mental health services in the refocusing of day services for working-age adults with mental health problems into community resources that promote social inclusion and promote the role of work and gaining skills in line with current policy and legislation. It follows on from the report Mental Health and Social Exclusion (Office of the Deputy Prime Minister, 2004) and progresses the implementation of the developmental standards as set out in National Standards: Local Action (DH, 2004).

The guidance provides fourteen supporting references: three are to the Social Exclusion Unit Report (2004) which reviewed much of the evidence; two are in non-peer reviewed journals; four relate to other NIMHE publications; four relate to reports of user-views, and the final two are reviews of the social supports and networks of people with schizophrenia, although both of these are in peer review journals, they are American.

Appendix 3h: Fair Commissioning – The Four Tests of Fairness Checklist (HSCCAT, 2004)

http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/Support_materials/Fair_Commissioning_-_A_good_practice_check_list.pdf [Checked 17.11.07].

This 2004 tool, developed originally by the Health and Social Care Change Agent Team (HSCCAT) and the DH, provides a checklist against which commissioners can test themselves to see if they are meeting the needs of service users:

> 'If you feel that your health and social care economy has not sufficiently met the Minister's Four Tests of Fairness and – by implication – may be failing to meet the service needs of the very people who depend upon the availability of a wide range of good quality services, the CAT may be able to help'.

The Four Tests are:

1. To be fair to people using services – and to ensure that they get good quality care, in the right place, in the right quantity, at the right time. Inevitably this will almost always mean they have been involved in designing the package of services they are receiving;
2. To be fair to tax payers – and ensure that the services they are supporting are giving value for money and being targeted at the right priorities;
3. To be fair to providers – ensuring that they receive a fair return for their services and they have not been set impossible objectives or given tasks for which they are not funded;
4. To be fair to commissioners from councils and primary care trusts who are entitled to choose between the services on offer and pay a price that offers quality at a price they can afford.

The document states that the tool should be used across health and social care systems as a tool to facilitate discussions, debate and decision-making. The

evidence supporting the statements in the checklist, appear to be based largely on the CAT (experiential or common sensical) understandings of what works. There are references to ‘what research shows’ but no references are given to support these statements. Beyond, the experiential, there is then no direct evidence provided then to support the statement as regard a direct connection between low (or high) checklist ratings and users’ direct experiences of the care that has been commissioned and delivered to them.

APPENDIX 4

COMMISSIONING eBOOK TOPIC GUIDE

In advance of the interview, please ask participants to familiarise themselves with the commissioning eBook. This can be found at:

http://www.csip.org.uk

A: The training and support you receive to develop your 'job role' as a commissioner

- Can you tell me about your role as a commissioner? What does your job entail?
- What is your professional background?
  - Highest level of (qualifications etc,)
  - Previous employment experience
- Please describe your position in the organisational hierarchy?
- What kinds of training and support do you receive to enable you to develop in your job role?

B: Your involvement with CSIP and views on 'service improvement agencies'

- How familiar are you with the CSIP brand? How have you been involved with CSIP? Which products and services have you used?
- Are you aware of the work of any the other service improvement agencies?
- How does CSIP compare?

C: The impact of the commissioning eBook on your working practices

- How user friendly is the eBook?
- How often do you use it?
- Does the content provide new and different perspectives, or is it more a review of current thinking?
- Is it theoretical, practical or a combination?
- Do the authors provide substantive references for their claims, ideas?
- What, in your opinion, are the major strengths or weaknesses (if any)?

- *"The commissioning eBook has become more relevant since it was conceived of as a means of helping to achieve effective commissioning outcomes"*
  (Commissioning eBook, Accessed November 2007)

  - What impact, if any, has the eBook had on your working practices?

- Overall, which CSIP products and services make the most impact and why? How does the eBook compare?

- Are there any other comments you would like to add?