CUBeC

Centre for Understanding Behaviour Change

www.cubec.org.uk

The use of evidence in commissioning children's services: a rapid review

Di McNeish and Sara Scott with Linda Maynard

National Centre for Social Research

September 2012

Short Policy Report No. 12/08

(Funded by Department for Education)

Centre for Understanding Behaviour Change
Centre for Market and Public Organisation
University of Bristol
2 Priory Road
Bristol
BS8 1TX
UK

www.cubec.org.uk

CUBeC delivers evidence and insight into the drivers of behaviour change to inform and improve policy-making. The Centre combines expertise in a wide range of academic disciplines: economics, psychology, neuroscience, sociology, education, and social research.

The use of evidence in commissioning children's services: a rapid review

Di McNeish and Sara Scott with Linda Maynard,

National Centre for Social Research

Summary

This review was commissioned by the Department for Education to identify what is currently known about how children's services commissioning is conducted and, in particular, what role evidence plays in commissioning.

How is the commissioning process for children's services conducted?

- There is a substantial body of guidance for commissioners, particularly with regard to commissioning from voluntary sector providers.

- There are several reports from 2007 onwards on the perspective of voluntary sector providers and their views on the strengths and weaknesses of commissioning practice.

- The main criticisms of commissioning are:

    - Inconsistency of practice within and between local authorities;
    - Poor understanding of what commissioning means, with the terms commissioning, procurement, and tendering used interchangeably;
    - A lack of focus on outcomes;
    - An inadequate assessment of needs and of the market available to meet those needs;
    - Poorly managed monitoring and evaluation.

- However, there is some optimism that commissioning practice has improved since the Commissioning Support Programme started in 2008.

- What is largely absent from the literature is the perspective of commissioners themselves and any authoritative evidence of what commissioners do and the extent to which they comply with the available models of good practice.

How important a factor is 'evidence' in the commissioning process?

- Although there is a range of advice and encouragement to commissioners to use evidence, the lack of research describing how commissioning is carried out means that we cannot be confident in saying whether or how they do so.

- The terms 'evidence' and 'evidence-based' have been the subject of debate. Some organisations in the sector prefer to use the term 'knowledge' which can encompass organisational, practitioner, user and policy knowledge as well as evidence from research.

- Evidence or knowledge can be relevant to commissioners in order: to understand needs or problems; to know what works; to evidence efficiency and effectiveness in achieving outcomes. Different kinds of knowledge may be relevant for each of these purposes.

- Making use of evidence to understand need involves collecting and analysing data. This requires effective information systems, timely analysis and protocols for sharing data between partner agencies based on agreed criteria. Information is required on local needs and for specific local population groups as well as national data.

- The Joint Strategic Needs Assessments (JSNA) is a key mechanism for identifying need, but there can be difficulties in using it to inform commissioning. This includes a mismatch between the information contained in the JSNA and what is needed by commissioners, practical difficulties in accessing and understanding it and JSNAs being too adult focused.

- The effective use of 'what works' evidence requires the information to be available and for commissioners to be willing and able to use it. Some researchers have identified a gap between the rhetoric of evidence-based policy and what actually happens on the ground. They argue that national policy is not primarily based on evidence and those implementing policy at a local level may choose to be informed by sources other than evidence.

- There remain some major gaps in the evidence base, particularly with regard to evidence on cost-effectiveness in children's services.

- Several commentators advocate the need for a greater emphasis on collecting information on outcomes rather than outputs. However, the accumulation of evaluative evidence is impeded by a lack of funding for evaluation, insufficiently clear expectations on the part of commissioners, and a lack of time, capacity and expertise on the part of service providers.

What are the most important barriers to, and facilitators of, evidence-based decision making?

Some of the barriers to evidence-based decision-making in children's services are on what is traditionally thought of as the 'supply' side e.g. researchers failing address the questions commissioners want answered and then not presenting evidence in ways that are accessible and useable. However, academic research is only one kind of knowledge and much of the other evidence that is relevant to commissioning is more likely to be generated by local

authorities themselves (e.g. assessments of need) and providers of services (e.g. service user feedback and outcomes monitoring).

Research on knowledge transfer in health and social care suggests that the key barriers to evidence-based commissioning are likely to be:

- Lack of demand or support for evidence-based commissioning from government, elected members or senior managers;
- Procurement rather than outcomes focussed commissioning;
- Competing organisational demands/insufficient resource;
- Decision makers not valuing research evidence;
- Commissioners with low research literacy/analytical skills;
- Relevant data not collected/not analysed to inform needs assessment;
- Research evidence on 'what works' not accessible/not well summarised;
- Reliable/comparable data from commissioned services not available for evaluation.

Evidence-based decision making appears likely to be facilitated by:

- Leaders who value evidence;
- An organisational learning culture and outcomes focus;
- Data being analysed to provide 'intelligence';
- High quality, easy to access research summaries;
- Interaction between researchers and decision makers to increase relevance and timeliness;
- Commissioners having good critical appraisal skills – and time to use them;
- Use of evidence embedded in the planning, delivery, evaluation cycle.

1. Background and purpose

Over the past twenty years there has been an increased recognition of the importance of evidence in planning and delivering social care services. A range of initiatives have reflected this growing emphasis on 'what works' and evidence-based practice, for example, the foundation of the Social Care Institute for Excellence, and, specifically for children's services, the Centre for Excellence and Outcomes. It is now widely recognised that the use of evidence is crucial in ensuring the most effective – and cost-effective – interventions are provided. This is exemplified in the emphasis given to the need for evidence-based early intervention in the Allen review[1].

Evidence-based local decision making requires an effective supply of high quality evidence, but it also requires there to be demand for this evidence from those who are making decisions at a local level. If institutions and organisations don't support evidence-based decision making, or the incentives facing commissioners do not take it into account, then

[1] Allen, G (2011) Early Intervention: Next Steps, An independent report to H.M. Government

they will have little reason to use or develop the evidence base, affecting their ability to improve outcomes. This review therefore aims to identify the most important barriers to evidence-based local decision making, what can be done to address these and help commissioners to deliver better outcomes.

1.2. Key questions for the review

The primary questions set for this review were:

- How is the commissioning process for children's services conducted, in the context of new relationships between central and local government and the public?
- What approaches do local areas take to evidence-based decision-making and how important a factor is 'evidence' is in the commissioning process?
- What are the most important barriers to evidence-based decision-making?
- What could be done to address these barriers?

1.3. Available evidence and its limitations

This review is based on searches of:

- Websites of relevant government departments, research, policy and practice organisations specialising in children's services and knowledge transfer and sector specialist organisations;
- Key bibliographic databases using the following search terms: commissioning + evidence; commissioning + children; commissioning + evidence + barriers; commissioning + evidence + incentives; children's services + evidence + decision-making; children's services + what works; children's services + research use/utilization; children's services + effectiveness + knowledge; children's services + commissioning + data.

Our searches have identified little research that describes how commissioners of children's services go about their task. This may be because the specific commissioning role in children's services is a relatively new development (compared to health services, for example) and the focus has been on supporting that development rather than researching how it is done. We are therefore reliant on a range of other (mostly non-research) sources for some insights.

The Department is interested in the different levels of commissioning within local authorities. For example, there is whole service commissioning/re-commissioning, with the aim of achieving the best outcomes for the most optimal cost, which may involve different considerations to the commissioning carried out by an individual service head. However, there is little in the literature to help us differentiate the issues between these levels of decision-making.

There are therefore considerable limitations to this review. Most of the evidence on which it draws relates to the broad health and social care field and what is known about the use of

evidence in decision-making generally. There is a small body of research on the use of evidence in children's services but very little which is specific to commissioning. Most of the information on how commissioners carry out their task is not research-based and is likely to date quickly, given the recent changes in the context in which commissioners are operating.

However, there are a number of studies on knowledge transfer in the health and social care field in general, including findings on the barriers and facilitators to evidence-based practice/policy, but again little that focuses specifically on the practice of commissioning. However, some of the research that relates to the use of evidence in decision-making is relevant to this review and we draw upon it here.

1.4. Structure of this review

The review is structured around the key research questions as follows:

Section 2: How is the commissioning process for children's services conducted?
In this section we explore what the literature suggests are the general principles of good practice in commissioning and whether commissioning in children's services reflects these principles.

Section 3: What approaches do local areas take to evidence-based decision-making and how important a factor is 'evidence' is in the commissioning process?
In this section we consider what is meant by 'evidence', the kids of evidence of relevance to commissioning, including: evidence to understand needs and problems; evidence of 'what works'; and evaluative evidence.

Section 4: What are the most important barriers to, and facilitators of, evidence-based decision-making?
Here we outline some of the environmental, organisational and individual barriers to evidence-based decision making and ask what facilitates the use of evidence.

2. How is the commissioning process for children's services conducted?

2.1. What are the principles of good practice in commissioning?

One of the sources of information specifically on children's commissioning is the Commissioning Support Programme (CSP), which operated from November 2008 to March 2011, with the goal of supporting local authorities and their partner organisations in achieving better outcomes for children and young people though improved commissioning. The Programme was jointly sponsored by the Department for Education and the Department of Health to support the commissioning of all services for children and young people, including schools and child health services.

CSP defined commissioning as:

The process for deciding how to use the total resource available for families in order to improve outcomes in the most efficient, effective, equitable and sustainable way.[2]

CSP also point out that:

Commissioners are not just those with 'commissioning' in their job title, but include all those who work within the children's services system and actively contribute to the commissioning process. They might be in a strategic role, helping to develop a local commissioning framework, in a procurement role as a local resource holder, such as a cluster manager for a group of schools, or in a role shaping the strategy for the children's workforce.

The three strategic aims established at the outset of CSP were that it should help to: create an engaged and sustainable community of commissioning practice; enable children's trusts to transform commissioning; and build understanding, capability and capacity across the system. The work of CSP is therefore a source of information on what is considered to be good practice in commissioning.

CSP advocated a thorough understanding of need, the early engagement of end-users and those delivering services, and a four-step commissioning approach: understand; plan; do; review. They produced a range of materials and examples to support commissioners in implementing each of these steps.

The principles advocated by CSP to some extent echo those promoted by World Class Commissioning in the NHS. However, with regard to the use of evidence it is interesting to note that whilst world class commissioning made evidence integral to their definition of commissioning, CSP's definition is not so explicit. The definition of World Class Commissioning is given as *'the act of committing finite resources to evidence-based interventions with the aim of improving health, reducing inequalities and enhancing patient experience*.'[3] Within the published guidance from CSP there is little specific emphasis on the need to make use of robust *research* evidence but more encouragement to make use of wider sources of information e.g. from service users and providers.

In addition to the Commissioning Support Programme, a variety of advice and guidance for commissioners comes from other sources. Much of this focuses on improving the commissioning of services from the voluntary sector. Acevo and Futurebuilders (2007)[4] conducted a research project on the leadership challenges presented by the evolving commissioning climate, which culminated in the production of an outline person specification for 'strategic commissioners' as well as a leadership framework for CEOs of third sector organisations. The Audit Commission (2007)[5] developed recommendations for what they termed 'intelligent' commissioning practice. This involves: consideration of the kind of services that commissioners want to procure for a range of service users; the types of organisations that are likely to be able to deliver at an affordable price; and how best to construct a commissioning process that will ensure that a variety of delivery organisations have the opportunity and incentive to deliver services, where they are well placed to do so, and that they receive funding in the most appropriate form. The Audit Commission also recommended that commissioners should improve how they measure value for money in

[2] Commissioning support programme (2010) Good Commissioning: Principles and Practice
[3] Sobanja, M (2009) What is World Class Commissioning?, Hayward Medical Communications, p 1
[4] ACEVO (2007) The Future of Commissioning: Leadership Challenges
[5] The Audit Commission (2007) Hearts and minds: commissioning from the voluntary sector

public services by shifting the current focus on inputs, outputs, and unit costs, towards long-term measurement of outcomes and effectiveness. This view was echoed by Action for Children and the New Economics Foundation[6] whose 2009 report advocated commissioning for outcomes in children's services, to include greater involvement of service users in defining needs and determining the outcomes to be measured.

2.2. Does commissioning reflect these principles?

From currently available evidence, it is difficult to ascertain the extent to which commissioners comply with the guidance on offer. A qualitative study by Tanner (2007)[7] focusing on commissioning practice in six London boroughs, found variable practice. Tanner noted that the key principles of effective commissioning as set out by the Office of the Third Sector were: the requirement to understand the needs and preferences of present and future users; the need to map existing provision and identify service gaps; taking a strategic approach to identifying service needs; maintaining an ongoing dialogue between commissioners and potential providers; using an evidence base to evaluate service performance. Tanner concluded that the evidence collected by his study showed that work to these principles is extremely rare amongst existing commissioning practice. He also found that the terms commissioning, procurement, and tendering were often used interchangeably to describe the purchase of services by public bodies from third party providers leading to confusion and poor understanding of the practice of commissioning. Other key findings from Tanner's study were:

- A high degree of variability in approaches to commissioning across the surveyed local authorities and Primary Care Trusts (PCTs), with no one model of activity seeming to exist;
- Internal support in local authorities and PCTs for commissioning commonly under resourced irrespective of the level and volume of commissioning activity being conducted;
- Gaps in commissioning skills amongst local authority and PCT officers, with skills amongst voluntary and community sector (VCS) staff in need of particular development;
- Key elements of commissioning practice – needs analysis and service specification development –conducted in piecemeal and uncoordinated ways between and within local authorities.

In summary, Tanner concluded that commissioning practice at the time of his study was a long way from the approach outlined in the action plan for third sector involvement in the delivery of public services, although Tanner did report some examples of emerging good practice.

[6] Aked, J and Steed, S. (2009) *A guide to commissioning children's services for better outcomes,* London: Action for Children/NEF

[7] Tanner, S (2007) Common Themes on Commissioning the VCS in Selected Local Authorities in Greater London; London Councils

Other information about the conduct of commissioning comes from those whose services are commissioned, again voluntary sector providers in particular. There have been a few reports in recent years highlighting both good and bad commissioning practices from the point of view of those being commissioned. In 2008 Shared Intelligence[8] carried out an evaluation of the National Programme for Third Sector Commissioning and found that:

- Not all commissioners were aware of the principles of good commissioning.
- Most commissioners recognised that engaging with TSOs could help them gain an understanding of users' and communities' needs but only 21% said they always consulted TSOs at an early stage in the commissioning process.
- Outputs rather than outcomes were still widely used by commissioners.
- Some commissioners lacked understanding of the full costs involved in service delivery with TSOs feeling that commissioners did not always recognise the added value that the sector could bring, tending to judge bids primarily on cost.
- It was noted that commissioners often lacked skills in commissioning more broadly, not just in relation to involvement of the third sector. The ability to be strategic - to use evidence to commission services that met identified needs, rather than simply put existing services out to tender - was questioned by the TSOs

Shared Intelligence (2008) also published a separate report exploring Black and Minority Ethnic (BME) TSOs' current experiences of commissioning and whether any additional barriers existed around their involvement in commissioning[9]. The BME TSOs reported that:

- Commissioners often showed a limited understanding of the diverse needs of their local communities –the BME third sector, was often regarded as one homogeneous group and the range of BME communities and their differing needs was not taken into account;
- There was a lack of diversity among commissioners and senior managers and a perception that some commissioners held prejudiced and stereotypical views of BME organisations in general;
- There was a perception that larger TSOs who had a more established presence in the area were favoured by commissioners. These were not always representative of the sector or of the diversity of local communities;

Similar issues emerged from research conducted for Children England by McNeish (2010)[10]. This qualitative study explored the impact of children's services commissioning on a sample of thirteen voluntary sector organisations over a two year period. A common concern among the voluntary organisations involved in the study was the inconsistency of commissioning practice, leading to waste rather than cost-efficiency. Negative practices included: restricting the length of contracts; 'rationalizing' services by packaging them into single contracts (thereby disadvantaging smaller, specialist organisations); introducing penalty clauses in contracts resulting in voluntary organisations facing major financial risk.

[8] Shared Intelligence (2008) Evaluation of the National Programme for Third Sector Commissioning: Baseline Report; I&DeA/Cabinet Office

[9] Shared Intelligence (2008) Evaluation of the National Programme for Third Sector Commissioning: Consultation with BME Third Sector Organisations; I&DeA/Cabinet Office

[10] McNeish, D (2010) Commissioning: A Better Way?, Children England

Interviewees described the 'hidden costs' associated with fulfilling demands for monitoring information which were sometimes disproportionate or inappropriate to the service being delivered. Some voluntary organisations felt that commissioning had put more power into local authority hands and reduced opportunities for involvement in planning, or for developing innovative services. In many cases, it was felt that relationships had become more distant and formal. Concerns were also expressed about the lack of understanding among commissioners about the nature of the services they were commissioning and the particular contribution of voluntary sector providers. In particular, interviewees expressed frustration at local authorities' interpretation of 'full cost recovery'.

A study by Lewis et al (2011)[11] looked specifically at the development of Children's Centres Again, Lewis et al found that although local authorities usually commissioned many core services across all or part of the authority, this did not always result in consistency. For example, one of the authorities commissioned its outreach service from two voluntary sector providers, yet there was no single model in either staff qualifications or ways of working. Monitoring at the local level did not provide a check on goals, consistency or quality. A majority of interviewees found the process of monitoring their services onerous and baseline data that the health and local authorities were supposed to provide were often unavailable.

So far, this largely conveys a rather negative picture of commissioning practice. However, as Tanner points out, the development of good practice takes time and commissioning has changed and developed over recent years. Hence, reports describing practice in 2007 and 2008 are likely to be already out of date.

A survey of children's service providers conducted in 2009[12] reported some improvements in commissioning practices. Respondents to the survey were more likely to agree than disagree that monitoring arrangements had improved and that the degree of provider involvement in needs assessment, planning and service design had increased, although they were less positive in relation to the clarity of tendering documents and the support offered by the commissioner or awarding body.

A more upbeat analysis is also provided by the Commissioning Support Programme in their final report produced at the end of their funding in March 2011.[13] Their assessment of progress made since 2008 was broadly positive. The report commented that:

- Local authority areas that were most behind in 2008 were effectively commissioning by 2011, and greater consistency of practice had been achieved across the country since CSP support had been in place;
- Leadership around the commissioning agenda had improved, with senior officers taking more interest in leading the commissioning agenda and commissioning less

[11] Lewis, J., Cuthbert, R., and Sarre, S (2011) What are Children's Centres? The Development of CC Services, 2004–2008; Social Policy & Administration Vol. 45, No. 1, pp. 35–53

[12] Phillips, R., Mackey, T., and Romanou, E. (2010) Commissioning – a survey of the views and experiences of providers of services to children, young people and families 2009, DCFS Research Report RR199, London: DCFS

[13] The Commissioning Support Programme (2012) The Commissioning of Children's Services in England: Learning from the sector, providing for the sector

likely to be viewed in isolation from wider developments in local government, health, police, the voluntary and community sector and other sectors;
- There had been a gradual move to more outcomes-focussed commissioning rather than functional service delivery in silos.
- Many local areas have developed joint commissioning teams, resulting in an increase in pooled budget arrangements, pooling of commissioning expertise and a focus on a shared agenda and priorities.
- Children's commissioning strategies were more commonly incorporated into a range of other existing strategies such as health, corporate or adult services.

However, CSP also reported some significant remaining challenges:

- Despite improvement, there remained variability across the whole system, with significant variations in capability of commissioning staff.
- The financial climate has had significant and often negative impact on commissioning. In some areas, commissioning was being used to make efficiency savings while still focussing on outcomes but in other areas, services were retreating to old silo ways of working, procurement decisions are overtaking commissioning decisions.
- The national turnover in senior commissioning posts (25 per cent) and DCSs (31 per cent in 18 months) was leading to a loss of expertise and reduced capacity and institutional memory.
- Relationships with PCTs, which had improved over the previous two years, were by 2011 starting to deteriorate due to reorganisation and job cuts. There were outstanding questions about GP commissioning, particularly around how this would be implemented through partnership working and multiple consortia.
- There was developing experience and understanding about market development relating to children's service provision but in some areas a sense of 'us' and 'them' was still prominent.

3. What approaches do local areas take to evidence-based decision-making and how important a factor is 'evidence' is in the commissioning process?

Because of the lack of research describing how commissioners commission children's services, we cannot be confident in saying how they use evidence. However, the range of guidance and support materials aimed at improving commissioning (e.g. CSP's commissioner's kitbag) does include plenty of encouragement to commissioners to use evidence.

There is also a larger body of research about the use of evidence (particularly research evidence) in decision-making generally in both children's services and beyond. It is reasonable to suppose that the main themes emerging from this literature can be generalised to commissioners.

3.1. What do we mean by evidence?

The terms 'evidence' and 'evidence-based' or 'evidence-informed' have been the subject of considerable debate. Organisations established to support and encourage the use of evidence, such as the Social Care Institute for Excellence (SCIE) and the Centre for Excellence and Outcomes (C4EO) tend to use the term 'knowledge' to denote a wider range of evidence sources than just research. In 2003, SCIE published a typology which identified five sources of knowledge relevant to social care:[14]

- Organisational knowledge
- Practitioner knowledge
- User knowledge
- Research knowledge
- Policy community knowledge

The authors argue that all these sources have a vital role to play as part of the social care evidence base, and that there is no hierarchy of knowledge. However, users of knowledge need to understand the **purpose** to which it can be put (some types of knowledge are more relevant to some purposes than others) and be aware of the **quality and reliability** of the knowledge. They suggest that all knowledge needs to comply with the TAPUPAS standards:

Transparency – is it open to scrutiny?
Accuracy – is it well grounded?
Purposivity – is it fit for purpose?
Utility – is it fit for use?
Propriety – is it legal and ethical?
Accessibility – is it intelligible?
Specificity – does it meet source-specific standards?

3.2. What sort of evidence might be relevant to the process of commissioning?

There is evidence relevant to each stage of the commissioning process: when seeking to:

- Understand what is needed;
- Planning what might be commissioned to meet those needs;
- Ensuring that the services are well delivered;
- Reviewing how effective they have been in improving outcomes.

Evidence to understand needs and problems

This evidence can be made up of a variety of information including: demographic/area profile data to help understand the needs of the local population e.g. neighbourhood statistics, indices of deprivation; information from the public on local priorities e.g. from public consultations; profile data on particular groups or localities e.g. data on the number

[14] Pawson, R, Boaz, A, Grayson,L, Long, A and Barnes, C (2003) Types and quality of knowledge in social care, SCIE Knowledge Review 3

of disabled children or the profile of the local looked after population; user knowledge from specific groups on how they perceive their needs or view services e.g. local and national research on the experiences of families with disabled children; research on the causes and correlates of problems e.g. research on the causes of child obesity.

Making use of evidence to understand need involves both collecting and analysing data. This requires:

- Effective information systems to collect and manage data;[15]
- An ability to analyse the data in a timely fashion to inform decision-making, understand demographic changes and develop scenarios.[16] CSP found that although a lot of data is collected by local authorities and PCTs it is not necessarily turned into intelligence, and that most places are better at obtaining data than analysing it;[17]
- Databases flexible enough to allow further drilling down to operational levels e.g. geographical areas, services, groups of children and young people.[18] CSP identified the need for more detailed specific needs analysis often at a smaller, local level.
- Protocols for partner agencies to share data and develop cross-departmental working including agreements on what is needed for baseline data and performance indicators e.g. how family and household patterns are changing, and performance data at school and area-based level.[19]

Ofsted (2011) reviewed the commissioning of youth services in 12 local authority areas.[20] It found that the more forward-looking local authorities recognised the centrality of needs assessment to commissioning and strategic planning and:

- Drew on knowledge/intelligence held by the voluntary and community sector;
- Took a 'whole area' perspective;
- Planned in relation to agencies such as teenage pregnancy, youth offending, mental health;
- Gave commissioners access to the local authority's procurement, tendering, commissioning, legal, financial and employment expertise;
- Linked planning to the broader areas of housing, social regeneration and health;
- Engaged young people in service design and delivery;
- Had jointly agreed and locally created performance measures.

A 2010 review of the commissioning process by the Institute of Public Care showed that inadequate systems for identifying needs can skew how services are set up and fail to

[15] PA Consulting Group (2007) Effective practice in commissioning in children's services: Final report, London: PA

[16] Dickinson, S. Clarke C, Sim, S, Swift J, Prabhakar, M, Pietikainen, A and Ivans, C (2010) Local Authority commissioning pathfinders study, DCFS Research brief RB231, London: DCFS

[17] Commissioning Support Programme (2011) ibid

[18] PA Consulting (2007) ibid

[19] Dickinson S. et al (2010) ibid

[20] Ofsted (2011) An evaluation of approaches to commissioning young people's services, Manchester: Ofsted

deliver services in the most efficient or effective manner[21]. This is self-evident where local needs are under-estimated and an insufficient level of provision is commissioned. But IPC also highlighted the risk of over-estimating need and cited examples of public money being wasted by lowering the threshold of service entry to ensure take-up. For example, work for one council specified that 100 families should be dealt with each year. At the bidding stage the provider had worked out that 100 families meeting the criteria did not actually exist in the borough, and furthermore that the contract would have been undeliverable in terms of costs if they had existed.

One of the key ways in which local authorities and partner agencies understand needs is through Joint Strategic Needs Assessments (JSNAs). CSP (2011)[22] suggested that JSNA's were not as effective as they could be at improving commissioning and that they are still very adult focused. How JSNAs are developed and used is evolving with, for example, the development of Health and Wellbeing Boards. However, in 2010, the North West Joint Improvement Partnership examined whether the relationship between strategic commissioning and JSNAs was occurring in practice.[23] It identified the following themes:

- There was sometimes a mismatch between what information was available within JSNAs and the likely requirements of commissioners;
- Commissioners were not involved in the design of the JSNAs;
- Children's services were less experienced in commissioning and the requirements of the Children's Plan[24] sometimes gave rise to a conflict with those of the JSNA;
- Some of the data was taken from national core data sets and there was limited local data and analysis on the distinctive health and social care issues faced locally;
- There were practical difficulties for commissioners in using JSNA's e.g. some required registration and passwords to access, some contained highly technical data and the recommendations for commissioners were not always clear.

The report made the following recommendations:

- The information base for JSNAs needs to be broadened to include social care data, case clinical data, the perceptions and views of local people and a greater sense of the health and social care market including the views of service providers, including those from the Third sector.
- Commissioners should be actively involved in the design of the JSNAs and the capabilities of commissioners to define what they needed to make informed decisions needed to be improved.
- Differences between public health analysts and social care commissioners in terms of background and training and understanding of the role and function of the JSNA

[21] Institute of Public Care (2010a), *North West Joint Improvement Partnership: Commissioning and Joint Strategic Needs Assessment. Report*, IPC: Oxford; Institute of Public Care (2010b), *North West Joint Improvement Partnership: Commissioner Development – Towards informing a strategy*, Oxford: IPC

[22] CSP (2011) ibid

[23] IPC (2010) ibid

[24] Regulations to the Children Act 2004 required Children's Trust Boards to publish a Children and Young Peoples' Plan for their area.

are not easy to reconcile. The capabilities of both commissioners and people working in public health need to be enhanced.

- For people working in Public Health there needs to be more: working jointly and across boundaries including children's and social care services; appreciation of quantitative and qualitative data from multi-disciplinary stakeholders and strategic commissioning awareness.
- Commissioners also need to work jointly and across boundaries; understanding whole and target populations approaches and harness the right intelligence to make evidenced based decisions and develop the market to procure the best service for users.

One approach used to augment JSNAs is the use of 'deep-dive' analysis on particular needs to include the perspectives of all those involved. [25]

Evidence of what might be effective in meeting those needs

Planning what might be usefully commissioned to meet identified needs can be informed by knowledge of what is likely to work. This might come from syntheses of national and international research on 'what works' in meeting the needs of particular groups. It might also include locally generated knowledge on what has been tried and found to be effective/ineffective. Knowledge of the market is also relevant at this stage e.g. information about the range of providers available to deliver services, what they can offer and their strengths and weaknesses.

Nesta (2011)[26] reported on the establishment of pilot projects for Project Oracle, established by the Greater London Authority to establish a standard for evidence-informed decision making on children and young person's policy in London. It recognised the lack of proactive funding for research and evaluation together with poorly designed research as real issues facing the project. As part of this process, Nesta set out *Ten Steps for Transformation* (2010)[27] which formed the basis for discussion at the inauguration of the UK Alliance for Useful Evidence in October 2011. The first of these is '*stop doing what doesn't work'* and argues for a shift away from funding ineffective interventions towards funding things which will make a difference. However, meeting this challenge requires commissioners to have access to the evidence for what works and to be willing and able to use it. There are difficulties with both of these.

Huxley et al (2010)[28] suggest that evidence made available to UK commissioners in guidance is less comprehensive than in the U.S. They examined the evidence base of published generic social care commissioning guides, published between 2003 and 2008 and concluded

[25] One example comes from Telford and Wrekin which used an Outcomes Based Accountability approach to include the perspectives of parents, children and young people in relation to speech and language needs. Chana, P (2009) Senior leadership team report, 11/9/09 www.telford.gov.uk

[26] NESTA (2011a), *Evidence for social policy and practice: Perspectives on how research and evidence can influence decision making in public services*, London: Nesta

[27] NESTA (2011b), *Ten steps to transform the use of evidence*, London: Nesta http://www.nesta.org.uk/blogs/ten_steps_to_transformation

[28] Huxley, P, Maegusuku-Hewitt, T, Evans S, Cornes, M, Manthorpe, J and Stevens Ml (2010), Better evidence for better commissioning: a study of the evidence base of generic social care commissioning guides in the UK, *Evidence & Policy*, 6(3), 291-308

that although the guides were generally clear and well-written, in contrast to the research evidence underpinning the United Way (2008) work in the US, the evidence-base relied heavily on government documents and guidance rather than research evidence. The authors conclude that:

Very little of the evidence underlying the reviewed commissioning guides fits into the category of systematically gathered evidence. The hierarchy of knowledge use in business/management and in social care commissioning, as evidenced here, is that organisational and policy knowledge are privileged, user knowledge is present and growing in influence, but practitioner and research knowledge is barely used.[29]

Of course, relying heavily on policy knowledge may not matter if the government guidance itself draws on the best available evidence. However, even when programmes have been nationally driven by central government, with a strong emphasis on the use of evidence, Coote et al[30] suggest that there can be a gap between the rhetoric of evidence-based policy and what happens on the ground, which is a great deal more complicated. Their interviews with those in central government responsible for establishing programmes (such as Health Action Zones) suggest that they have been designed, by and large, on the basis of informed guesswork and expert hunches, enriched by some evidence and driven by political and other imperatives. Coote et al point out that this is not surprising and does not, necessarily, lead to less effective interventions. They argue that the research that forms the evidence base tends to be the result of haphazard and unrelated decisions by funders and researchers, so acting only on what has been shown to work could greatly reduce the scope for activity, and inhibit creativity and risk-taking.

A Canadian study of evidence-based decision-making in children's services (Jack et al)[31] similarly commented that national policy was not primarily informed by research evidence but by the values of the political party in power, accountability and liability issues, perceptions of best practice and the availability of financial resources. The decision-making environment was described as being "reactive" or "crisis driven" which militated against evidence-based decision-making. In addition research evidence was not well disseminated.

Coote et al[32] found that at local level, where practitioners are under pressure to deliver tangible results, there are few opportunities to have their own experience recognised or to contribute to the evidence base themselves. They point out that there can be a tension between the desire for evidence-based policy and practice, and the wish for local empowerment. When local people gain control of local decision-making, they may choose to be guided by 'common sense' and experience rather than the formal 'evidence base'.

[29] Huxley et al (2010) op cit p.304-5
[30] Coote, A, Allen J and Woodhead, D (2004) *Finding Out What Works* King's Fund
[31] Jack, S. Dobbins M, Tonmyr, L, Dudding P, Brooks S and Kennedy B (2010) Research evidence utilization in policy development by child welfare administrators, *Child Welfare*, 89(4), 83-100
[32] Coote et al (2004) ibid

An example of this is provided by Lewis et al (2011)[33] who found staff querying the validity of evidence-based programmes in Children's Centres. Workers delivering programmes varied in role from place to place, and tended to adapt programmes according to their own judgment. If 'evidence-based' interventions are delivered in different ways by each facilitator, then they are no longer 'evidence-based'.

Commissioners can have an important role to play in promoting evidence-based interventions by including them in specifications. However, to do so they need to know what is cost-effective and in children's services this information can be difficult to find. Stevens et al (2010)[34] reviewed the evidence on the cost-effectiveness of interventions in children's services. They found that:

- Good quality economic evaluations in social care are still relatively few and can be difficult to locate. The data that do exist, in social care, public health and child mental health, is variable in quality, often context specific or narrow in perspective.
- The cost-effectiveness of an intervention will be dependent on factors such as the extent of the problem in a particular locality, the services (if any) already dealing with the problem and the skills and resources available.
- The evidence is difficult to find (many irrelevant citations have to be screened out in order to identify the real evaluations) and where present (e.g. in home visiting), it is difficult to interpret.
- The lack of economic evidence reflects in part the complexity that is apparent in children's services. Interventions are multifaceted, involve multiple agencies and have multiple objectives or desired outcomes. This makes evaluation of their effectiveness difficult, and as a consequence there is not a great deal of effectiveness evidence available upon which to base an economic evaluation.
- Where economic evaluations have been attempted, they have often resorted to very different and sometimes very imaginative means of incorporating whatever outcome data are available.

They conclude that in the area of children's services, advances in the methodology, including in assessment of effectiveness, comparability and ease of interpretation of economic evaluations are going to be needed if greater use of economic evidence by those planning services can be expected.

Evidence to demonstrate that services are being delivered to an acceptable level of quality, and evaluative evidence to show whether the commissioned services are making a difference to outcomes

Monitoring data and feedback from service users and providers can provide evidence on the acceptability of the service, its take up and the efficiency of its delivery. Where the prior evidence base is good, monitoring data may be sufficient to check fidelity of interventions.

[33] Lewis, J, Cuthbert, R and Sarre S. (2011) "What are Children's Centres? The Development of CC Services, 2004-2008, *Social policy & administration*, 45 (1), 35-53

[34] Stevens, M. Roberts H and Shiell, A (2010), Research review: economic evidence for interventions in children's social care: revisiting the What Works for Children project, *Child & family social work*, 15(2), 145-154

To assess outcomes of services where the evidence base is less certain, evaluative research may be needed to assess the extent to which the needs that services were commissioned to meet are actually being met. As we have noted in section 2, there are criticisms from those providing services that commissioners put too much emphasis on monitoring requirements (sometimes in a contradictory and onerous fashion) but not enough on collecting evidence of outcomes.

The Audit Commission (2007)[35] concluded that local public bodies seeking a better understanding of value for money need to collect evidence on outputs and outcomes as well as inputs. Where commissioners want to measure added value or innovation, for example, they need to understand how the data they collect will help them to do so. Likewise, the data they collect should enable them to assess the value they secure from having a diverse supply base, which includes voluntary sector providers.

Research by New Economics Foundation (NEF) for Action for Children[36] found that there was still a focus on outputs rather than outcomes in tender documents. This focus was encouraged by national measurement frameworks, such as National Indicator Sets, which the authors pointed out contained more output indicators than outcome indicators. The report argued that providers are still not required (or resourced) to collect sufficient outcomes data to track long-term change and that commissioners need to develop frameworks for measuring performance against outcomes, a significant cultural shift from measuring providers against output targets.

Their report builds on a wider one by the New Economics Foundation (NEF)[37] arguing for the introduction of a 'children and young people's well-being assessment duty' to improve the effective targeting of resources and commissioning. NEF recommended that: commissioners use outcome indicators, and develop intermediate indicators or indicators that measure "the distance travelled" towards an outcome such as the 'Outcomes Star'; calculate the social return on investment; and provide adequate funding for measurement.

Research by Ilic and Puttick (2012)[38] suggests that there are some difficulties for providers in fulfilling these recommendations. They report a survey of mainly youth sector providers conducted by the GLA on organizations' ability to evaluate. Lack of time (72%), funding (54%) and expertise (49%) were identified as the primary constraints for having good evaluation. This was coupled with inconsistent expectations from funders: groups were unlikely to become good generators of evidence without greater clarity and consistency from funding and commissioning organizations. Service providers continue to face different expectations from funders and commissioners and they note that demand for evidence is not always institutionalised in decision-making. Funding and support in kind were identified as effective mechanisms to prompt a shift in behavior.

[35] Audit Commission (2007) ibid
[36] Aked and Steed (2009) ibid
[37] Aked, J, Steuer, N, Lawler, E. (2009) Backing the future: why investing in children is good for us all, London: Action for Children/NEF
[38] Ilic, M. and Puttick, R. (2012) The development of Project Oracle: Generating and using evidence in the real world, London: NESTA

Ofsted (2011)[39] reviewed the commissioning of youth services in 12 local authority areas and found that in many areas commissioning was seen narrowly as a procurement exercise. Planning for youth support was often shaped largely by existing organisational and delivery structures in these areas rather than by determining the desired outcomes and critically evaluating the kind of provision that was needed. The final report of the CSP (2011) commented that there is still some way to go before elected members grasped the role of commissioning, as opposed to procurement, in driving outcomes and efficiency.

4. What are the most important barriers to and facilitators of evidence-based decision-making?

4.1. Barriers

Barriers to using evidence in the commissioning of children's services can be identified from a small number of specific studies and from the larger body of research on evidence-based decision making in related fields.

One study of how senior child welfare administrators in Canada use research evidence in their decision making (Jack et al, 2010)[40] identified barriers to an evidence-based practice approach operating at three levels: ***environmental*** barriers (which may include factors ranging from the availability of relevant evidence to the political climate) ***organizational*** barriers (which may include what data is collected and how it is analysed, the value attached to evidence in the organisational culture, competing priorities and the resources available) and ***individual*** barriers (including the capacity, experience and training of commissioners). We have clustered the barriers under these three broad headings, although they do not fall into discrete categories and barriers clearly overlap e.g. some individual barriers are linked to organizational ones and vice versa.

Environmental barriers

Jack et al found that **environmental barriers** to evidence-based decision making in Canadian children's services included the political climate and, as we have already noted, the policies which often drive commissioning priorities may themselves be only partially informed by evidence.

The availability of accessible and relevant research is a further environmental barrier. Allen et al (2007)[41] point out that there are several reasons why research evidence can be difficult to use:

[39] Ofsted (2011) ibid
[40] Jack et al (2010) ibid
[41] Allen, P; Peckham, S; Anderson, S; Goodwin, N. (2007), Commissioning research that is used: the experience of the NHS service delivery and organisation research and development programme, *Evidence and policy*, 3(1), 119-134

- It does not always address questions that decision makers need answered. This may be because the commissioners of research and the researchers themselves do not have a full understanding of the issues currently facing decision makers. Issues which interest researchers may not be of current concern to those who could use the evidence.
- Even if the research does address issues that were or still are important to potential research users, it may not be timely. The time needed for undertaking rigorous empirical studies is often longer than potential users can wait for the answer they need.
- The results of the research may be expressed in such a way that it is difficult for potential users to pick up on the messages relevant for their circumstances. This is partly because researchers often write in a different, more theoretical and generalisible language than that used by people faced with current practical problems. Serious time constraints are also likely to apply to busy managers, making it difficult for them to read lengthy documents reporting research findings.
- For many potential research users, the day-to-day pressures of running a financially viable organisation and responding to other national targets are likely to override any desire to make decisions about how services are run using formal research-based evidence.

The lack of relevant and clear data for local areas and/or for specific services can also be a barrier. This includes the lack of reliable, comparable data from commissioned services themselves. Powell et al's (2003)[42] case study of the commissioning process of drug services for young people identified considerable differences in how services recorded their information on service users, assessments and programmes of activity. Different services worked to different definitions of, for example, young people, vulnerability, harm minimization. The authors concluded that in the absence of shared definitions, and the kind of standardised data collection that would enable commissioners to compare costs and outcomes across services, it was information shared through informal networks that became 'the evidence' upon which decisions about allocation of resources were based.

Coote et al[43] found that practitioners are often faced with a lack of appropriate evidence and, even when it is available, they may lack the capacity, organisational support and resources to make 'evidence-based' decisions. They also point out that in developing new social programmes, other factors may be viewed as more important than evidence, in particular the desire to develop initiatives which are community-led. From their case studies, Coote et al conclude that a rigorous approach to evidence ***can*** be combined with community development and capacity-building but only where specific and relatively straightforward issues are concerned. Where issues are more complex, there is often far less – or no – evidence of 'what works'. And in order to replicate 'what works' in different settings, a considered, systematic approach is important.

[42] Powell, J., Jones, M. and Kimberlee, R. (2003) Commissioning drug services for vulnerable young people, Drugs: education, prevention and policy, 10(3), 251–262

[43] Coote et al (2004) ibid

Organisational barriers

Organisational barriers include limited resources for the collection and assimilation of data. This includes a shortage of analytical capacity and skills within organisations to support decision-makers to comprehend and make use of data. This becomes more challenging in the current financial climate. The CSP final report (2011) suggested that recession was driving some areas back to old silo ways of working. The CSP also found that organizational factors including restructuring and high turnover of senior leaders in local authorities and PCTs resulted in a serious loss of experience and limited the confidence and capacity of staff to deliver improved commissioning. An evaluation of C4EO and the Commissioning Support Programme by PriceWaterhouse Coopers (2011)[44] identified that barriers to take-up of their programmes by some local authorities included a lack of political drive to engage with the programmes, less awareness of them among Directors, lack of staff capacity, and competing priorities such as internal restructuring.

However, some of the literature suggests that organisational culture is an even more fundamental barrier to evidence use. Jack et al (2010)[45] noted the importance of "anecdotal knowledge" or "soft" evidence to Canadian children's service managers. They relied largely on professional expertise and judgment, clinical experience, community expectations, client preferences, best practices shared by other child welfare agencies in their regions, and 'innovative programs' adapted from other provincial or international jurisdictions. A key barrier to the take-up of an evidence-based practice approach was the cultural shift required which was believed to be a slow process. In the UK, Allen et al (2010)[46] reviewed the experiences of the NHS Service Delivery and Organisation Research and Development Programme (the SDO) in transferring knowledge from research into practice. They concluded that knowledge transfer is difficult because decision makers do not necessarily value research evidence as a source of help in making decisions.

A study in the U.S. (Horwitz et al, 2010[47]) focused on the reasons why Child Welfare agencies were not implementing evidence-based parenting interventions. They identified two key factors: the ability of organisations to access research-based information on the appropriateness/effectiveness of parent-training programs; and the ability of organisations to implement programmes and to adopt new practices.

Horowitz et al argue that traditional social work education has not focused on evidence-based practices and that there is little data on strategies to improve adoption, with a few isolated exceptions. They suggest that across human service organizations, it is those with a strong focus on the development of new knowledge and on giving incentives to adopt best practices, e.g. medicine, which have embraced the need for innovation most strongly.

[44] PriceWaterhouse Coopers (2011), Joint evaluation of the Commissioning Support Programme (CSP) and Centre for Excellence and Outcomes (C4EO), London: DfE

[45] Jack et al (2010) ibid

[46] Allen, P et al (2010) ibid

[47] Horwitz, S. M., Chamberlain, P, Landsverk, J and Mullican C (2010), Improving the mental health of children in child welfare through the implementation of evidence-based parenting interventions, Administration and Policy in Mental Health and Mental Health Services Research , 37(1-2), 27-39

However, even in medicine, the adoption of evidence-based practices can be patchy and slow and some studies suggest that in practice physicians do not frequently access evidence from research but rather rely on ''collectively reinforced, internalised, tacit guidelines'' developed by experience, colleagues, patients, opinion leaders and other sources (Gabbay and le May 2004[48]). Horowitz et al argue that since child welfare services have a weaker focus on knowledge development, a strong policy drive accompanied by funding may be critical in getting organisations to adopt new interventions or practices.

Organizations which are more likely to explore evidence-based practices and eventually initiate them tend to have the following features, according to Horowitz et al: they start with good knowledge/skills, they can incorporate new knowledge, are highly specialised and have mechanisms in place to spread knowledge throughout the organization. Child welfare agencies suffer from a number of defects in this area. They often have a work force with varied levels of education and considerable workloads, have multiple responsibilities ranging from investigations to direct delivery of services and have few readily available venues for knowledge sharing.

Other organisational characteristics important for adopting evidence include leadership, clear goal setting and prior success in undertaking practice change (Greenhalgh et al. 2004).[49]

Individual barriers

Organisational factors can also affect the likelihood of individuals making use of evidence. Individuals who do not view the climate of their organization as welcoming innovation and organizations whose cultures do not promote exploration of practices in response to challenges are unlikely to explore the use of evidence-based practices (Simpson 2002).[50]

However, the characteristics of individuals also influence the extent to which organisations will or will not explore or initiate the use of EBPs. Horowitz et al identify three features of individuals which appear to be important: values and goals, social networks and the perception of the need to change. These are linked to an individual's ability to identify a problem and feeling sufficiently empowered to effect change in their day to day work.

Other individual barriers identified include a lack of critical appraisal skills and lack of time to locate, access, review, and appraise research evidence[51]. Huxley et al, (2010) noted that social care staff and professionals do not have the same degree of basic training in research techniques and critical appraisal skills as healthcare professionals[52]. Their ability to appraise

[48] Gabbay, J., and le May, A. (2004). Evidence-based guidelines or collectively constructed ''mindlines?'' Ethnographic study of knowledge management in primary care. *BMJ*, 329(7473), 1013

[49] Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly*, 82(4), 581–629

[50] Simpson, D. D. (2002). A conceptual framework for transferring research to practice. Journal of Substance Abuse Treatment, 22(4), 171–182

[51] Jack et al (2010) ibid

[52] Huxley et al (2010) ibid

evidence may be limited and this may lead to an uncritical acceptance of findings or a lack of confidence in using them at all[53].

Relevant skills may be a particular challenge within children's commissioning. SHM (2009) carried out research with practitioners of children's commissioning in six local authority areas and found commissioners were finding it hard to recruit candidates with the right skill set to fill lead commissioning roles. They also noted a need for a relevant competency framework for commissioners and accredited training to 'plug the skills gap'[54].

An evaluation of the Commissioning Support Programme and C4EO by Pricewaterhouse Coopers[55] commented that commissioners are not required to have knowledge of the Common Core of Skills and Knowledge for the Children's Workforce. Consequently not everyone involved in commissioning is likely to have the same appreciation of the needs of young people and what they may require if their needs are to be met adequately. In an evaluation of approaches to commissioning young people's services, Ofsted (2011)[56] found that officers assigned to manage a portfolio of youth services work were often inexperienced in commissioning and the final report of the CSP commented that there are still significant variations in the capability of commissioning staff and that their analytical skills need to improve.

Other key individuals within organisations are leaders and politicians. These senior decision-makers ultimately shape the nature of commissioning within local authorities. However, as Davies (2005) and others[57] point out, there is a wide range of influences working on decision makers, amongst which formal research evidence plays only a small part. Indeed, decision makers themselves do not necessarily value research evidence as a source of help in making decisions. Davies' study of central government decision-makers found that personal contact with advisers, irrespective of the source of the advice (i.e. whether it was based on research evidence or not) was the most valued type of information on which to base policy decisions. The next most favoured group were so-called 'experts' (decision makers did not think that these experts had to base their advice on research evidence), followed by 'think tanks' and then by those advocating the demands of particular interest groups. Formal research evidence did not even appear on the list.

4.2. What facilitates evidence-based decision making?

[53] Orme, J. and Powell, J. (2008) Building research capacity in social work: process and issues, British Journal of Social Work, 38:5, 988–1008

[54] SHM (2009) Commissioning services for children, young people and families: a study of the dynamics in six local authority areas, DCFS Research Report RR133, London: DCFS

[55] PriceWaterhouse Coopers (2011) ibid

[56] Ofsted (2011) ibid

[57] Davies, P. (2005) 'Survey of senior Whitehall policy makers', Presented by Dr Davies, Deputy Director, Chief Social Researcher's Office, Prime Minister's Strategy Unit, at a workshop on 'Conducting and Commissioning Syntheses for Managers and Policy Makers', December, Montreal, Canada.; Buse, K., Mays, N. and Walt, G. (2005) *Making health policy*, Maidenhead: Open University Press

The study of Canadian commissioners of child welfare services identified organisational and individual facilitators to the use of evidence which echo many UK studies of knowledge transfer/evidence-based practice[58].

Organisational facilitators included:

- Leadership that values EBP and supports a learning culture;
- Identification of an organizational EBP champion;
- Establishment of linkages with universities or partnerships with researchers;
- Involvement in networks that bring together EBP champions; and
- Access to technology i.e. internet and email

Individual facilitators included:

- Exposure to research during higher education;
- Critical appraisal skills;
- Work experience in fields outside of children's services;
- Access to databases of evidence; and
- Being open-minded or having a personal dedication to inquiry/wanting to make a difference in the field.

The PriceWaterhouse Coopers evaluation of C4EO and the Commissioning Support Programme identified similar organisational facilitators in Local authorities in England[59]. Those factors which increased use of support included the LA being outward-facing and open to learning and change, championship by senior management, and a culture of embedding evidence as part of planning, delivery and evaluation.

A broad picture of the use of research evidence by health policy makers is provided by Innvaer et al (2002)[60] who carried out a systematic review of 24 interview studies. The most commonly reported facilitators to the use of research evidence were personal contact (13/24), timely relevance (13/24), and the inclusion of summaries with policy recommendations (11/24). This fits with a number of knowledge transfer studies which have identified deficits in the 'supply side' and advocate a more interactive approach to knowledge production.[61]This would involve closer relationships between researchers and policy makers to improve the relevance, timeliness and user-friendliness. The PriceWaterhouse Coopers evaluation of C4EO and the Commissioning Support Programme confirms the relevance of these factors. It identified that C4EO's closeness to the LA agenda and the quality and value of its research summaries and publications were vital to its effectiveness.

In 2009 Communities and Local Government, in partnership with the Audit Commission and the Local Government Association (LGA), published an external review[62] of how to

[58] Jack S et al (2010) ibid
[59] PriceWaterhouse Coopers (2011) ibid
[60] Innvaer, S., Vist, G., Trommald, M. and Oxman, A. (2002) Health policy-makers' perceptions of their use of evidence: a systematic review, *Journal of Health Services Research and Policy*, 7(4) 239–44
[61] Nutley, S., Walker, I. and Davies, H.T.O. (2003) From knowing to doing: a framework for understanding the evidence-into-practice agenda, *Evaluation*, 9(2) 125-48.
[62] CLG (2009) Supporting local information and research: Understanding demand and improving capacity

strengthen support to the use of local information and research in decision-making. The report concluded that there was considerable scope for helping local information and research teams to provide faster, better and smarter support for their decision-makers – and also for decision-makers to increase their appreciation and use of evidence.

Facilitators of the use of evidence by decision-makers included external pressures from various directions. For example:

• If government expects local partnerships to set stretching outcome targets – this requires strong awareness of local needs and priorities; and understanding what is required in setting realistic targets.
• The emphasis on shared duties across local partners raises the importance of shared understanding of the evidence base and agreement of strategic priorities.
• With funding increasingly following user choices – for example, the move to Individual Budgets in social care - knowledge of user needs in relation to different groups and communities is increasingly important.

The review found that progress in local information and research over the local authorities ten years had been focused on improving the quantity and accessibility of data and on analysis tools, rather than the more subtle matters of understanding the needs and use of information by decision-makers. Two priorities identified in terms of facilitating better local research use were:

- More time to be spent on *analysing* information.

It was recognised that significant improvements have been made in recent years in the supply of datasets, and in the software to analyse these, but insufficient use of them is being made to derive valuable information. This could be achieved by better local co-ordination of research staff, capacity building to increase their analytical skills and improving efficiency e.g. by research and intelligence units anticipating standard enquiries/demands.

- Improved communication between analysis and decision-makers.

Many analysts need to improve their understanding of the needs of users and decision-makers and their presentation, while research and policy staff needed to have close links at all levels.

The final report of the Commissioning Support Programme identified the following facilitators within the commissioning process relevant to this review:

- Training - The roles of strategic commissioners should be professionalised and measures should be taken to further up-skill the existing cadre of senior commissioners.
- There are increased expectations for commissioning in children's services (CSP has raised the bar) and therefore for training and development support.
- There is a recognised need for continuing roll-out of commissioning training/development to embed and enhance skills.

- Reduction in national indicators and requirements guidance may result in less time spent in developing audits and more time focusing on how to apply the most important data sets and findings from them – this could free people to take a more innovative approach.
- It is helpful to link local outcomes to agreed national indicators.
- Needs analysis is often not used well to inform decisions. Local areas need help learning how to use it. Improved structures, such as having groups responsible for linking planning and performance, have helped direct the collection and usefulness of needs assessment.

5. Implications and discussion

Some of the barriers to evidence-based decision-making in children's services are on, what is traditionally thought of as, the 'supply' side e.g. researchers failing to address the questions commissioners want answered and then not presenting evidence in ways that are accessible and useable. Work to improve 'knowledge transfer' has often focused on these challenges by increasing the availability of accessible research summaries, encouraging researchers to place a higher priority on communicating their work to decision-makers, and equipping potential end users with the critical appraisal skills to have a better understanding of research.

However, academic research is only one kind of knowledge and much of the other evidence that is relevant to commissioning is more likely to be generated by local authorities themselves (e.g. assessments of need) and by providers of services (e.g. service user feedback and outcomes monitoring). This implies that a 'supply' and 'demand' model in which 'demand' and evidence is 'supplied' from elsewhere is neither accurate nor useful. Commissioners are clearly playing a role in generating evidence as well as utilising it, but the research currently available on commissioning practice sheds little light on this. For example, commissioners for children services in Gloucestershire are currently working with OPM[63] to develop an evaluation framework for use around targeted services. It is intended to measure:

- The level of progress or 'distance travelled' by children and families who are working within all types of interventions associated with children services;
- The cost of interventions expressed at unit level and aggregated at various levels;
- The financial impact of progress achieved with each child and family and at aggregate levels;
- A subjective assessment to show the views of children, parents and carers alongside the other assessments.

There are likely to be other examples of local areas developing initiatives to make better use of evidence which are not yet reported in the literature.

[63] Based on information received from OPM, July 2012

What the literature suggests is that in respect of the three kinds of evidence needed for effective commissioning (needs assessment; 'what works' and evaluation of outcomes) there are some weaknesses for the commissioning of children's services. If commissioners are to play an effective role in relation to helping generate evidence on at least two of these fronts they may need skills and guidance in relation to effective needs analysis and evaluation design as well as in the critical appraisal of existing research.

So what might support commissioners to make better use of evidence? The specific research to answer this question is very limited. However, some suggestions can be inferred from the general literature as well as recent evaluations of the Commissioning Support Programme and C4EO:

- Providing easy access to evidence and to other tools and resources e.g. on-line materials such as those provided on the LGA Knowledge Hub.
- Providing opportunities for commissioners to share their practice and learn from each other. This can be via on-line communities of practice as well as face to face networks. The evaluations of CSP and C4EO found support for the principle of sector-led support and shared learning.[64]
- Providing more specific resources on particular service areas. There are recent and forthcoming examples of these on topics such as speech and language[65] and the provision of short breaks.[66]
- Maintaining the emphasis on the importance of effectiveness as a key driver of commissioning as well as cost.
- Maintaining government attention on good commissioning. Sustaining improvement is not a short term change and keeping it on the agenda as a priority may be particularly helpful when there's a lot of turbulence and other pressures in the system.

[64] PWC (2011) ibid
[65] OPM (forthcoming)
[66] McDermid, S., and Holmes, L. (forthcoming) *Cost comparisons of short break services for disabled children and their families*: report to Action for Children. Loughborough: Centre for Child and Family Research, Loughborough University.

Acknowledgements

The authors would like to acknowledge the information and advice provided for this review by Hilary Thompson, Chief Executive of OPM and Lisa Holmes, Assistant Director Centre for Child and Family Research Department of Social Sciences, Loughborough University.