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Changes in commissioning home care: an English survey

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Abstract

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Purpose

This paper examines changes in the nature, form and range of commissioning arrangements for home care

Design/methodology/approach

Data from two discrete national surveys of English local authorities with social service responsibilities were used. In the first, undertaken in 2007, responses from 111 of the 151 local authorities (74%) were received and in the second, undertaken in 2017, responses from 109 local authorities (72%) were received. A combined dataset of 79 complete cases, 52% of local authorities, was created. Percentage point differences across the two time periods were calculated and tested to identify significant changes and a systematic analysis of the free-text responses regarding intended changes to the commissioning process in each dataset was undertaken.

Findings

Findings identified substantial changes in some aspects of the commissioning of home care in the decade 2007-2017. Collaboration between stakeholders had increased, particularly regarding the identification of future needs. Improved conditions of service and remuneration for home care workers were evident within the commissioning process. Standardised charges for home care (regardless of time and day) had also become more widespread. Initiatives to prompt providers to deliver more personalised care were also more evident.

Originality/value

This paper describes the evolution of commissioning arrangements for home care in localities in response to national policy initiatives. It provides guidance to commissioners in meeting the needs of current service users and emphasises the importance of collaboration with stakeholders, particularly providers, in securing future capacity.

Keywords: Commissioning; Older People; Home Care; Social Care

Introduction

For older people with complex needs, care at home involves the provision of personalised care and other support activities to enable them to continue to live at home, rather than move into residential or nursing care. Assistance is usually provided by home care agencies through multiple visits each week and may take the form of help with basic activities of daily living (e.g. bathing), activities that further support an independent lifestyle (e.g. shopping) and more recently, assistance to engage in local social activities outside the home. Following the community care reforms of the early 1990s in England, the role of local authorities changed from that providing home care to an 'enabling' role (Cm 849, 1989) focusing on the assessment, planning, procurement and monitoring of

services. Policy developments, specifically the introduction of personal budgets in adult social care, have led to further evolution in the arrangements for commissioning and provision of home care. The allocation of funding to users through personal budgets have allowed older people and carers to assume responsibility for their own care plans and enter into direct negotiations with home care providers, prompting changes in contracting arrangements for home care towards more flexible and personalised approaches. Additionally, local authority commissioners of home care must respond to policy initiatives promoting the joint commissioning and provision of services with other agencies, particularly commissioners of community health services, along with guidance supporting the greater involvement of providers within the commissioning and contracting processes (Legislation.gov.uk, 2015; Department of Health and Social Care, 2018). However, although most home care services are now commissioned by local authorities and provided by independent agencies, little is known about this process and how arrangements have evolved in the 21st century in England.

Nevertheless, complexities in the process of commissioning home care are now increasingly acknowledged and approaches are constantly adjusted to reflect the interests of multiple-stakeholders within a market model where services are competitively bought and sold (Donovan, 2017; Hudson, Commissioning for change: A new model for commissioning adult social care in England, 2019). As a result of these challenges, it is helpful to think about the commissioning of home care in localities as a wicked problem. In this context 'wicked' is used not to signify evil, but describes a problem that is difficult or impossible to solve as requirements are difficult to identify, contradicting or changing (Rittel & Webber, 1973). Due to the complexity of the process, solving one aspect of the problem may lead to unexpected consequences and create problems elsewhere. However, little is known about the impact of policy changes and the nature, form and range of home care commissioning practices and what is required to promote its capacity to respond to increasing expectations resulting from the changed policy environment. This paper examines this knowledge gap. The research was undertaken as part of a larger study to explore current commissioning arrangements for home care and provide guidance for commissioners and providers. The aim of this paper is to investigate: (1) how commissioning arrangements have changed over time and (2) identify emerging trends in commissioning arrangements. Data on current arrangements were supplemented through qualitative interviews with commissioners and providers and a literature review which explored the lessons from research for commissioners of home care for older people which will be reported separately.

Method

Data collection

These data were generated through the combination of data collected through two discrete national surveys of all local authorities in England with social service responsibilities. To capture changes in commissioning arrangements, data collected in a 2017 survey was compared with previous data collected in 2007 to provide a historical control group (Bowling, 2014). Surveys were completed by individuals tasked with commissioning adult social care services within the authority. In the earlier postal survey responses from 111 of the 151 local authorities were received providing a response rate of 74 per cent [redacted]. The 2017 survey (electronic and postal completion) was undertaken as part of a larger study exploring current commissioning arrangements and emergent trends relating to the range, content and practice of service commissioning for home care. Responses from 109 local authorities were received providing a 72 per cent response rate. This high response rate was achieved with the assistance of regional commissioning groups, operating through the Association of Directors of Social Services (ADASS).

Creation of a matched dataset

Cases (local authorities) from the 2007 dataset were extracted and matched with the corresponding cases from the 2017 dataset. In matching cases, approaches to manage local authority boundary changes over the period were considered, however, as complete responses from modified authorities had not been received this was unnecessary. Measures contained within both the 2007 and the 2017 survey were then paired by case. These repeat measures of the same variables allowed comparison over the two time periods. The combined dataset contained 79 cases, representing 52 per cent of local authorities. The distribution of these matched responses varied by region. The highest paired response rates were obtained in the North West of England (78%) and Yorkshire and Humber (66%), in comparison the lowest rates were in the South East (33%) and the West Midlands (25%).

Data analysis

To assess change in individual measures, percentage point differences in positive responses across the two time periods were calculated. The McNemar's test was used to identify statistically significant changes between 2007 and 2017 in paired dichotomous variables. Data was analysed using SPSS for Windows.

To further appraise service evolution, a systematic analysis of the free-text responses regarding intended changes to the commissioning process was undertaken. For both 2007 and 2017 surveys conceptual categories were developed, these data were then coded and analysed in an excel spreadsheet (Bowling, 2014). This was undertaken by one researcher (ED) and reviewed by another (SD). Differences of interpretation were resolved through discussion.

Results

Firstly, data presented within this section concerns the organisational arrangements of adult social care commissioning operations within the organisation they are located. Following these organisational arrangements, the reporting framework presents data under broad themes. Its construction was informed by Goertz (Social Science Concepts: A User's Guide, 2006) who identified three levels of concept: basic; secondary; and indicator. "The basic and secondary levels are in reality the theory of the concept, while the indicator/data level is the connection to measures and data collection" (p. 10). Three basic levels of the framework were constructed: market management; shaping local provision; and managing delivery. As illustrated within the results tables, under these headings, secondary level attributes were identified and operationalised by indicators, measures from the survey were then arranged by indicator. Those which were statistically significant are highlighted within the results tables. However, it should be noted that indicators which did not reach significance criteria nevertheless, display a real change in commissioning practice. The final section, service evolution, reviews future service development plans.

Organisational arrangements

These data reflect change in the organisational arrangements of commissioning in adult social care services. The proportion of these located within a combined organisation (for example with health partners or children's services) had decreased over the period. In 2007 about a third (38%) of adult social care commissioning services were located within a single department, in contrast to around three quarters (72%) in 2017. Most local authorities located contracting units within adult social care services; however, the location of these in corporate/central service departments had increased (4% in 2007 to 16% in 2017).

Market Management

Findings regarding market management are presented in Table 1. The use of smaller scale providers, defined within the questionnaire as those operating only within a single local authority, had seen some change over the period. The proportion of authorities commissioning care from such providers had increased (74% in 2007 to 88% in 2017). Despite this increase, the overall prevalence of these locally based providers had changed little, representing around a third of all providers.

The extent of stakeholder involvement was assessed by the regularity of contact with home care commissioners, with consistent engagement defined as *always* engaging with stakeholders. Engagement with all stakeholders had increased over the period, however, these arrangements varied across stakeholder groups. Consistent engagement with providers were reported in all areas, a 17 per cent point rise from 2007. However, in another measure of involvement, provider forums, most authorities reported having these meetings but the proportion of those with six or more annually was slightly less (43% in 2007 to 37% in 2017). In 2017 most home care commissioners reported consistent engagement with service users (99%), their carers (99%), health partners (98%), advocacy groups (94%), ethnic minorities (89%) potential service users (87%) and local housing partners (77%). Engagement with potential service users exhibited the largest increase (55% in 2007 to 87% in 2017).

Joint commissioning arrangements with health partners had changed little. A small decrease in the use of joint plans and planning processes (76% in 2007 to 67% in 2017) was reported, whilst those employing a single lead commissioner for health and social care had slightly risen (28% in 2007 to

33% in 2017). There was a small increase in the number of authorities reporting that more than 20 per cent of services were jointly commissioned (26% in 2007 to 36% in 2017). However, the proportion of local authorities reporting the joint commissioning of specialist services for people with dementia was broadly comparable (46% in 2007 to 49% in 2017).

Shaping local provision

Service specification and contracting and monitoring arrangements are presented in Table 2. The focus on staff conditions and training specified within service frameworks, developed to guide the commissioning process, varied across local authorities. In 2017, the payment of travel time for home care staff was the most frequently specified service condition (64%), followed by sick pay (46%) and the payment of mileage (42%). Between 2007 and 2017 the largest increase was in the specification of payment of travel time (23% point increase). The inclusion of stipulations of training for front line staff in service framework increased (35% in 2007 to 46% in 2017) as did training specific to caring for people with dementia (51% in 2007 to 61% in 2017). However, the proportion stipulating management training had fallen slightly over the period (63% in 2007 to 57% in 2017). Considering the mechanisms for service improvement specified within the service framework, little change was evident, the exception being the increased requirement of providers to have a medication policy (82% in 2007 to 92% in 2017).

Changes in contractual agreements, regarding both contract duration and purchasing approach, were evident. In 2017 contracts of four or more years were employed in almost two-thirds (61%) of authorities increasing from two-fifths (43%) in 2007 when shorter-term contracts of 2-3 years were favoured. Preferred contract type had shifted from the use of block contracts (payment for a given volume of service agreed in advance) (from 65% in 2007 to 38% in 2017). The use of more individual contract types was evident in 2017, when 90 per cent of authorities employed methods allowing the purchase of services as and when needed by an individual.

In 2017, most home care commissioners relied on information from home care providers in the monitoring of services, including CQC reports (99%), provider returns (94%) and levels of service use (90%). Between 2007 and 2017 the use of provider generated monitoring data had seen some increase, the largest being in the use of provider returns (13% point increase). Other monitoring data largely used included feedback from users and carers via complaints (98%), user satisfaction survey returns (90%) and information from care managers (70%), with the proportion of authorities using these data was relatively unchanged between 2007 and 2017.

Managing delivery

Table 3 presents data concerning the delivery of home care services. Despite a small increase, in both 2007 and 2017 few authorities had an integrated health and social provider (5% in 2007 to 8% in 2017). There was an increase in the proportion of authorities requiring providers to deliver evening services (81% in 2007 to 92% in 2017) but the requirement to provide weekend services was similar (84% and 85% respectively). The provision of specialist services for people with dementia had increased significantly over the period (from 18% of authorities in 2007 to 54% in 2017). A standard price for home care was charged in over half (56%) of authorities in 2017, increasing from just over a third in 2007 (38%). When charges varied, they fluctuated according to travel costs (26%), service user requirements (14%), time of day (14%) and day of week (9%). In meeting needs, pre-contract tendering specified the requirement of providers to deliver flexible/out-of-hours services

increased (61% in 2007 to 84% in 2017) as did the requirement of crisis response capabilities (47% in 2007 to 60% in 2017). However, the inclusion of conditions ensuring equity of access for those from ethnic minorities had slightly fallen (87% in 2007 and 80% in 2017).

There was a decrease in the proportion of authorities requiring that front-line staff were qualified to nationally recognised standards (85% in 2007 to 75% in 2017) but the requirement that new home care staff receive any training was unchanged (87%). In terms of management of the performance of home care agencies the regular use of CQC national reports had increased significantly (38% of authorities in 2007 to 91% in 2017), the use of information from care managers had changed only slightly (94% in 2007 to 91% in 2017).

Service evolution

Analysis of the free-text allowed for identification of a number of common themes regarding anticipated service development. Within the 2007 dataset six themes were identified. Here they are listed with the proportion of authorities expressing them: 1) flexible contracts/responding to the policy goal of personalised care (49%); 2) increasing partnership working with colleagues in health (22%); 3) commissioning for outcomes (19%); 4) service specific improvement or modernisation (14%); 5) improving monitoring systems/quality (9%) and; 6) promoting provider engagement (4%). Almost a quarter of authorities (23%) provided no details of plans for service development.

Ten themes were identified within the 2017 dataset; 1) service specific improvement or modernisation (35%); 2) commissioning for outcomes (28%); 3) flexible contracts/ responding to the policy goal of personalised care (20%); 4) recruitment and retention of care workers (19%); 5) improving monitoring systems/quality (18%); 6) locality/community based commissioning (18%); 7) contractual arrangements (15%); 8) provider supply (10%); 9) increasing partnership working with colleagues in health (14%) and; 10) promoting provider engagement (9%). The proportion of authorities providing no details of planned change was similar to that in 2007 (22%).

Discussion

This paper has presented data from a national survey of local authorities undertaken in 2017 alongside comparable data collected in 2007 to describe local arrangements for commissioning services to support older people living at home and explore changes over time. These findings reveal the shifting trends in the commissioning process to deliver home care. Changes in the management of the market are evident with the increase in collaboration with all stakeholder groups, particularly to identify future need. In the shaping of local provision, change in preferred contract type is apparent with the decrease in block contract use. Further modifications to provision were shown through increased training and financial reimbursement for home care workers. Changes concerning the delivery of services were evidenced through a growth in standardised charges for services and raised expectations that services are accessible outside of conventional business hours. Furthermore, these findings indicate a shift in the earlier focus of collaboration with health partners to improving relationships with providers. Also highlighted is the longstanding issue of commissioning for outcomes. However, it is important to note there were three limitations. Firstly, these data were collected through two self-completion questionnaires, with the possibility of the over reporting of perceived 'good practice' with responses not verified by other means and also the limitations associated with pre-coded choices (Bowling, 2014). Furthermore, there were regional variations in the response rate. Secondly, the omission of incomplete cases across the two data collections resulted in a reduced response rate making identification of statistically significant change problematic. Caution must be taken when interpreting the results of the conservative McNemar test in the analysis of data with a reduced sample size. Thirdly, the findings solely reflect the perspective of local authorities on the way services are commissioned and contracted, these may differ from the perspectives of other stakeholders with whom they collaborate, particularly independent providers of care. Despite this, the study has successfully identified change-trends and the future challenges in commissioning services to support those living at home. In this study, changes in the commissioning of home care are demonstrated by an increased emphasis on market shaping. As defined within the Care Act (2017) market shaping involves collaboration with partners to promote a diverse range of quality services (type, volume and quality of services and types of provider organisation) to ensure the market of care remains vibrant and sustainable. Here, market shaping is evidenced in: the promotion of wellbeing and individual outcomes, the collaboration with stakeholders and activities to ensure sufficient local supply. These are explored in more detail below.

1. **Wellbeing and individual outcomes**

The concept of 'wellbeing' is described within the Care Act guidance (Department of Health and Social Care, 2018) as relating to a number of aspects, those of particular relevance to older people include the assurance of personal dignity, physical and mental health and emotional wellbeing, protection from mistreatment and the control over daily life, including the provision of care and support. The care and support functions of adult social care must reflect the needs and goals of an individual and assist in the achievement of outcomes that matter most to them. Within this study, progress in the pursuit of wellbeing has been noted through the development of commissioning practices aligned with the realisation of outcomes for individual service users, however, much remains to be achieved. Aspirations to commission services to achieve individual outcomes prevail, indicating the challenges associated with the departure from the traditional 'time and task' cultures of care planning (Koehler, 2016). One challenge is the measurement and monitoring of the

achievement of outcomes within social care. As previous research has shown, measures of intermediate outcomes, relating to provider performance, are easier to capture than final outcome measures, relating to service user experience ([redacted]). Within this study the significant increase in the use of provider generated data as means of monitoring from 2007 to 2017, suggested an increased awareness of the value of more bespoke measures of performance. A lack of trust between commissioners, providers and care workers has been cited by (Koehler, 2016) as a barrier to commissioning for outcomes and an increase in performance monitoring raises concerns regarding providers' autonomy within this relationship.

Further evidence from this study suggested changes in commissioning to promote a more flexible and responsive service delivery deemed more compatible with achieving personalised goals for service users within an outcomes-based framework. The reported increase in standard charges for care, regardless of time and day, suggests that bespoke provision is becoming more commonplace. The use of block contracting was also reduced indicating the use of more individual and personalised contracting (Stevens, et al., 2019). Locality based planning for home care was also identified as a means of linking home care with neighbourhood services and thereby enabling support plans to address the needs of service users in the round. These efforts to personalise care are however, at odds to the market model in which these services are provided as a commodity (Stevens, et al., 2019). Furthermore, instability of the market may occur with the reduction of block contracts and the security they provide (Rodrigues & Glendinning, 2015).

2. Stakeholder collaboration

Local authorities are required to lead collaboration with all partners allied to care at home to develop and shape the market of care, support and related services. However, this *shared endeavour* (Legislation.gov.uk, 2015) requires cooperation between commissioners and the numerous stakeholders beyond simply those organisations delivering care and the individuals and their families in receipt of it. It may include dialogue with social care managers and social workers, independent advocates and support organisations (those helping people who need care to consider their choices) to successfully reflect the range and diversity of the older population in order to meet existing and anticipate future local need. These data revealed that whilst engagement with all stakeholders has risen, the largest increase was evident in collaboration enabling an improved understanding of the future needs of the population (via potential service users) and of the specific needs of more marginal individuals (via users from ethnic minority groups). Interestingly, the role of collaboration with either of these two stakeholder groups is not specially referred to within the Care Act guidance (Department of Health and Social Care, 2018).

Relationships between commissioners and providers have long been identified as key to the provision of quality services (Wistow & Hardy, 1999; Glendinning, et al., 2008; [redacted]). This study has revealed a significant increase in this aspect of stakeholder engagement in the decade between 2007 and 2017. Collaboration between local authority commissioners and the providers of care was evident, specifically in the development of commissioning practices. However, despite these reported accomplishments, many respondents cited the need to improve working relationships with providers as a priority of change in both 2007 and 2017, indicating that challenges remain. However, difficulties in establishing relationships between commissioners and providers have been noted in recent research ([redacted] (under submission and review)) concluding

that partnerships must go beyond formal mechanisms and the encouragement of a more relational approach to commissioning to develop a trusting and collaborative partnership is required.

The importance of partnership working between health and social care in commissioning home care for older people is well documented (Glendinning, et al., 2001; Goodman, et al., 2011; [redacted]; Mellors & Bolton, 2016). Linked to successive legislation and accompanying statutory guidance, efforts to increase partnership working were evident (Legislation.go.uk, 1999; Department of Health, 2010; Department of Health and Social Care, 2018; Cm 4169, 1998). However, the extent to which real change has occurred is debatable, with collaboration remaining static or even slightly decreasing (in terms of joint commissioning) from 2007 to 2017. The implications of this apparent disconnect for those with complex care needs spanning both health and social care, such as people with dementia in the oldest age groups likely to also exhibit physical frailty, remains a concern (Matthews, 2016).

3. Securing supply

Recent national statistics revealed the instability of the home care market which challenges commissioners (Age UK, 2017). Hudson (2018) attributed this volatility to decades of unregulated outsourcing of care with current markets failing to meet standards of choice and control. To secure an adequate supply of home care, commissioners must both understand the local market and facilitate change and development. The Care Act (2017) placed a statutory duty on local authorities to ensure sufficient provision of home care to meet the needs of its population. Sufficiency in supply relates to both ***competence*** in the delivery of care and the ***capacity*** of the market to meet demand, whether that is state or self-funded. Overall this study provided evidence of both activities to shape the market by commissioners.

Within localities, sufficiency of supply in the home care market is partly contingent on the recruitment and retention of competent personnel by local providers with opportunities for training to enhance their skills and knowledge. Labour force issues are of particular concern within home care. Skills for Care (2016) reported vacancy rates of 11 per cent within the sector, higher than that of the care labour market as a whole of 7 per cent. Turnover rates for home care workers were also almost 10 per cent higher than the care industry average at 38 per cent. This study revealed that the supply and quality of home care workers remained a concern in 2017 despite initiatives to promote the development of the workforce and remuneration (such as the payment of sick pay and travel time) in the decade following the first survey in 2007. More positively, strategies to develop the role of carers in achieving commissioning for outcomes were proposed, address some recruitment and retention concerns. Furthermore, the most recent survey demonstrated that commissioners were more likely in 2017 to award longer contracts to providers which may assist in the recruitment and retention of staff (Knapp, et al., 2001). These may in the medium to long-term help to create sufficiency in supply in the provision of home care, both in terms of recruiting staff and their knowledge and competence.

There are currently increasing pressures for commissioners to secure sufficient capacity to meet demand which will become more important in the future. For example, a recent survey reported that 11 per cent of UK home care providers anticipated closure in the next year and almost three-quarters planned to reduce the provision of care funded through local authorities (United Kingdom Home Care Association, 2016). The key to securing capacity in both the short and long-term is

engagement with local providers to identify future demand for services and providing suitable support to meet it. These issues were acknowledged by commissioners within this study, striving to support the sustainability of the market and achieve an adequate supply of providers to meet anticipated needs.

This paper has evidenced the complex nature of market shaping in commissioning home care within a multi-stakeholder setting reflecting national guidance and local traditions of service delivery and collaboration between commissioners and providers. Despite the reported modifications and developments in commissioning practice, the achievement of outcome related objectives remain largely aspirational and inadequacy in supply persists. In social policy terms these challenges may be seen as 'wicked problems'; longstanding and multifaceted, without a shared understanding by stakeholders or apparent solution. Moreover the complex interdependencies inherent in the processes of commissioning and providing home care demonstrated in this study suggest that attempts to solve one problem may reveal or create others, another feature of a 'wicked problem' (Rittel & Webber, 1973). Data from this study has suggested that meaningful collaboration is required between commissioners of home care, providers and other stakeholders to address these issues in localities.

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Table 1: Market management

Attribute	Indicator	Measure	2007		2017		Change (% points)
			n	%	n	%	
Provider characteristics	Organisational type	Presence of local providers	36	74	43	88	14
Stakeholder involvement	Provider	Provider engagement*	66	84	79	100	16
		Frequent provider forums	34	43	29	37	-6
	Service users/carers and their representatives	Service user engagement*	71	92	78	99	7
		Potential service users engagement*	42	55	69	87	32
		Engagement with ethnic minorities*	52	66	70	89	23
		Carer engagement*	70	89	78	99	10
		Advocacy groups engagement*	59	75	74	94	19
		Primary care engagement*	70	89	78	98	9
		Housing partner engagement*	46	58	61	77	19
Joint commissioning	Arrangements	Single lead commissioner for health and social care	22	28	26	33	5
		Joint plans and planning processes	60	76	53	67	-9
	Focus	Specialist dementia services	36	46	39	49	3
	Extent	More than 20% of services	19	26	26	36	10

* Significant change identified at 0.05 level

Table 2: Shaping local provision

Attribute	Indicator	Measure	2007		2017		Change (% points)
			n	%	n	%	
Service specification	Staff focus	Training	28	35	36	46	11
		Dementia training	40	51	48	61	10
		Management training	50	63	45	57	-6
		Condition of service: sick pay*	23	29	36	46	17
		Condition of service: travel time*	32	41	50	64	23
		Condition of service: mileage	26	33	33	42	9
	Service user focus	Medication policy	65	82	73	92	10
	Service improvement	Service redesign: commitment to monitoring	67	85	67	85	0
		Service redesign: innovative ideas/cost savings	39	50	43	54	4
		Staff development	67	85	72	91	6
		Supervision of staff	67	85	73	92	7
Contracting arrangements	Length of contract	Four or more years*	34	43	48	61	18
	Block contracts	Presence of*	51	65	30	38	-27
		Prevalence: used in >20% of hours (n=51/n=33)	46	90	15	46	-44
Monitoring	Information from home care providers	Routine data: service use	62	79	71	90	11
		Routine data: provider returns*	64	81	74	94	13
		CQC reports	75	95	78	99	4
	User and carer feedback	Complaints	75	95	77	98	3
		Satisfaction surveys	71	90	71	90	0
	Information from practitioners	Interviews with care managers	55	70	55	70	0

* Significant change identified at 0.05 level

Table 3: Managing delivery

Attribute	Indicator	Measure	2007		2017		Change
			n	%	n	%	(% points)
Assessing need	Type of organisation	Integrated health and social care provider	4	5	6	8	3
Meeting needs	Availability of home care	Day time*	72	91	79	100	9
		Evenings	64	81	73	92	11
		Weekends	66	84	67	85	1
	Determinants of price of home care	A standard price for home care*	29	37	44	56	19
		Varies by travel cost (n=48)	10	21	9	26	5
		Varies by individual requirements	5	10	5	14	4
		Varies by time of day	15	31	5	14	-17
		Varies by day of week	15	31	3	9	-22
	Pre-contract tendering specifies	Equity of access to services	69	87	63	80	-7
		Crisis response	37	47	47	60	13
		Service availability*	48	61	66	84	23
	Specialist provision	Older people with dementia*	14	18	43	54	37
	Service framework specifies	Training of new staff	70	89	69	87	-2
		Staff have national qualifications	67	85	59	75	-10
	Performance management	CQC national reports*	30	38	78	91	53
		Care manager views	74	94	78	91	3

* Significant change identified at 0.05 level