

## **SSIA / National Commissioning Board for Wales**

**Two discussion papers on  
domiciliary care  
commissioning and  
procurement**

**August 2016**



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## Two discussion papers on domiciliary care commissioning and procurement

### Introduction

This document contains two discussion papers which have been produced by the Institute of Public Care at Oxford Brookes University (IPC) for the Social Services Improvement Agency for Wales (SSIA) and the National Commissioning Board for Wales.

The first discussion paper explores some of the opportunities and challenges presented by taking an outcomes-based approach to the commissioning of domiciliary care, and is intended to stimulate further discussion about how this vital range of services for people who need care and support in Wales can be further developed and improved. It is based on a short review of literature including previous work in this field by IPC in England, Wales and Scotland. The lead writer of the paper was Professor John Bolton.

The second discussion paper sets out the major options that are available to local authority commissioners for the procurement of services, primarily with regard to domiciliary care services but also considering supported living services for people with learning disabilities. The lead writer of the paper was Michael Mellors.

We are indebted to the SSIA and NCB, and particularly to Steve Vaughan, for initial feedback on the contents of the papers, but both papers comprise views and opinions which are those of IPC not the NCB or SSIA. We have endeavoured to ensure that information and interpretations are correct at time of production and to make the information useful and accessible. Nothing in either discussion paper should be interpreted as constituting formal legal advice.

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**August 2016**

# Discussion paper 1

## Outcomes-based commissioning in domiciliary care

### 1 Introduction

This paper explores some of the opportunities and challenges presented by taking an outcomes-based approach to the commissioning of domiciliary care, and is intended to stimulate further discussion about how this vital range of services for people who need care and support in Wales can be further developed and improved. It is based on a short review of literature including previous work in this field by IPC in England, Wales and Scotland.

### 2 Context

The Social Services and Well-being (Wales) Act came into force in April 2016. The legislation has a strong focus on the well-being of the people who are helped or supported through adult social care. The act also has a focus on prevention and early intervention to help people to live more independent lives where that is feasible. Local authorities and their commissioning partners, including in particular NHS local health boards will need to ensure that the services that they use to help and support people are focused on these key objectives – promoting the well-being of people and helping people to defer or delay their need for care. This philosophy for social care and its customers will also lead commissioning agencies to review the way in which they both assesses users for services and the way in which they procure services. In particular, a number of themes will emerge as the legislation is put into practice:

- The help that will be offered will look at what preventive actions may be taken to reduce the longer-term reliance on formal social care.
- People are equal partners within the assessment framework.
- The focus of the assessment is on what matters to the person and how they can use their own strengths and resources to do those things that matter to them.
- Assessments will focus on the well-being of the Care Users.
- Assessments will focus on getting the appropriate help to people that delivers the best possible longer-term outcomes.

These will require local authorities and Local Health Boards (LHBs) to re-examine the way in which they commission or procure domiciliary care services for people who will need them. One particular option that commissioners will want to consider is in what circumstance they might determine to commission the services with a focus on the outcomes the provider might deliver.

### 3 Commissioning and outcomes

For more than a decade commissioners of domiciliary care have focussed on driving the price for services down to maximise the amount of care a person can get at the lowest possible cost. It is now widely recognised that extending this approach further is unsustainable as it threatens the existence of those providers who deliver local services, particularly acute within rural areas. In response, there has been recent move by local authorities across the UK to consider a change in the way in which they procure services in adult social care, towards an approach which looks at how those providing services are held to account for the outcomes they achieve rather than just the activities that are delivered. This is often referred to as “outcome-based commissioning”<sup>1</sup>.

However, it is not always easy to be clear about what we are dealing with - this is a complex field with a range of different terms often used interchangeably. So, to be clear in this paper, the meaning of the following terms used in the report are<sup>2</sup>:

- **Commissioning:** is the processes which includes understanding assessing the needs of a population, and designing and then achieving appropriate outcomes with and for them. The service may be delivered by the public, private or civil society sectors.
- **Procurement:** or purchasing refers to the process of finding and deciding on a provider and buying a service from them.
- **Outcomes:** are the perceived benefits to a person from the care and support they have received.
- **Payment by Results:** is the process whereby a service provider is rewarded financially because they have ensured the delivery of pre-agreed set of outcomes for an individual or for a population of people in an area.
- **Promoting Independence:** is the process whereby a person is helped to be less reliant on state funded support in order to have their needs met.
- **Prime Provider:** a single provider is procured by the council to deliver a set of services (at an agreed price). This provider then sub contracts work and manages the local supply in the market to deliver the required service.

### 4 Why Outcomes – and what might they look like?

There is much debate within the NHS and adult social care currently as to whether there are sufficient resources within the system to fund a sustainable model of care and support. This leads commissioners to be very careful about how every pound is spent. It is in part this approach to value for money that has also led to councils looking at an outcome-based model of social care. It is very important that the resources available are spent in the best possible way, and advocates argue that one impact of outcome-based commissioning is that it can lead to a more cost- effective and sustainable model of social care.

<sup>1</sup> See IPC Paper on Outcomes Based Commissioning - <http://t.co/bXZL9iEJsB> (pdf)

<sup>2</sup> Definitions are taken from the book “Commissioning for Health and Social Care” published by SAGE and IPC (Oxford Brookes University) in 2014

There has also been much consideration about the evidence for preventive actions and how a person can be helped in a way that may reduce or eliminate their need for longer term care and support. There has been much discussion and debate about the methods that commissioners might take to help manage longer-term demand for health and social care<sup>3</sup>. This is in part developed from a range of new approaches that have been given serious consideration in the last decade – the role of re-ablement in helping older people's recovery; the role of rehabilitation in helping people meet the challenges of physical impairments; the recovery model that is widely used as an approach to assist people with poor mental health and the promoting independence work-streams for adults with a learning disability.

If all these approaches are considered, then for each person using care and support there is a serious question to be asked – “Do we have the right help for this person and is it being delivered in a way that will maximise their opportunities for greater independence?” It is this question that has led commissioners to adopt an approach which focuses on outcome based commissioning. The model is based on having the right intervention available to help a person most appropriately, given their particular circumstances at a given point in time.

For domiciliary care an outcomes based approach means that the service provider is delivering the right service for that particular individual – for some people this means helping them to live with their long-term condition(s), whilst for others it means helping them continue to recover. The main aim is to assist people with personal care needs to remain safely and happily in their own home for as long as is feasible. It can include the following different types of home-based care and support:

- Short-term recovery (domiciliary care re-ablement) – this might be the continuation of a programme for someone who hasn't recovered within the current standard six-week re-ablement period that local authorities across Wales offer to people to support recovery from illness or injury.
- Longer term recovery – many older people will recover to some degree from particular conditions over a longer period (for example a study in Wiltshire<sup>4</sup> showed that many older people's recovery takes place between six months and a year).
- To support health care specialists to deliver health care and support to a person e.g. medicine management or wound management.
- Helping a person through home-based practical support to live with or manage a long-term condition (or set of conditions) which may involve helping a person to do more tasks for themselves.
- Helping a person live with or manage having memory loss or dementia.
- Helping a person through end of life care.
- Supporting a carer who is helping any of the above.

In any particular situation it will be up to the individual to agree with the service provider 'what matters' to them in terms of the perceived benefits they want, and therefore what

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<sup>3</sup> Paper by Professor John Bolton on the evidence for prevention - [Reimagining Adult Social Care: RiPFA \(2015\)](#) - <https://t.co/iYoKANpHtd>

<sup>4</sup>Wiltshire Council Help to Live at Home Service – An Outcome-Based Approach to Social Care. Case Study Report, Institute of Public Care - April 2012

specific outcomes are aimed for as a result of the care and support agreed. However, the table below<sup>5</sup> describes for purpose of illustration, a range of potential outcomes that a service might aim to achieve, and a range of outcomes that an individual might aim to achieve.

<b>Service Level Outcomes</b>		
<b>A service that can...</b>		
1. Contribute to the initial reduction of the levels of care and/or support over an agreed period of time	2. Support the on-going care and support needs of individuals and reduce the likelihood of admission to long term care	3. Contribute to the prevention of hospital admission/ re-admission (this could be following a period of re-ablement, rehabilitation, rapid response/support from another service)
<b>Individual Level Outcomes</b>		
a. Improvement in being able to undertake daily living function	a. Ongoing improvement, maintenance or minimised deterioration in ability to undertake daily living functions	a. Prevention of ill health
b. Improvement in undertaking the ability to self-care	b. Ongoing improvement, maintenance or minimised deterioration in ability to self-care	b. Ongoing improvement, maintenance or minimised deterioration in health – both physical and mental health
c. Improvement in mobility function	c. Ongoing improvement, maintenance or minimised deterioration in mobility function	c. Prevention of hospital admissions and readmission
d. Improvement in confidence and independence in own home	d. Ongoing improvement, maintenance or minimised deterioration in confidence and independence at home	d. Reduced stay in hospital
e. Improvement in health or the capacity to sustain health – both mental health and physical health	e. Ongoing improvement, maintenance or minimised deterioration in physical and mental health	e. Ability to return to a suitable home environment following hospital discharge

<sup>5</sup> Based on unpublished work by The Institute of Public Care with a home care provider in England.

Individual Level Outcomes		
	f. Continued involvement and support for family and spouse carers	
	g. Reduced anxiety about ill health by individual and their families	
	h. Ability to remain in own home for as long as possible	

Although this table summarises the range of outcomes that might be negotiated, it is of course important to remember that the approach described has to be highly personalised. Each person may have a unique set of outcomes they want to achieve, and this may require unique interventions to which they will respond in personal and individual different ways.

### Key Message

Domiciliary care involves a wide range of activities and purposes. To be successful in developing an outcome-based approach commissioners need to work with their providers to design new approaches at both service and individual level.

## 5 The role and nature of re-ablement

In some situations where outcome based commissioning has been introduced for domiciliary care<sup>6</sup> the move has also led to the commissioners replacing a separate domiciliary care re-ablement service, as the new outcome-based domiciliary care service is able to ensure that all domiciliary care that is provided is based on the principles of re-ablement. This can apply to both for new packages of care and for longer-term existing customers, and there is no need for a separate re-ablement service.

In Wiltshire for example, it was found that the recovery of some older people who needed help did not take place within the six weeks for which a re-ablement domiciliary care service has been provided (free of charge) but could occur at any time within a year of the service being offered. The rate at which older people will improve following an illness or injury does vary. It varies according to the particular condition or range of conditions that an older person may have and it will vary according to the personal resilience of the older person.

This means that for all older people who have “completed a course of six weeks re-ablement” there is still a possibility that they may make a part or full recovery in any of the months following the specific help they received. Because someone still needs care after an episode of re-ablement based domiciliary care doesn’t mean that they will always need care for the long-term. This needs to be considered both by those

<sup>6</sup> Wiltshire Council -Help to Live at Home Service – An Outcome-Based Approach to Social Care, Case Study Report – IPC April 2012

commissioning care and for those who are providing care. One of the aims of outcome-based commissioning is to find a way of rewarding or at least encouraging providers to help people in a way that doesn't mean that they will have to rely on care for the rest of their lives (though of course some people will need care to support them long term). The traditional approach to health and social care has always inadvertently encouraged providers to actually increase the amount of care a person needs.

Some commissioners argue that all services should be re-ablement based – so at every opportunity providers should be looking to help a person do more for themselves. It is important to remember that one of the challenges with helping people who have care and support needs is to ensure that the right balance is offered between helping a person who cannot do something for themselves whilst not removing from them the ability to provide that self-care in the future. When people stop doing tasks for themselves they are likely to deteriorate further. This is a difficult balance about which care workers have to use a careful judgement.

The term re-ablement can sometimes be limited to be only seen as beneficial for those where there is a clear likelihood that the person will improve. Recent evidence<sup>7</sup> has shown that a range of people with quite complex conditions can be assisted if the help is offered in “the right way”. People with depressive illnesses and other long term conditions for example can all be helped through a focussed period of help. In some areas those with the early stages of dementia can be assisted to better manage the condition and to prepare for the longer term impact. For example, anecdotally one of the providers in Wiltshire which runs a specific support service for those diagnosed with dementia reports significantly improved outcomes for their customers (and low admission to residential care).

One of the challenges faced by assessors for services and providers of services is that there is not yet a clear enough knowledge-base about which people are likely to improve - and which people are unlikely to improve. This means that everyone should be given the opportunity for recovery or part-recovery before any longer-term plans are made for them. Even when longer term plans are made the focus of help might still be on maximising the opportunities for a person to live as independently as possible.

If the new “outcome-based” service replaces the former re-ablement domiciliary care service one might expect that it will have a significant impact on the numbers of older people receiving longer-term care. In Wiltshire the providers have found that around 60% of the people referred to them no longer require care after 12 weeks. If people will only be referred to an outcome-based service after they have had an opportunity of a re-ablement package, then the likely outcomes in relation to people needing less care will be significantly lower. There are important transition and change management issues which need to be taken into account if going down this route – including ensuring that skilled and valued staff are not lost, that skills training and development is provided, and that service transition for customers is smooth and maintains consistency of worker wherever possible.

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<sup>7</sup> The Torbay Case study in the Local Government Association's Adult Social Care Efficiency Programme

**Key Message**

Commissioners should consider if they do want to replace the existing re-ablement service or to have a service that continues to offer help after a period of intense re-ablement.

## 6 The role and nature of providers in the care market

### 6.1 Fewer providers?

In some places that have adopted an outcomes-based approach to domiciliary care commissioners have also moved to contract with a smaller number of providers than had previously been the case. There are a number of reasons for this:

- It is more manageable for commissioners to work with a limited number of providers to develop a new approach to the service.
- Many providers report that they would find the change to the new approach difficult to deliver as they don't have the staff trained to support the outcomes required.
- It has enabled some costs to be reduced as providers are allocated an area in which to work which can reduce travel time and transport costs.

For those councils who have moved to fewer providers there are some risks as well as benefits. Even though existing staff working for providers who do not win contracts (which result in them losing or closing their business) may be protected by the rules governing TUPE<sup>8</sup> it is the experience elsewhere that staff can be reluctant to move to a new employer. This can give a new employer a problem with recruiting staff to set up the business in a new area in a speedy manner.

One of the reasons that commissioners have tended to encourage a range of providers to operate in their area is in order to both have a good and range of supply in their area and with healthy competition on price and quality. They might also offer a wider choice for customers who want to take more control of their own services through a Direct Payment. Some Commissioners will argue that this might also help manage the risks in the market around the failure of any one Provider, though the evidence for this is not clear.

Commissioners need to work closely with existing providers on any changes they want to make in the domiciliary care market. There are some benefits in both reduced direct costs and transaction costs if the contract is with fewer providers. However, if a commissioner is to take this approach they should be careful to ensure there is an appropriate period allowed for any new provider to build their work force.

A further emerging model for commissioners to consider is for the council to contract with a single "Prime Provider" who then has the responsibility for managing the rest of the market. The council has a relationship with a single provider. That provider sub-contracts work to other local providers. The prime provider is held to account for the

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<sup>8</sup>"Transfer of Undertakings (Protection of Employment) Regulations 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014"

outcomes of the whole sector. This approach is being developed in Torbay in south-west England. The approach avoids the problems of closing down contracts with smaller providers but can still reduce the transaction costs for the council. This approach may work particularly well if a commissioner wanted to consider procuring services on behalf of a population of people with needs rather than for a group of individuals).

## 6.2 In-House Services and Local Authority Trading Companies

Some of the service and interventions that have been mentioned in this paper are still run by the local authority, and there is no clear preferred model regarding governance or ownership of domiciliary care services across the health or social care sectors. There are implications of a shift to outcomes-based commissioning for all services, and if commissioners are considering such a move then all services that are provided should be held to account for their performance and the outcomes they deliver. Many councils for example do not know the outcomes from their domiciliary care re-ablement service, and in some councils the domiciliary care re-ablement service 'cherry-picks' the people it will help to ensure a good performance (in relation to the number of people who have no long term or a reduced package of care). It is important clear criteria which include both throughput and outcomes are defined and measured for these in-house services.

Some councils have in recent years moved their previously run in-house services into a Trading Arm (or social enterprise). There are a number of risks to this approach as it can give the council a longer term problem in being tied to budgets and services that it may not require in the longer-term or may require changes which were not specified in the original agreements. With a strong emphasis on the value of social enterprises in the Social Services and Wellbeing (Wales) Act 2014, if a council does wish to pursue such a venture it is very important that the contract from the council specifies the outcomes (with specific measures) it will be holding the service to deliver.

### Key Message

Commissioners should consider how they want to manage the market if they are moving to a new approach (outcome-based commissioning). They should understand the benefits and risks of the approach they adopt.

## 7 The Outcomes Framework – a basic requirement for every domiciliary care contract

In November 2015 the Welsh Government published the National Outcomes framework for people who need care and support and carers who need support. The main objectives for the framework are:

- To describe the important well-being outcomes that people who need care and support and carers who need support should expect in order to lead fulfilled lives.
- To set national direction for services to promote the well-being of people in Wales who need care and support, and carers who need support.

- To provide greater transparency on whether care and support services are improving well-being outcomes for people using consistent and comparable indicators.

In order to support the policy, the Welsh Government produced a Code of Practice in relation to measuring social services performance. It included the following key outcome measures in the performance framework for local councils.

1. People reporting that they live in the right home for them
2. People reporting they can do what matters to them
3. People reporting that they feel safe
4. People reporting that they feel a part of their community
5. People reporting they feel satisfied with their social networks
6. Children and young people reporting that they are happy with whom they live with
7. People reporting they have received the right information or advice when they needed it
8. People reporting they have received care and support through their language of choice
9. People reporting they were treated with dignity and respect
10. Young adults reporting they received advice, help and support to prepare them for adulthood
11. People with a care and support plan reporting that they have been given written information of their named worker in social services
12. People reporting they felt involved in any decisions made about their care and support
13. People who are satisfied with care and support that they received
14. Parents reporting that they felt involved in any decisions made about their child's care and support
15. Carers reporting they feel supported to continue in their caring role
16. Carers reporting they felt involved in designing the care and support plan for the person that they care for
17. People reporting they chose to live in a residential care home

These are key measures and providers of domiciliary care would be expected to undertake the processes to ensure that this information is collated and collected in a proper manner for all of the customers it serves, although numbers 6, 10, 14, and 17 won't apply to most domiciliary care contracts. Each contract that is issued by a local council or by its NHS partners should ensure that this happens as required and this should be clearly stipulated. This is the simplest form of outcome-based commissioning.

At its simplest all domiciliary care contracts should include a requirement to measure the reported outcomes and for each supplier of care to be held to account for the performance of their services within that authority. The continuation of any contract beyond its stated term should be dependent of the provider being able to demonstrate a

good performance in each of the relevant measures. The provider should be expected to understand how their service can contribute to each of these outcomes.

However, this approach can be taken a bit further through setting out some basic performance measures on which the provider of domiciliary care is to be judged. A set of examples is laid out below.

<b>Example Service Outcome Measurement Framework</b>		
<b>A service that can contribute to the initial reduction of the levels of care and/or support over a period of time</b>		
<b>Individual Outcome</b>	<b>Measures</b>	<b>Methodology</b>
a. Improvement in being able to undertake daily living function	<ul style="list-style-type: none"> <li>■ % of service users who perceive that their ability to undertake a daily living function has improved since receiving the service, e.g., cooking, caring for their own home</li> <li>■ % reduction in the number of hours/visits attending to service users daily living outcomes</li> </ul>	Self-assessment / assisted assessment via discussion Service provider records, service users files
b. Improvement in undertaking the ability to self-care	<ul style="list-style-type: none"> <li>■ % of service users who perceive that their ability to undertake self-care has improved since receiving the service, e.g., personal washing, toileting, self-medicate</li> <li>■ % reduction in the number of hours/visits attending to the personal care outcomes</li> </ul>	Self-assessment / assisted assessment via discussion Service provider records, service users files
c. Improvement in mobility function	<ul style="list-style-type: none"> <li>■ % of service users who perceive that their mobility has improved since receiving the service, e.g., mobility around their own home, outside their home etc.</li> </ul>	Self-assessment / assisted assessment via discussion Service provider records, service users files

<b>Example Service Outcome Measurement Framework</b> <b>A service that can contribute to the initial reduction of the levels of care and/or support over a period of time</b>		
Individual Outcome	Measures	Methodology
	<ul style="list-style-type: none"> <li>■ % reduction in the number of hours/visits attending to mobility</li> </ul>	
d. Improvement in confidence and independence in own home	<ul style="list-style-type: none"> <li>■ % of service users who perceive that their confidence has improve since receiving the service, e.g., to undertake tasks with less support, self-medication, reduced isolation, interaction with other service users etc.</li> <li>■ % reduction in the number of hours/visits attending to service users confidence and independence outcomes</li> </ul>	Self-assessment / assisted assessment via discussion Service provider records, service user's files
e. Improvement in health or the capacity to sustain health – both mental health and physical health	<ul style="list-style-type: none"> <li>■ % of service users who perceive that they have seen an improvement in the overall health since receiving, e.g., less tired, ability to concentrate, make decisions etc.</li> <li>■ % reduction in the number of hours/visits attending to overall health outcomes</li> </ul>	Self-assessment / assisted assessment via discussion Service provider records, service users files

Adopting this approach can give some very specific information about the effectiveness of each provider in an authority area. The information becomes part of the contract monitoring. Providers need to be clearly informed during the tender process as to what will be expected from the service if a contract is awarded. This can be used to judge which providers are helping people in a way that improves outcomes and which ones are not. There is no payment mechanism in this approach but contract compliance would expect a provider to look to be able to demonstrate that it is meeting the outcomes as described.

The benefits of this approach is that the provider is given a clear focus on the outcomes they are delivering without the necessity of a complex financial payment mechanism that can lead to higher transaction costs in the “payment by results” models described below. The disadvantage is that there are no clear rewards for those providers who are successful in helping deliver improved outcomes. It may be possible to withhold a percentage of the value of the contract which is only paid if the commissioner is satisfied that targets have been met. This would have to be clearly stipulated at the beginning of the contract.

### **Key message**

All providers of domiciliary care can be required to comply with the performance framework laid out by the Welsh Government. Commissioners can go further and require additional data on the performance of the provider. The examination of the data (for either approach) for each provider an important part of the contract compliance process.

## **8 Moving to a more effective outcomes approach for domiciliary care**

The traditional way in which domiciliary care is commissioned is based on a model of determining tasks to be carried out by a provider of care within a given timescale. The outcomes-based approach does not specify the timescales, only the outcomes that are required. The amount of time spent ensuring that any specific outcome is delivered is left as a negotiation between the customer and the provider of care (and is not specified by the commissioner of the service). Different approaches are described below.

### **8.1 Moving to outcome-based objectives**

In order to move to outcomes-based commissioning those assessing for services need to define this in the form of desired outcomes. An assessment of need drafted in the form of outcomes that may be delivered is completed and providers are rewarded for delivering the outcomes in a timely manner. The circumstances in which commissioners might consider more requirements from a provider of domiciliary care are:

- Where an outcome-based assessment has taken place by a social worker/care manager and a provider is required to deliver the outcomes laid out in the care plan.
- Where there is an expectation that the provider will work to ensure their users are less likely to enter residential care.
- Where there is an expectation that the service user, with appropriate help, will improve their condition and is likely to need less care.
- Where the person has had frequent admissions to hospital and part of the care being offered is to assist the person to better manage their condition to reduce admissions.
- Where a provider has to be ready to take new customers at short notice e.g. where a swift discharge from hospital is required.
- Where a customer needs to be trained to self-manage their condition e.g. manages their own medication (or uses the assistive technology available in order to do so).

These approaches require certain conditions to be in place:

- That a health or social care professional has clarified the outcomes that could be achieved.
- That these outcomes are agreed by/with the customer.
- That the provider has staff who are trained and skilled in delivering the range of outcomes that may be required.
- That these outcomes are realistic within a reasonable time period (less than one year).
- Where the outcome is likely to lead to the customer requiring a lower level of support in the longer term.
- That the outcomes focus on features where there may be longer term cost reductions for the service. Outcome-based commissioning requires more from the care system than a new form of contract between Local Authorities (Health Boards) and Providers. It requires a transformation for all those involved in Care (and Health). Those assessing people for domiciliary care; those providing domiciliary care and those procuring domiciliary care may all have to change their approaches.

The most important feature of a service is to be clear for each individual how the service can deliver in a way that delivers the stated outcomes. In this model it is particularly crucial that assessments are undertaken effectively, that they work on the basis of a real 'what matters to the individual' conversation, and results in a clear understanding of the outcomes to be aimed for, and the care and support which will be provided to help achieve this.

### Key Message

Make sure you understand to what extent providers of domiciliary care are encouraged and rewarded for helping people who might need less care as well as supporting and helping people remain in their own homes (when that is their wish).

## 8.2 Rewarding the achievement of outcomes

In this second approach, outcomes are stipulated for each individual who needs care and support. Providers are paid a sum of money according to the outcomes they agree to deliver with the customer.

The early adopters of outcome-based commissioning from English Local Authorities (Wiltshire, Windsor and Maidenhead, Hertfordshire, (all domiciliary care contracts) and Nottinghamshire (learning disability community support contract) have all focused on looking to reward providers who can deliver those outcomes which help people in a way that helps them either to better self-manage their conditions and to reduce the level of care they will need in the longer-term. The key challenge has been how to make a payment schedule within the contract which can reward those who deliver improved outcomes without making the transaction costs too high. This process is sometimes called – “payments by results”.

The commonly adopted mechanism is to pay a set sum to the Provider for each outcome that is delivered. A schedule is worked out which guestimates the amount of

time a provider might need to deliver a specific outcome. The calculation is usually based on the findings from the PSSRU study on re-ablement<sup>9</sup> which estimated that each person receiving a re-ablement care package on average received just over 100 hours of care costing about £2,000 per package. This is an offer of intensive support over a six to eight-week period. Other estimates suggest that this figure is slightly too high and a better average cost is £1,575 per intervention (includes the costs of therapeutic support). Based on this estimated cost it is possible to suggest that this might be the starting point to consider how much a provider might be paid to meet a short-term objective. The Provider is rewarded if they deliver the outcome in a shorter period and meets the cost if the outcome is not delivered in the agreed period.

This approach is the one adopted by Wiltshire County Council and is supported by the providers who are contracted with them. Each Council may want to develop a local model with their providers. In Wiltshire they trialled real time cost for six months with their providers before agreeing the final payment schedule. Average costs might look like:

- Re-ablement £1,575 per episode
- Lower Level Dom Care £75.00 per customer week
- Higher Level Dom Care £150.00 per customer week
- Intensive and Specialist Dom Care £320.00 per week<sup>10</sup>

An alternative option is to agree the time frame within which a defined outcome might be met and to pay an hourly rate to the provider in line with the current payment model. A financial bonus could be paid when the outcome is delivered if it leads to the person needing a lower amount of longer term support.

The approach adopted has some close parallels with the development of Resource Allocation Systems in England for people with personal budgets. The advantage of the approach is that each plan and each payment is unique and personalised for each individual receiving help. The need to calculate the cost of each package of care on an individual basis in order to ensure that the outcomes for a person are delivered can have quite high transactional costs, which is why this approach is not necessarily a preferred approach for commissioners.

### Key message

To adopt a payment by results process, commissioners need to work out the required payment mechanism very carefully with the providers of care. Both will want to ensure that the transaction costs of doing this don't outweigh the benefits.

<sup>9</sup> Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study) Caroline Glendinning, Karen Jones, Kate Baxter, Parvaneh Rabiee, Lesley A. Curtis, Alison Wilde, Hilary Arksey, Julien E. Forder November 2010 Working Paper No. DHR 2438

<sup>10</sup> These figures are for indicative purposes only and would need to be calculated locally in the context of how domiciliary care is used within the wider care system.

### 8.3 Outcome-based objectives for populations

In addition to the approaches being developed above, there is a third approach which is to commission a set of outcomes for a given sub-set of the population e.g. a group of eligible older people or a group being discharged from hospital.

In this approach commissioners only assesses that people are eligible to have their care needs met. The onus is then on the provider to ensure that each person gets the best possible help in the right way to both help people regain independence and to ensure that admissions to residential care are kept to a minimum (in the model the Provider pays the costs of any of its customers who enter residential care). Providers can bid for a contract and may win a contract on price. However, the contract is awarded to those providers who can deliver the best outcomes for the population which might include speedy discharges; reducing long-term demand and reducing admissions to residential care. The expectation is that a single provider can deliver a better set of outcomes for a population than the current system is able. If this is possible it is likely the cost of the service to the commissioner will be lower (in part because of the significantly lower transaction costs) with all of the risk being passed to the provider e.g. any overspends on the budget has to be found by the Provider. A number of English councils (including Torbay and Wiltshire) are exploring how this approach might work for them, and there are echoes of the approach in the NHS 'accountable care organisations' recently advocated as one option for the future delivery of health care in England by the King's Fund.<sup>11</sup>

The payment mechanism for a population based outcome model again will need to be established locally. The approach expects that all older people in the defined area who are deemed to be eligible for care are referred to the lead provider. The service would include all aspects of domiciliary care from short-term re-ablement to longer term support. The service provider would expect, for example, to deliver a minimum of 50% of people re-abled so they need no further support after eight- ten week; a further 10-15% helped within the first year; and to sustain low admissions to residential care by ensuring people get the help to live at home. The cost of the service would be based on achieving these outcomes. A simple calculation considered that the price would equate to around £600,000 per annum per 100 older people referred. This figure is based on provider being paid the equivalent of £15.00 per hour (this can be adjusted for local circumstances).

So in summary this approach is where a lead provider is appointed to deliver services to those people who are eligible for care. The price of the contract is agreed based on the expected outcomes that the provider will deliver. The risks are held by the provider but there are rewards if they can meet people's needs in a way that reduces their care needs over time.

#### Key Message

A population-based outcomes model may be the most cost effective model but will require a strong sophistication from providers to understand what the best help they can offer people which maximises their independence. This requires a well-trained and motivated staff group.

<sup>11</sup> 'Options for Integrated Commissioning' King's Fund 2015

## 9 Conclusion: a set of design rules for outcome based commissioning?

The following design rules are suggested for consideration by commissioners who want to take an outcome-based commissioning approach to domiciliary care - whatever specific approach is being considered:

- Link the move to outcome-based commissioning to a model of social care which focuses on prevention and promoting independence.
- Get the right set of providers in place to deliver the new model and work with them in a collaborative way in order to get the best possible system in place. Be clear (with these providers) what the likely outcomes that any specific service is being asked to deliver.
- Get the right range of care staff skilled up to deliver the service with the right training and aptitude to deliver the outcomes based approach. This can take some time.
- Ensure that all assessment staff are skilled and understand how to assess people for outcomes (that will promote their independence) – this is not the usual way in which staff will have been trained. The IT systems and all of the forms will also need to support the process which should not be over bureaucratic. Staff will need to understand the evidence for particular interventions to assist people with different conditions or to rely on the providers to deliver this – which ever approach is adopted assessment staff and providers need to work closely together.
- Agree who will ensure that customers have all the equipment they need (including telecare) to assist them in maximising their opportunities for independence – this can either be set up by professional staff (Occupational Therapists, Physios and those with specialist knowledge of how telecare can support different conditions) before the care is delivered or set up by the care agency as part of the contract.
- Be aware of the need to ensure that all stakeholders are engaged and understand the nature of the changes that may impact on them in the way in which the new service will be delivered. This is particularly important for carers and their families.
- Make the payment mechanism as simple as possible – consider whether any rewards will be paid for good performance in delivering outcomes. Consider if payments should be made on each individual outcome achieved or for outcomes for sub-sets of the population e.g. hospital discharges.
- Recognise the range of interventions that are required to deliver different assistance for people with different needs to meet their set goals. Help the provider(s) to organise their services appropriately and to link with others when they cannot provide a specific service to meet a specific need – without creating a whole bureaucracy of assessment and approvals. There needs to be significant trust on the providers to have the skills and knowledge to deliver the right outcomes in the most appropriate way.
- Allow providers to recognise with their customers when outcomes have been delivered. It may not require a further assessment to demonstrate that they are right particularly when there is agreement that no further service is required.
- Recognise that an outcome can be attained for most customers to assist them in become more independent – even if the first steps are hard and may seem small.

- Ensure that the performance management system that is put in place is clear and simple and is reported and considered on a regular basis both to meet demand and outcomes.
- If a new provider is brought into to deliver an outcome based contract (to replace an existing provider) do not rely on staff transferring across (through TUPE). The new provider is likely to have to recruit their own workforce. This will also take time.
- There does have to be work undertaken across the health, care and wellbeing system to ensure that all partners understand and can contribute to the approach. For many older people it is ensuring that they are getting the right help for their health needs that make a significant difference to the outcomes that are possible for them. This particularly involves NHS resources to be allocated to therapists and community nurses. Important service such as memory clinics (that have an outcome focus for people to better manage their memory loss), incontinence services (that have a focus on helping people to regain continence); falls services) that focus on reducing further falls through a proper check of hazards, medication, promote fitness etc.).

Health, wellbeing and social care commissioners who are looking to develop their approach to outcomes – based commissioning for domiciliary care in Wales my wish to consider these design rules when planning the most appropriate and potentially effective approach which might be used for their specific local population.

## 10 Appendix: A summary of approaches and their potential strengths and weaknesses

This section summarises the models and approaches described in the main body of the report and considers their strengths and weaknesses. It is intended as an aid to option analysis and decision-making.

### 10.1 Option One

#### **Set clear outcome-based performance standards for each contract against which they can be measured**

This is the simplest approach to outcome based commissioning. It does not require any payment mechanism to reflect the outcomes but does hold the providers to account for the outcomes they are delivering. This is more likely to affect the award of continued contracts than any immediate reward for the performance that is delivered. It does require a simple set of measures by which the outcomes are to be judged. It is probably easier to undertake this with a limited number of providers. It does require the whole system to understand the approach.

The lack of financial incentives in this model may mean that providers of care are not motivated to make the changes required. Under the current procurement approach adopted by many councils the incentives tend to favour providers who can deliver more care and they are not incentivised to deliver less. The way in which care is delivered will make a difference to whether a person is helped to regain independence or if they become more and more reliant on the care provided. The organisation requires a strong focus on performance management of the contracts in place. This in turn means

that it is best introduced into a market where there are fewer providers who can be more closely monitored. This approach might be best used to look at the outcomes from Intermediate Care Services or Supported Living/Extra Care accommodation, though it can work for all domiciliary care providers.

## 10.2 Option Two

### **Set a clear set of outcomes for each customer against which providers can be measured and rewarded**

This slant requires a major shift in the approach of the assessment and care management teams. Each assessment should agree with the customer what the potential outcomes might be. The outcomes should focus on those that will assist the person in being more independent over time. There is a view that these assessment skills are often seen at their best in Occupational Therapists and Physiotherapists as well as social workers. This should then be linked to the payments made to the provider of care who should be incentivised to deliver the agreed outcomes in the best time scale. This model may work for most types of service user.

The approach seeks a change in both assessment procedures and the behaviours and attitudes of providers. There is a risk that the transaction costs in the system increase as all parties need to agree both the defined outcomes and the cost of delivering these. Again this may be best managed with fewer providers who have the scale and capacity to manage the delivery of the system and put their investment into staff training and support. It requires sophistication from providers to ensure that they are offering the right type of care in the right way e.g. different care for people who are recovering from a medical intervention or those with a dementia.

## 10.3 Option Three

### **Commission a lead provider to deliver services to a sub-set of the population where the cost can be calculated based on an optimum performance where the provider will deliver improved outcomes which will mean that a percentage of people will require less or no care over a given period of time.**

This approach puts much of the onus onto the provider. They will need to have therapists working for them alongside care workers in order to produce the best possible outcomes for customers. The model will be cost effective if the proportion of people who only require short term care increases and more people are helped to remain at home without the need to go into residential care. This is the most radical of the approaches and is likely to produce the best cost options for both providers and councils. The provider makes a profit when they can out-perform the way in which the current system works. It is not the cost per hour that counts but the outcomes that are delivered.

The model is both radical and probably most challenging for commissioners and to some extent for providers. It requires a full understanding of the outcomes achieved within the current system and what would be required to improve it. However, both the transaction costs would be low as the councils will assess that someone is eligible for a service and the provider will then determine how they will best help them and there are limited brokerage costs involved. This does mean that many customers will not have a “choice” of service – though that may be an illusion in the current system.

## Discussion paper 2

# Procurement Options for Social Care in Wales

### 1 Introduction

The purpose of this paper is to promote good practice by setting out the major options that are available to local authority commissioners for the procurement of services, particularly with regard to two key areas – domiciliary care services and supported living services for people with learning disabilities.

### 2 Background

For some time now there has been a growing concern in Wales about the state of the care market and the continued ability of the system to ensure that services are available in sufficient quantity and of sufficient quality to meet the needs of the population.

Because of this there has been renewed focus on those aspects of the system that may be impeding its ability to deliver the required services to the required standards. One such area is that of procurement and the contention that the competitive tendering element of most current procurement arrangements detracts from the main task of securing and delivering services, and potentially de-stabilises the operation of the market. The market in adult social care services in Wales is an extensive one. In 2014/15 CSSIW reported<sup>12</sup> that there were:

- 422 domiciliary care agencies.
- 443 younger adult care homes.
- 661 older adult care homes.
- 11 adult placement agencies.

The WLGA reports that social care services in Wales currently support over 125,000 vulnerable individuals and employ more than 70,000 people.<sup>13</sup> Much of this activity is now located in the independent sector and is commissioned by local authorities with and on behalf of people who use those services and their families and carers. In its 2016 Annual Report<sup>14</sup> the UKHCA identified that in Wales in the preceding year:

- 47,300 people used domiciliary care.
- 15.4 million hour of social care were delivered.
- £309 million was spent.

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<sup>12</sup> 'Chief Inspector's Annual Report 2014/15 – 'Improving adult care, child care and social services' – CSSIW 2016

<sup>13</sup> WLGA website - <http://www.wlga.gov.uk/social-services-3>

<sup>14</sup> UKHCA 'An Overview of the Domiciliary Care Market in the United Kingdom' May 2016

- £293 million was spent by local authorities.
- 4,000 + people received a direct payment.
- Total expenditure on direct payments of £49.5 million.
- Total people employed in the domiciliary care sector: 26,100.

Information from the Welsh Government shows that on 31 March 2015 there were just over 15,000 people on local authority learning disability registers. Of these:

- 84% were in community placements (including with parents) of whom;
- 17% lived in lodgings or supported living.
- 2250 lived in lodgings or supported living.

There have been a number of high profile procurement failures in Wales over the last 2 years or so. In Powys, for example, an initial tendering exercise for home care services was halted because the council received no bids for the provision of services within some of the designated areas within the county. The contract was re-let on a different basis and contracts were awarded. However, it soon became clear that some of the newly-contracted providers were not able to deliver the services for which they had tendered and a period of poor quality services followed in some locations within the county and eventually some service contracts were terminated. An enquiry and further work on strategy has been undertaken and new plans are being progressed for some locations to ensure the supply of quality domiciliary care services.

Other parts of Wales have had similar problems with the domiciliary care market, but perhaps not so severely. Cardiff City Council, for example had some difficulty in securing adequate supply of domiciliary care services in 2014 and had to review its procurement processes. In 2014 CSSIW conducted a review of commissioning for social services in Wales<sup>15</sup>. In it they said:

*“It is widely acknowledged by the social care sector that transformation in the commissioning of social care services is required to develop the services for a sustainable future.”*

It went on to say:

*“The current and projected service demands for adult social care services and the resulting financial pressures present a significant challenge to local authorities and local health boards if they are to meet the current and future needs of vulnerable citizens.”*

CSSIW also made the point that:

*“The vision for the Social Services and Well-being (Wales) Act (2014) is of a complete change of approach (to commissioning) built on citizen centred services, a focus on delivery and greater collaboration and integration of services”*

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<sup>15</sup> National Review of Commissioning for Social Services in Wales, CSSIW, 2014.

John Skone, in a report written for the Minister for Health and Social Services in 2015<sup>16</sup> put forward the view that:

*“The overall conclusion reached is that commissioning which is over reliant upon competitive procurement as a first option is no longer fit for purpose. It benefits those who commission rather than those who are users of services. The focus upon price does not facilitate the achievement of high quality innovative services. Commissioning has a cost. Not just in terms of local authority budgets but more importantly in terms of the emotional and practical well-being of those users of services affected. Finally, the rigid procurement approach is increasingly becoming irrelevant in an environment of increasing person-centredness and financial austerity...As a result this paper concludes that co-production and co-design approaches provide an appropriate, relevant and practical approach to the challenges faced by social care in the future.”*

Skone suggested procurement had “crept up” on many commissioners and identified a number of areas where current procurement practice was unlikely to be effective in meeting the requirement of the sector and of the Social Services and Well-being Act, including:

- Planning and strategy
- Market development
- Quality of Care
- A citizen focus
- Opportunity for innovation

A number of very relevant further observations are made in that paper including the following referenced from Mark Cook and Gayle Monk<sup>17</sup>:

*“..although commissioners must adhere to the principles of the EU Procurement Rules and their own Financial Standing Orders, there are a number of ways in which services may be commissioned, including:*

- *The commissioner delivering the activity itself, by employing people and providing the necessary resources.*
- *Giving a grant or subsidy to an organisation to carry out the activity.*
- *Giving an organisation the right to provide the service (a concession or license).*
- *Providing capital funding to the organisation, which is then able to carry out the activity on a self-financing basis.*
- *Setting up a joint venture.*
- *Giving financial support to service users to meet fees charged by the service provider organisation or so that they can purchase their own service.*
- *Providing in-kind support (such as seconding staff or providing services, equipment or assets) to the organisation delivering the activity.*

<sup>16</sup> ‘Are the current approaches to commissioning, particularly procurement and contracting still fit for purpose to achieve the aspirations of current and future users of services and the Social Services and Well-being (Wales) Act (2014)?’ – Report to the Minister for Health and Social Services, J Skone, 2015

<sup>17</sup> Pathways through the maze, – a guide to procurement law Mark Cook and Gayle Monk, 2010  
<http://www.supporthub.org.uk/resources/pathways-through-maze-guide-procurement-law>

- *Undergoing a ‘procurement’ which covers everything from advertising through to the final contract arrangement.”*

One of their pieces of advice for commissioners is that:

*“Contrary to popular belief, competition is not always legally required when commissioning services. Formal EU procurement is only one way to commission, and may be a poor approach for delivering services if used without thought. Commissioners should avoid excessive use of the full EU tender process when it is not needed. Alternative approaches can improve the chances of achieving the required outcomes and stimulate local markets. Commissioners should avoid over-dependence on competition as the main driver for demonstrating best value, as alternative ways of choosing contractors, in addition to written submissions, can be useful and constructive. This does not, of course, affect the position where a commissioner must follow the full EU procurement rules.”*

It is, of course, for each local authority to determine whether or not the arrangements it has in place are compliant with EU and national regulations on public procurement (see below). However, as John Skone points out there are a variety of different ways that services can be secured and these are looked into in more detail below.

### 3 Legal Context

#### 3.1 Procurement Law

Whilst there are legitimate points to be made about the role and position of procurement regulations in social care commissioning an awareness and understanding of the legal requirements is essential if the approach to commissioning is to be improved and developed. As the EU directive is effectively copied into UK regulations any change in the UK’s EU status will not automatically affect the applicability of these requirements.

The regulations were revised in April 2015 and the changes made undoubtedly allow for a more flexible regime than was the case before. However, it is worth remembering that whilst the detailed requirements around procedure and thresholds may alter, the principals that underpin the regulations remain much the same and must be held to in any public procurement exercise. A number of law firms (E.g. Mills and Reeve<sup>18</sup>, Pinsent Masons<sup>19</sup>) have produced guides to the revised EU and national regulations and the detail is not repeated here. However, it is worth highlighting the principles that underpin procurement law and the main features of the new regime as they apply to social care. The principles are largely unchanged and as follows:

- Efficiency
- Sustainability
- Proportionality
- Suitability

<sup>18</sup> Mills and Reeve briefing ‘User Guide to the Public Contracts Regulations’ 2015

<sup>19</sup> Pinsent Masons ‘A Short Guide to: The New Public Contracts Regulations 2015 From a Contracting Authority’s Perspective’ 2015

- Simplicity
- Fairness
- Equality

(Adapted from 'Department of Health, Report of the Third Sector Commissioning Task Force part 2 (2006)').

In terms of the detailed requirements the new regulations introduced a higher financial threshold and special "light touch" regime for health and social services procurement. The new 2015 Regulations did away with the old Part A/ Part B distinction and introduced a new "light touch" regime that applies to all health and social care procurements that cost more than €750,000 over the whole period of the contract. Also, in limited circumstances an authority may depart from the procedure it has previously outlined to bidders. However, there is an obligation on authorities to inform bidders of this variance. Despite these changes, the "light touch" nevertheless still requires the following:

- A contract notice must be published or a prior information notice used as a call for competition (the circumstances for doing so are prescribed).
- The award procedure must comply with principles of equal treatment and transparency.
- The contract must be awarded in line with the advertised procedure • time limits must be reasonable and proportionate.
- Also, procurements that fall under the thresholds still need to be undertaken within a clear procedure and in line with the procurement principles outlined above.

The Regulations do permit competition for certain contracts to be "reserved" to organisations such as mutuals and social enterprises meeting certain limited criteria, as described in Article 77 of the Public Contracts Directive. The 'light touch regime' referred to above has to be used, but only allowing bids from organisations meeting the mutual or social enterprise criteria

There are a number of other new provisions, including one that allows bidders to be excluded on a number of grounds, including previous poor performance which has led to early termination, damages or other comparable sanctions. It is also worth noting the *EU 'Remedies' directive* of 2009 and the *'Public Contracts (Amendment) Regulations 2009'* that implemented it in UK law (although it is currently under review). Amongst the effects identified<sup>20</sup> by Hill Dickinson in their briefing<sup>20</sup> on the directive are that it contains a number of provisions with regard to:

- The letting of contracts.
- The rights of disappointed bidders who wish to challenge the decision.
- A compulsory standstill period before a contract is let.
- An automatic right to cancellation or variation of any contract awarded to another bidder in breach of the rules.

<sup>20</sup> 'The EU remedies directive explained' Hill Dickinson,  
[http://www.hilldickinson.com/downloads/client\\_services/knowledge\\_and\\_publications/health/health\\_e-shots/16\\_november\\_2010.aspx](http://www.hilldickinson.com/downloads/client_services/knowledge_and_publications/health/health_e-shots/16_november_2010.aspx)

Once proceedings are brought to challenge a procurement decision it is automatically unlawful to enter into a contract until the matter has come before the court. Also, when a contract has been awarded after the standstill period, any bidder not awarded the contract is entitled as of right to a remedy known as the 'Declaration of Ineffectiveness', which the court is obliged to make if a contracting authority has committed any one of a number of breaches of the procurement rules.

The 2009 Regulations also introduced a number of other changes, including:

- Improved transparency including an explicit duty to debrief losers.
- New, explicit standstill duties before letting a contract.
- Expanding the required content of letter notifying bidders of the decision.
- Bringing framework agreements into line with other contract procedures.

Generally, the directive increased the burdens on commissioners and narrowed the exceptions that are allowed. It does perhaps explain much of the caution that can creep into procurement procedures and decision-making. The directive also includes provision for a 'Dynamic Purchasing Systems' (DPS). Section 34 of the Public Procurement Regulations (2015) set out clearly how these are to be operated (this is covered in more detail below).

Finally, the revised procurement directive introduced a new 'innovation partnership procedure' that can be used where the aim is to develop *'an innovative product, service or works'* and to subsequently purchase *'the resulting supplies, services or works'*. The European Commission states that the **new procedure** is designed to enable contracting authorities to:

*'Select partners on a competitive basis and have them develop an innovative solution tailored to their requirements.'*

Under the procedure any potential providers may submit a request to participate by providing the responses to the selection criteria requested as part of the tender process.

Adult social care services come in all sorts of shapes and sizes and can be characterised in a wide variety of ways. Increasingly they are being tailored to the needs of the specific individual (see below) but there are, nevertheless some general categories that can be identified, often based on factors such who uses them, where they are delivered and for how long. Domiciliary care services for older people and supported living services for people with learning disabilities tend to be developed in response to different kinds of needs and require different levels and types of skill and understanding to be delivered effectively. By their nature domiciliary care services tend to operate within narrower parameters than some other services, although that is beginning to change. They also often operate to different timescales with different expectations as to how they may change and develop over time. Accordingly, they may need to be commissioned and procured in different ways to reflect these differences. Reference is made to each in the different sections of this paper.

### 3.2 Welsh Social Care Law

The legal context includes, as well as the procurement and the procurement regulations the national legislation with regard to social services in Wales. The recently published Part 8 Code of Practice on the Role of the Director of Social Services (Social Services Functions) helpfully sets out the main themes of Social Services and Well-being (Wales) Act 2014 that was implemented on 6 April 2016. They are:

- **Focus on people** – ensuring people have a voice and control over their care and support to support them to achieve the outcomes important to them and also ensuring services are designed and developed around people.
- **Well-being** – measuring success in relation to outcomes for people rather than process.
- **Prevention and early intervention** – delivering a preventative and early intervention approach to minimise the escalation of need and dependency on statutory services.
- **Partnership and integration** – effective cooperation and partnership working between all agencies and organisations, including health, to best meet the needs of people.
- **Accessibility** – improving the information and advice available to people and ensuring that everyone, irrespective of their needs, is able to access that information.
- **New service models** – the development of new and innovative models of service delivery, particularly those that involve service users them

As intimated by John Skone all these themes have implications for commissioning and how the procurement of services is approached.

Also important is the Well-being of Future Generations (Wales) Act 2015, that requires public bodies to do what they do in a sustainable way. They need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. Under the Act they are expected to:

- Work together better.
- Involve people reflecting the diversity of our communities.
- Look to the long term as well as focusing on now.
- Take action to try and stop problems getting worse - or even stop them happening in the first place.

*'Fulfilled Lives, Supportive Communities'* Commissioning Framework Guidance and Good Practice<sup>21</sup> continues to be in force and helpful in commissioning adult social care services. It has two parts:

**Part 1** provides guidance under Section 7(1) of the Local Authority Social Services Act 1970 in the form of standards which local authorities are expected to achieve.

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<sup>21</sup> *'Fulfilled Lives, Supportive Communities Commissioning Framework Guidance and Good Practice'* Welsh Government 2010

The Framework's commissioning standards set the benchmark against which the effectiveness of local authority commissioning can be measured. The standards centre on the development of evidence-based commissioning plans and their delivery through effective procurement.

**Part 2** of the Framework provides good practice in commissioning and procurement. This is not statutory requirement, but it includes 9 key commissioning challenges which local authority commissioners face.

The good practice described is based on a model of commissioning which places the citizen at the centre of commissioning activity. It includes definitions of the key processes and gives descriptions of the different activities involved in strategic commissioning.

As with the Social Services and Well-being (Wales) Act 2014 it is clearly possible to envisage circumstances where it might be argued that complying strictly with the procurement regulations could conflict with the requirements of this Act. Finally, whilst it is not legislation it is also worth remembering Welsh strategic plan for social services<sup>22</sup>. The plan set out eight priorities for action. In summary, they were:

- A strong national purpose and expectation; and clear accountability for delivery.
- A national outcomes framework.
- Citizen centred services.
- Integrated services.
- Reducing complexity.
- A confident and competent workforce.
- Safeguarding and promoting the wellbeing of citizens.
- A new improvement framework.

Again, achieving each of these priorities has an impact upon the commissioning and procurement of services. Achieving integration, for example, may mean there is a need to procure some (if not all) services in conjunction with the NHS. However, it is also clear that all the aspects of the legal background to the commissioning of services apply equally whatever group of (eligible) people those services are intended to support.

## 4 Commissioning

The relationship of commissioning to procurement has been much debated. IPC takes the view that commissioning is a broader process of which procurement is an integral part. There are very many definitions of commissioning. One definition of commissioning, developed by IPC is:

*“The process of identifying needs within the population and of developing policy directions, service models and the market, to meet those needs in the most appropriate and cost effective way”.*

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<sup>22</sup> ‘Sustainable Social Services for Wales – A Framework for Action’ Welsh Government 2011

The process of commissioning is set out in the IPC commissioning cycle that illustrates the whole process including procurement.



Looking at the commissioning cycle it is possible to identify some aspects of it that are clearly likely to be different, depending upon which group of people for whom the services are being commissioned (older people, people with learning disabilities etc).

Assessing individual needs, developing specifications developing the market, assessment against outcomes and the evaluation of services may all be done differently for different groups and for different types of services. To take an obvious example, the numbers of people involved when looking to commission domiciliary care services will generally be much greater than for people with a learning disability. The state of the market, equally may be very different. One local authority area may have an excellent range of providers for one group of service users but be really struggling to develop the market for another group. A narrow focus on the procurement process without paying due attention to the requirements of a broader commissioning approach can lead to mistakes being made and serious problems emerging, as has been evidenced in some recent instances in Wales.

Wider commissioning activity, then, must not be neglected. In addition, a key part of the **commissioning** task, is to determine how services are secured in order to best meet need, whether or not that should involve procurement and if so, how that procurement should be carried out.

At any point a local authority may consider (on the basis of its Needs and Resource analysis) that a service currently being provided is no longer required and should be **de-commissioned**. This is a decision not to be taken lightly, but may occur when existing (time limited) arrangements are coming to an end or mid-term (in which case any

existing contractual arrangements will need to be taken into account - e.g. provisions for early termination of contract or not taking up permitted contract extensions.)

The complete and final de-commissioning of a service is generally straightforward. However, complications can arise, particularly around TUPE, where a service is being partially replaced or replaced with something where the difference between the old service and a new service is a matter of degree.

Once it has been identified that a new or modified service is required, or that the existing arrangements for securing a service may be coming to an end (and the service needs to be continued) commissioners need to consider both what they want that service to look like in the future and how they intend to secure it. That might be influenced by some of the characteristics of the population involved and the needs that are identified. Numbers might be small, for example, and needs highly complex, requiring highly specialised services and support. Alternatively, numbers might be large and the services required quite straightforward and easily repeatable. In some instances, it might mean that a single provider is needed and in others that multiple providers might be what is required.

Clearly the options go beyond just procurement. A service may be retained within in-house provision or returned to it. Delivery of the service may be picked up by another provider within the parameters of their existing contractual arrangements with the council (especially where two providers are contracted to deliver the same service). A service may be delivered in partnership with another local authority or public body (e.g. one from the NHS). One of the standards set out in *'Fulfilled Lives, Supportive Communities'*<sup>23</sup>

*"Collaborative options have been explored for securing directly provided and contracted care services with partners, including health services and other local authorities."*

Alternatively, the local authority may decide that some identified needs can be better met through paying a grant to a third sector organisation. Contracts and partnerships with other public bodies

Grant Thornton<sup>24</sup> have identified that partnerships between public bodies have increased significantly, with common examples including:

- Shared management teams.
- Joint service provision.
- Joint commissioning of social care with the NHS.

Grant Thornton say that they 'consider that further partnership working and joint arrangements will play a significant role in helping local government move towards achieving financial security'.

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<sup>23</sup> *ibid*

<sup>24</sup> 'Responding to the challenge: alternative delivery models in local government' Grant Thornton, January 2014

They also identify seeing an increase in the number of joint ventures with the private sector, although there seem to be relatively few in the social care arena. Public-Private Partnerships are longer term agreements between a government entity and a private company, under which the private company provides or contributes to the provision of a public service<sup>25</sup>. In their Recommendations on the Public Governance of Public-Private Partnerships<sup>26</sup> OECD identified the importance of:

- Recognising that Public-Private Partnerships are increasingly becoming a prominent method for delivering key public services, can deliver value for money transparently and prudently in so far as the right institutional capacities and processes are in place.
- Noting that the public governance framework for Public-Private Partnerships should be set and monitored at the highest political level, so that a whole of government approach ensures affordability, transparency and value for money.

Robust governance and contractual arrangements need to be in place for this type of joint venture from the beginning of the arrangement and maintained to the same quality throughout the duration of the venture. However, they remain a relatively unused option in social care. Finally, following discussion, some existing service users may take up the option to access direct payments, meaning the council no longer need to continue commissioning that particular service. Richard Dooner has characterised all this as<sup>27</sup>:

*“The basic choice is Make or Buy. We can:*

- Provide services directly
- Contract for them
- Fund or otherwise support others to do what they do
- Collaborate
- Influence and shape the environment
- Choose not to do something”

Dooner also suggested that there is a further option for local authorities around “*letting a concession*” to a particular provider to deliver a given service in a particular locality. However, ordinarily concessions may be let by an organisation but the good or services they provide are purchased by others. Seeking legal advice would be strongly advised before pursuing this option. Finally, given the complexity and importance of some commissioning decisions the local authority may also want to consider some form of wider analysis, perhaps based upon a methodology such as PESTLE<sup>28</sup>, which looks at the wider political, economic, social, technological, legal and environmental aspects of a decision.

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<sup>25</sup> ‘PPP Basics and Principles of a PPP Framework’ PPIAF, 2012, <http://www.ppiaf.org/sites/ppiaf.org/files/documents/Note-One-PPP-Basics-and-Principles-of-a-PPP-Framework.pdf>

<sup>26</sup> ‘Recommendations on the Public Governance of Public-Private Partnerships’, OECD, May 2012

<sup>27</sup> Presentation to WLGA workshop on procurement options, June 2016

<sup>28</sup> <http://pestleanalysis.com/what-is-pestle-analysis/>

As a high volume/high turnover service **domiciliary care** presents particular challenges for commissioners and there are a number of aspects in the commissioning process that require particular attention.

Firstly, it is important to understand the level of demand for the service, the distribution of that demand (particularly in rural areas) and also any projected changes in that demand over the next period of time. There is a general and growing awareness of the changing demography of old age and the likelihood of increasing numbers of older people. It is important, though, to know who they are, where they are and what levels of need they are likely to experience, when.

Secondly, however, it is important to be clear about the range of services that the local authority (and the NHS) plans to deploy to meet that need. It is important not to commission on the basis of trying to meet future demand by 'always doing what we have always done'. As John Bolton has suggested<sup>29</sup>

*"There may still be some scope in most councils to introduce or refine the model of care and approach to social care which looks to both avoid the use of formal care where that is safe but helps people in other ways; ensures that the maximum opportunities for recovery and recuperation is consistently offered; not rushing to make an assessment when someone is in a crisis (e.g. at the point of hospital discharge) and avoiding residential or other institutional solutions where this is feasible."*

Domiciliary care is only one of the possible options to use to support older people, and there are several variants of domiciliary care itself. Thirdly, therefore, local authorities need to be clear about what model(s) of domiciliary care they are looking to commission. Some domiciliary care services have been developed to operate solely on an outcome-based model (eg Wiltshire in England) whilst others continue to be more traditional in approach. Some are focussed specifically upon people with dementia or facilitating hospital discharge and others on responding to crises. The interface with Reablement services is particularly important and something that commissioners have to ensure that they understand and take into account. Where changes in the model are planned, it is vital that they communicate that change to assessment and care management staff as well as to domiciliary care providers. It may be somewhat anecdotal, but there is ample evidence from a number of sites that the re-commissioning of domiciliary care services has failed because other staff within the local authority have not been engaged effectively.

Fourthly, commissioners have to have a good understanding of the provider market, both structurally and in terms of the capacity and capability of the providers. Again, geography and location can be important in this regard. Engaging with providers on what can and should be delivered, and how it should be procured will help ensure that procurement exercises do not fail. The best commissioners engage with providers (separately and collectively) on a regular basis and particularly so in the run-up to a re-procurement exercise or a change in the procurement system. Understanding the current state of the workforce and the labour market is also important, as is an awareness of self-funders and their impact upon the market.

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<sup>29</sup> 'What are the opportunities and threats for further savings in adult social care?' John Bolton, IPC February 2016

Sharing the intentions of the local authority through a market position statement specifically for domiciliary care services can be helpful, although it needs to be set firmly in the context of wider services as outlined above.

In terms of **supported living services for people with learning disabilities** the challenges for commissioners can be somewhat different. Learning disability commissioners are often dealing with relatively low volume but high cost services. Whilst individual levels of need and packages of care may be much bigger, the value of the related contracts may be much smaller than for high volume services. People with learning disabilities often have more complex packages of care that involve a number of different services over substantial periods of time and learning disability commissioner often have to operate at an individual level with services users, ensuring the housing support services being commissioned contribute to the meeting of needs via a complex package. Learning disability providers are much more likely to need the skills and understanding to work with service users and their families at an individual level.

Commissioners of supported living services for people with learning disabilities also often have to take into account not only the needs of individuals but also which individuals might prefer (or at least be suited) to share the accommodation and services that they receive. Reconciling the needs of groups of people so that they can share accommodation etc whilst retaining their rights to choice and control is often a complex process with which commissioners have to engage.

Securing the right accommodation is also often part of the role of the learning disability commissioner and dealing with the housing market often requires a longer-term perspective on levels and types of need that may or may not align with the emerging identified needs of people with learning disabilities. Longer term planning for individuals and for the service as whole has to be brought together in some way.

Securing the right accommodation often also involves in engaging with the wider care and benefits system and having liaison with Supporting People teams and housing departments as well independent builders and private sector developers and landlords.

In addition, the learning disability commissioner then needs to ensure that the right care and support services are being commissioned. Again, understanding the market is crucial as is ensuring that the specification for the service properly reflects the needs (and possibly changing needs) of the people being supported. Increasingly the people who use these services and their families expect to have a say in the choice of provider and the commissioner will need to ensure that they can do so, without compromising the integrity of any procurement exercise that takes place. Extra time and attention may be needed in both designing the procurement process and ensuring service users and carers understand the parameters within which the choice must be made. Advocates may also be needed to assist people through the decision-making process.

## 5 Approaches to Procurement

If, having been through those first stages of the commissioning process, the local authority decides it does wish to secure a new or existing service from an outside body, there are a number of options open to it and a number of further matters to consider. Whilst this paper focuses primarily upon these procurement issues, there will only be a

successful conclusion if the other elements are all in place as well. For example, undertaking consultation exercises with both service users (and their families) and current and prospective providers is often vitally important. That consultation needs to inform and help shape the strategic decisions taken with regard to both the model of service to be secured and the procurement arrangements to secure it. It is also helpful to note the commissioning standards published by Birmingham University<sup>30</sup> and the National Audit Office Principles of Good Commissioning<sup>31</sup>. Some of the more important commissioning considerations are set out below.

## 5.1 Overall commissioning approach

The local authority may already have a well-defined approach to the commissioning and procurement of services set out in its existing policies and procedures. Whilst these cannot, for example, negate the legal requirements around procurement they can add to them or apply a specific interpretation to some elements of them. Some local authorities, for example, have standing financial orders that regulate how procurement for social care services should be conducted when the amounts involved fall below the identified EU procurement thresholds. One example might be that for contracts below, say, £50,000 require four written quotes to be obtained. Another might be the local emphasis placed upon sustainable development, or collaborative working with the NHS.

Whatever, particular characteristics there are, each local authority will have its own locally-determined approach that (hopefully) reflects its own local needs and requirements.

However, it is important that the commissioning arrangements are flexible enough to deal with the range of different needs and circumstances that are being met. As has already been identified, commissioning high volume domiciliary care services can be quite different to commissioning supported living services.

## 5.2 Existing commissioning arrangements

In addition to the overall approach applied locally, there may also be arrangements in place for commissioning services of a particular type. The most common type of arrangements of this sort are Framework agreements that are established by organisations as a vehicle for carrying out future procurements without having to go through a full procurement process each time. (See further discussion below).

Also, authorities have often made decisions about the models of service they wish to procure and how they want to structure their services. For example, most authorities appear to be keeping their Re-ablement and other specialist services separate from domiciliary care, and often (though not always) they have chosen to still retain these services in-house. An alternative approach may be to include Re-ablement within the mainstream domiciliary care service to avoid the disruption caused by moving from a re-ablement service to a separate domiciliary care service after 6-8 weeks. However, this kind of issue is approached, it will impact upon the procurement options to be considered.

<sup>30</sup> Commissioning for better outcomes: a route map (2015) Birmingham University

<sup>31</sup> <https://www.nao.org.uk/successful-commissioning/general-principles/principles-of-good-commissioning/>

Again, existing commissioning arrangements may be very different for different groups of services and service users. This may simply be historical or the result of careful commissioning activity. The commissioning of domiciliary care services for older people is, perhaps more likely to be locked into an historical model than supported living services for people with a learning disability. However, both should be moving towards commissioning approaches that reflect a more personalised and individualised model of service and allow greater flexibility of provision within the overall approach.

### 5.3 Outcome based approaches

Even before the implementation of the Social Services and Well-being (Wales) Act 2014 there was a general move towards trying to incorporate some notion of outcomes (or at least outcomes measurement) into commissioning and service provision. Evidence from elsewhere (e.g. Wiltshire in England)<sup>32</sup> suggests that any significant move towards an outcomes-based model cannot be implemented in provider services alone, and it needs to be part of a much wider programme of change within all of adult social care, and particularly the assessment and care management system.

The shift towards an outcomes-based approach is evident in both the domiciliary care and supported living markets. In either case, the challenge with commissioning outcome-based services is to ensure that the provider is delivering value for money and that the achievement of the identified outcomes is commensurate with the value of the contract. What those outcomes are may very well be different for older people than for younger people with learning disabilities, and to a different timescale. However, in both cases it is important to ensure that in working to outcomes basic issues of safety and the quality of good care are not overlooked.

### 5.4 Working with the Voluntary Sector

The Knowhownotforprofit website<sup>33</sup> has a very good checklist designed to ensure proper involvement of the voluntary sector. Generally helpful, it identifies 12 key points for commissioners to get right. Experience at IPC suggests the addition of two further items, relating to stakeholder engagement and the establishment of any new arrangements:

- Knowing the market
- Developing the supplier base
- Identifying needs and designing services
- *Engaging with stakeholders* \* added to the original model
- *Award of contracts/establishment and/or establishment of new procedures/arrangements* \* added to the original model
- Developing a procurement strategy
- Specification writing
- Publishing contract opportunities
- Pre-qualification

<sup>32</sup> 'Emerging practice in outcome- based commissioning for social care Discussion paper' Bolton, J IPC April 2015

<sup>33</sup> <http://knowhownonprofit.org/how-to/how-to-ensure-a-five-star-public-sector-commissioning-process>

- Invitation to tender
- Contract and payment terms
- Evaluation and clarification of tenders
- Award of contract
- Contract management

## 5.5 Market Analysis

Market analysis is a critical and ongoing element of commissioning activity. Essentially it is being aware of and understanding who is operating in the local market for adult social care services, and particularly in that segment of it likely to be interested in delivering these services. It should be about the likely quality of potentially available services, as well as the number of potential providers.

This has a crucial impact upon how the local authority might go about securing that service going forward, with some obvious (and some less obvious) questions to be asked, including:

- How is the existing market structured? (e.g. does one provider dominate current provision?)
- How many potential providers are there?
- Are they on a sound financial footing?
- Are there new providers who might be drawn into this particular market?
- What are the barriers to entry into the market?
- What is the state of the workforce and workforce development?
- What quality of service can providers deliver?
- How many providers can deliver a quality service?
- How many of these providers also operate in other markets?

If, for example, the market analysis shows there are a large number of financially, sound, competent providers and a strong workforce then this may lead to the conclusion that a competitive procurement process based largely upon price is most appropriate.

Market analysis can also help in determining how procurement arrangements are structured. For example, there is sometimes a tendency to think (even in large counties) that domiciliary care procurement exercises need to cover the whole county. In fact, good market analysis might indicate that a staggered approach (with services for different localities procured at different times) is more helpful to both commissioners and providers and leads to better outcomes.

In some circumstances, there may be a move towards reducing the number of providers delivering particular services. There are some good reasons for looking to have more providers rather than less (for example, providing opportunities for social enterprises, providing greater choice for service users), but these may be outweighed by other factors. These include a lack of provider viability at the available volumes of work, and the difficulties local authorities may face in terms both of the number of different

organisations with whom they have to manage transactions and incorporate into effective quality assurance systems and processes.

Traditionally, voluntary sector organisations have played a significant part on the delivery of services to both older people and people with a learning disability. However, generally those roles have perhaps been somewhat different – in the learning disability field not-for-profit organisations are often major providers of quite resource intensive services. For older people they often (though not always) tend to be providers of more peripheral and ‘light touch’ services.

## 5.6 Extending existing contract(s)

A local authority may consider whether or not to further extend an existing contract without going out to further procurement. Skone<sup>34</sup> argues that this can be done almost indefinitely in order to maintain continuity of service for service users. Whether (or how) this should be subject to EU regulations and compliant with them remains a matter of discussion. Certainly the contracts entered into can stipulate that support provided to an individual may be continued for the duration of that person’s requirement for the service. Contracts can stipulate that a provider takes on all new referrals in a certain category and remains the provider until either the needs or the preference of the service user change. However, this can have an impact upon the wider market and also a provider who loses the contract for new referrals might find it unviable to continue with a diminishing number of existing service users.

Contracts can be extended for other reasons. Some have extension clauses built into them, allowing for a further term to be entered into subject to the meeting of certain criteria, or simply at the wish of the local authority (although this cannot be merely an arbitrary decision)

Other extensions can occur because alternative arrangements or a new procurement process cannot be entered into or completed in time to ensure continuity of service. Generally, this is a matter of necessity and expediency and repeated extensions could cause questions to be raised. Good governance and forward thinking can alleviate many problems (For example, being very clear about when existing contracts are due to end, what extension options are built and what may be required to authorise extensions or further extensions).

## 5.7 Timescale for new contract(s)

The local authority may need to consider for how long it wishes to secure (or extend) the provision of a particular service/the length of the contracts let. This may be affected by the general approach set out by the local authority (see above) but may well be specific to the particular service and circumstances (including the state of the market). For example, contracts offered need to be long enough to be attractive to prospective providers (perhaps including potentially new ones if the market is seen as under-developed) but not so long that they may leave the local authority continuing to contract for a service that is considered outmoded or for which demand has declined. Service continuity may be an issue (again discussed above) but then also may be complacency

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<sup>34</sup> *ibid*

on the part of providers who have secured very long contracts. Also, markets may stagnate if dominated by a small number of providers with very long contracts.

Nevertheless, flexibility is possible. Domiciliary care contracts can be let that stipulate that the support provided to each individual service user can continue for as long as that person requires it.

However, one factor to take into account is the likely turnover in service users over a given period of time. When dealing with people with learning disabilities the timescales are often much longer, often with the expectations that whilst their circumstances and relationships may change over time, their basic needs may remain unchanged over a long period of time. With older people who come into services, on the other hand, there may be an expectation that their basic needs can change often change quite rapidly over a relatively short period of time.

## 5.8 EU and national procurement regulations

As described in the Legal context section, above, all public sector procurements have to comply with the EU directive on public sector procurements and the national regulations that give it force. Compliance is clearly important, and local authorities can be subject to legal redress, including that initiated by unhappy providers who feel they have been treated unfairly in a procurement process. As well as the specific regimes required in given circumstances, local authorities must also comply with the principles of public sector procurement:

- Efficiency
- Sustainability
- Proportionality
- Suitability
- Simplicity
- Fairness
- Equality

EU procurement requirements are often characterised as hoops to be jumped through in order to put a service in place and meet the needs of service users. As in most circumstances, the need to comply with a detailed and technical set of “rules” can bring its own frustrations. However, few people would argue with these principles as they stand, and they do relate to the process of procurement and to the commissioners’ dealings with providers and potential providers. They do not relate as much to the population and the needs of service users, and commissioners sometimes need to work hard to ensure that the two things mesh together. Clear thinking and good planning can assist with that.

The existence of the regulations does push local authorities into having detailed procedures and processes in the attempt to avoid either non-compliance with the regulations generally and/or coming under the ‘Remedies’ directive. It may be that in some cases that it is adherence to those procedures and processes, rather than complying with the principles of the regulations that can create problems in terms of service user choice and control. One example of this was an English local authority

taken to judicial review because it would not include people with learning disabilities and their families on procurement evaluation panels for fear of an unsuccessful provider seeking a legal remedy on the basis that they (service users and carers) may not apply the evaluation criteria in the right way.

## 6 Models of Procurement and Allocation

Just as the number of possible models of service delivery have increased in recent times, so has the number of available models for procuring services and for determining which provider should undertake which pieces of work.

IPC has found that local authorities are exploring different approaches to procurement and the allocation of work and that there is no one consistently preferred approach, with different areas responding to their own particular circumstances and context. In terms of domiciliary care, for example North Yorkshire CC helpfully listed the different contracting options open to them<sup>35</sup>. They are:

**Block Contract** – a tendering exercise is used to establish a successful provider to deliver all the services required at a given time. The specification for the service will indicate what is to be included within it, the volume of service and/or the geographic area covered (if appropriate).

Block contracts can be for a fixed amount of service or for a volume of service that falls within a minimum level (which the commissioners agree to buy no less than) and a maximum level (up to which the provider must be prepared to deliver a service). However, they tend to be more fixed than other arrangements and ‘lock’ commissioner and providers into the agreement on fixed terms. This can provide a degree of security for both, but generally at the expense of flexibility. Block contracts, therefore, are best suited to very stable situations where only little or slow-moving change is expected.

Domiciliary care can be quite a volatile market for a variety of reasons and many people nowadays see them as unsuitable for domiciliary care services. However, as long as the provider is willing to adapt to the changing needs and preferences of the service users involved, they remain a viable option for supported living services. However, especially where new people are coming into the system (perhaps through the transition process from children’s services) it may be very limiting in terms of allowing them any degree of choice as to the provider of their services.

**Approved Provider List** - Providers indicate their willingness to accept work from the Council and can be accepted on the list at any time, subject to any requirements and stipulations a council may make (eg evidence of financial due diligence). This approach can be used in a variety of circumstances, but tends to give a lower degree of control over quality than, say, a framework agreement. It may also mean that the local authority has to deal with a large number of potential providers which can add to the burden around the actual procurement process each time it takes place and also around

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<sup>35</sup> [http://www.northyorks.gov.uk/media/26041/Presentation-from-the-domiciliary-care-in-North-Yorkshire-event/pdf/Re-procurement\\_of\\_domiciliary\\_care\\_presentation.pdf](http://www.northyorks.gov.uk/media/26041/Presentation-from-the-domiciliary-care-in-North-Yorkshire-event/pdf/Re-procurement_of_domiciliary_care_presentation.pdf)

contract management. Within these limitations, they can be used for supported living and domiciliary care services.

**Framework Agreement** – A tendering exercise is used to identify one or more successful providers and to establish the terms of a contract for a defined period of time. It establishes terms and condition covering each contract that may be awarded during the lifetime of the agreement.

There may not be a guaranteed amount of work under the Framework agreement and providers are expected to undertake all work issued to them (Although it is possible to combine elements of a block contract and a framework to set “*floor*” and “*ceiling*” limits on the potential amount of work in order to ensure providers have a greater degree of security). Also, prices may or may not be agreed at the outset.

A framework agreement cannot be for longer than four years and will have an agreed end date, but contracts let under the agreement may be let for a longer period than the Framework agreement itself.

This clearly makes sense when you consider that the time left on a Framework Agreement reduces every day – if contracts were limited to the duration of the Framework agreement itself by the end of the Framework the timescale on contracts would be very short indeed. Should it be appropriate, a 20-year contract could be let under a four-year Framework agreement with only weeks left to run.

Setting up a Framework agreement is a commissioning activity, and crucial to a good Framework agreement is the preparation undertaken at the outset

A framework agreement can be with one or many supplier and can allow for mini-competitions for contracts.<sup>36</sup> Terms can be set down in the original framework agreement but may not be specific, allowing for a further mini competition to be undertaken with all suppliers on the framework capable of meeting the identified need. However, commercial information does not need to be evaluated each time as this will have been evaluated as part of the original tender. Also:

- The process is limited to the suppliers already on the framework.
- The basic terms such as price or specification cannot be renegotiated or subsequently changed.

The areas that can be competed on are generally:

- Delivery timescales
- Invoicing and payment profiles
- Additional security needs
- Incidental charges
- Particular associated services (e.g. installation, maintenance and training).

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<sup>36</sup> Durham University, Procurement Procedures,  
[https://www.dur.ac.uk/procurement/procurement\\_policy/8euregulations/](https://www.dur.ac.uk/procurement/procurement_policy/8euregulations/)

Mills and Reeve on their procurement portal<sup>37</sup> identify that a framework agreement will generally allow for more flexibility both in terms of volume and also the detail of the relevant goods and services. A multi-supplier framework allows a contracting authority to select from a number of suppliers for its requirements, helping to ensure that each purchase represents best value. Also, they confirm that it is possible to use a framework that another organisation has set up, if your "class" of organisation, is listed as being a contracting authority who is permitted to use it. They also note that:

*"it is possible to enter into a framework agreement with a single supplier. However, where the contracting authority enters into a framework with more than one supplier, there must be a minimum of three. There is no maximum number of suppliers in the procurement Regulations, but in practice frameworks with a very large number of suppliers become difficult to manage, as contracting authorities may have to approach each supplier appointed to the framework in relation to a proposed call-off."*

OGC/Cabinet Office<sup>38</sup> guidance points out that a contracting authority who uses a framework without being entitled to do so is, in effect, awarding a contract directly and without the proper element of competition. Framework agreements can be used to commission both domiciliary care services and supported living services for people with learning disabilities. In both cases it simplifies the process for providers and commissioners and limits the amount of work to be done each time a new service (or unit of service) is commissioned.

**Tiered Framework Agreement** – similar to the above, but allows for the identification of a second tier of providers who may pick up work that the Tier 1 provider does not have capacity to do. This provides a safety valve that allow needs to meet where demand is greater than can be delivered by the Tier 1 provider (Tier 2 providers may score less well on quality and/or price in the tendering process).

**Neutral Vendor** – Includes also the option of a successful tenderer acting as both a provider and a broker of services, or just as a broker.

**Innovation Partnership** – Introduced under the new EU Procurement directive issued in 2015, clearly this is as yet largely untested as an approach. A local authority looking to establish an innovation partnership needs to<sup>39</sup>:

- Identify the need for an innovative product, service or works that cannot be met by purchasing products, services or works already available on the market, and
- Indicate which elements of this description define the minimum requirements to be met by all tenders.

It may limit the number of suitable candidates that it *intends* to invite to tender although the minimum number of candidates is three. Once the initial choice of providers has

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<sup>37</sup> <http://www.procurementportal.com/frameworks/>

<sup>38</sup> OGC Procurement Policy and Standards Framework, [http://webarchive.nationalarchives.gov.uk/20110601212617/http://www.ogc.gov.uk/policy\\_and\\_standards\\_framework\\_calling\\_off\\_overview.asp](http://webarchive.nationalarchives.gov.uk/20110601212617/http://www.ogc.gov.uk/policy_and_standards_framework_calling_off_overview.asp)

<sup>39</sup> 'The Innovation Partnership Procurement Procedure explained' Local Government Lawyer briefing, [http://www.localgovernmentlawyer.co.uk/index.php?option=com\\_content&view=article&id=23577%3Athe-innovation-partnership-procedure-explained&catid=53%3Aprocurement-and-contracts-articles&Itemid=21](http://www.localgovernmentlawyer.co.uk/index.php?option=com_content&view=article&id=23577%3Athe-innovation-partnership-procedure-explained&catid=53%3Aprocurement-and-contracts-articles&Itemid=21)

taken place, negotiations may take place in successive stages in order to reduce the number of tenders to be negotiated. There are a number of issues which can arise in practice when using the innovation partnership procedure including<sup>40</sup>:

- This is a new procedure so care should be taken to ensure that the rules are followed and applied and all steps are documented carefully.
- Preparation and scoping of the project is critical in terms of running a successful and focused negotiation procedure.
- Pre-procurement activity is usually key if the innovation procurement procedure is to be used.
- Good project management is essential.
- Timetables need to be realistic and allow sufficient time for bidders to prepare responses.
- A contracting authority needs to ensure confidentiality of all proposals and must not 'cherry pick' aspects of bidders' solutions.
- a contracting authority will need to determine what in fact it considers a 'solution' to be and when it will close the negotiations and end the dialogue/negotiation stage of the procurement process.
- Ensure well-developed bid documentation and clear evaluation methodologies to avoid complaints and potential challenge.

The contracts let under the DPS can be for any volume of service down to that provided to individual service users, or even elements thereof.

**Further variations** - There are also further variations that can be added-in by the commissioning local authority. Those authorities that cover a large geographic area or communities with quite distinct identities may wish to divide up the local authority area into zones to give more localised provision and also the possibility of different rates of payment for the service (reflecting, for example, different degrees of rurality or the different labour market conditions).

As outlined above, local authorities may wish to further differentiate the type of service being commissioned by, for example complexity of needs to be met or timing (operating outside of normal working hours, etc).

**Individual Service Funds** - Another possible variation is the move towards the establishment of Individual Service Funds (ISFs) that are intended to give service users the opportunity to work closely with a provider who not only provides them with a service but also assists them in putting together a wider care package and accessing other resources.

**Dynamic Purchasing Systems** - Dynamic Purchasing Systems (DPS) can be used with a range of services and allow the allocation of individual service users to providers on the basis of a mini-competition. A DPS is an electronic system that is established for the purchase of commonly used goods, works or services and is open to new supplier admissions throughout its operation. They are regulated by section 34 of the Public Contract Regulations 2015, in which it stipulates that '*The dynamic purchasing system*

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<sup>40</sup> *ibid*

*shall be operated as a completely electronic process, and shall be open throughout the period of validity of the purchasing system to any economic operator that satisfies the selection criteria.*<sup>41</sup>

Some proprietary systems exist and allow for the process to be managed online, with no need to for providers to purchase or download specific software. (This is considered to be an advantage particularly for smaller providers.) Many local authorities now use such systems for procuring domiciliary care services, for which they are particularly suited.

Typically, the providers on the system are notified daily of new care packages that need to be fulfilled. Depending upon the criteria chosen (availability, price, speed of response to the notification or having the required service in place, submission of an effective care plan, or some combination of these) the case is then allocated to the winning 'bidder'.

The criteria for winning mini-competitions need to be carefully thought through and will depend upon the levels of need and also the state of market. The key is to ensure that the packages being offered are attractive to providers whilst ensuring some level of competition. Where, for example one type of package is only ever applied for by one provider, then the DPS and the market are not operating properly.

There are potential benefits and drawbacks to a dynamic purchasing system. The potential benefits include:

- Flexibility by allowing a range of providers, subject to meeting the identified requirements.
- A standard framework contract would not allow entrance for new providers for a fixed period of time, which does not support flexibility in the market.
- A dynamic purchasing system sets out a clear quality threshold that providers are required to achieve in order to be part of the DPS.
- The system can be more approachable for smaller suppliers without the resources to invest in applying to join framework agreements.
- A dynamic purchasing system requires less admin time for all parties, benefiting smaller suppliers.
- The process can be more open and transparent for all parties.
- A dynamic purchasing system offers person-centred placements, based on the individual needs of the service user
- A dynamic purchasing system provides a more structured process, which allows providers to submit prices, based on the care package of the service user, but within clear parameters through the use of the floor and ceiling of the price envelope.
- There is no set price for care packages - the market will drive the price.
- A dynamic purchasing system offers the ability to suspend providers on the system, if a level 3 safeguarding and embargo are in place.
- A dynamic purchasing system removes the need for panels

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<sup>41</sup> The Public Contracts Regulations 2015, section 34

The potential drawbacks to using a DPS include:

- There may be a cultural change for those involved in working in and providing social care, as care managers will not be part of the placement process for a service user.
- In line with personalisation, a service user may have a preferred provider. Following the mini-competition process, the preferred provider may not have won the care package. In this circumstance, if a service user insists on their preferred provider they may do so, but be asked to pay the difference in the cost of the service.
- Providers need to be competent and familiar with the system.
- Providers need to register on the system to be able to have new business.

Clearly a dynamic purchasing system is more appropriate for use with a service such as domiciliary care for older people rather than supported living services for people with a learning disability. The high numbers and rate of turnover for the former make it an obvious choice with which to use a DPS.

Supported living schemes can be expensive, and the services for even a relatively small number of people can cost a considerable amount, often easily exceeding the threshold for the 'light touch' EU regime. In most cases, therefore, they will need to be let under that regime. However, in most instances the service users who will be supported by the service will be known as either existing or future tenants in the scheme and need to be involved in any selection process for new providers. (See above).

How the contracts for supported living are 'batched' can be of great importance. Any number of houses/accommodation units can be included in a given procurement exercise. Some local authorities see merit in going down to the individual house whilst others let contracts for much bigger 'schemes'. Amongst the issues to be considered here are how best to involve service users and carers, the state of the market and how to ensure that providers can deliver an effective service and maintain their viability. Also, commissioners may want to combine the procurement of some supported housing services along with other services such as outreach support.

One further point is the importance in re-tendering exercises of being clear with everyone about the TUPE position with regard to existing staff, although potential incoming providers cannot really be required to give guarantees about maintaining existing staff in their current roles. Nevertheless, it is important to recognise that for service users across all services, continuity and stability of staff is a primary consideration.

Long contracts are one way of securing greater stability, although there are risks and issues with letting 'very long contracts'. One is the possibility that the overall service requirements will change, and services need to be 'down-sized'. Another is that providers become somewhat complacent. Effective contract management and the option to give notice on contracts are both needed to counteract these risks. One example of this is Islington Council in London which has a procurement strategy<sup>42</sup> that makes provision for contracts of up to 9 years on the basis that:

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<sup>42</sup> 'Supported Living Accommodation – For Service Users with Learning Disabilities (Complex/Physical and Sensory Needs) Medium to High Needs' Islington Council March 2016

*“The contract length should run over a 3 + 3 + 3 year period. This gives an extended time for a provider to embed the care and support but also the flexibility of two three-year extensions to account for any changes in direction by either local or national drivers legislation.”*

The procurement strategy itself is a helpful example of how the commissioning process can lead to a clear and positive approach to procurement.

## 7 Conclusions

This paper has sought to outline how the required approaches to procurement under the EU and UK statutory requirements impacts upon the wider process of commissioning social care services, especially domiciliary care services for older people and supported living services for people with a learning disability. There are some complexities to be addressed. However, it is for local authorities to address them not to pass them onto providers and, particularly, service users and carers.

The nub of EU and UK procurement requirements is to ensure fairness and transparency and to achieve this primarily through ensuring fair and open competition. This applies even to services that come under the ‘light touch’ regime and those contracts that come under the monetary threshold for even that regime.

Where these requirements most seem to come into conflict with current thinking in social care (in Wales and in the rest of the UK) is in terms of service user choice and control and also the need for flexibility and adaptability that arises out of the personalisation agenda. The degree of ‘process’ seen as needed to ensure the procurement requirements are met can also be a problem.

Whilst these are important requirements, they are not the only ones that have to be met when procuring services and local authorities may at times have to deal with the conundrum of how to commission services in circumstances where they can either comply with the procurements regulations or comply with the social care legislation. Careful risk analysis may play a part in that decision, but fundamentally it would be important to properly secure the care and support needed by the service user as a first priority.

Having said that, effective commissioning before moving to procurement, as outlined above, can go a long way to ensuring that there are minimal conflicts or that they are identified and resolved very early on. Being clear about the most appropriate approach to procurement is vital, as is ensuring that the procedures to be followed have the flexibility to allow service user and carer involvement in the process where desired.

**Institute of Public Care  
August 2016**