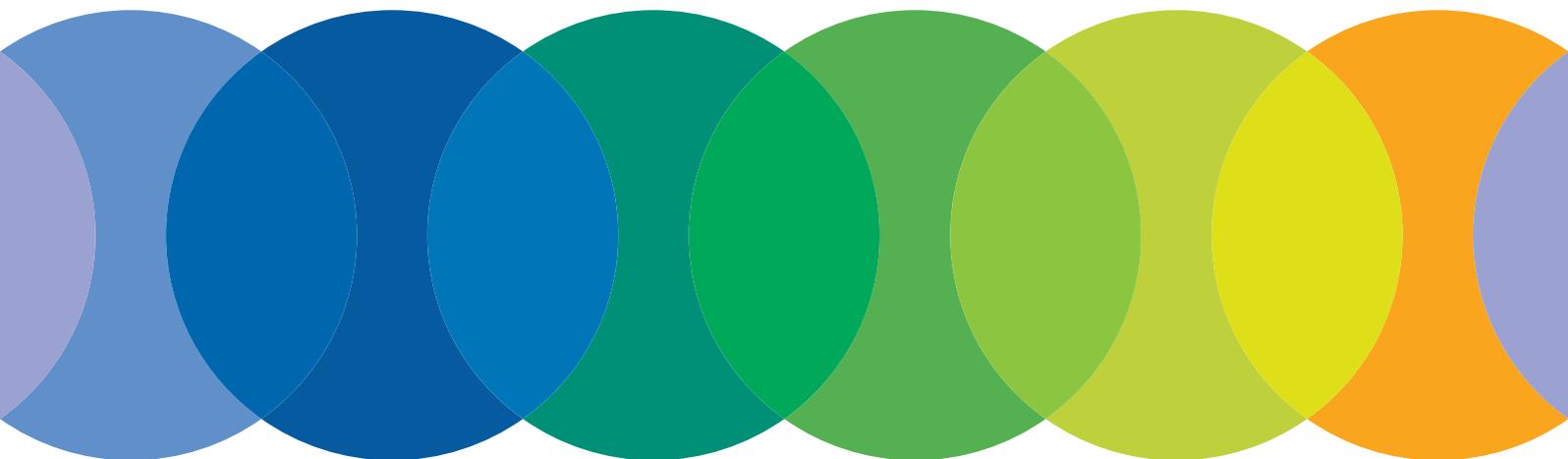


outcome based commissioning and contracting



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introduction

as the costs of social care increase year on year, it has become more important than ever for commissioners of services to ensure that their investment gets results and achieves the desired outcomes

The importance of outcomes in social care has been widely recognized for many years. A focus on outcomes which encourages services users to express the outcomes they want for themselves provides scope for user empowerment and choice. It involves moving from a traditional activity-based approach to service planning and delivery, to a more flexible and responsive model where new thinking is needed about how to measure success.

The government's new *Local Government Performance Framework* takes the objective of achieving better outcomes for all people as its starting point (ODPM, 2005). The Framework promotes an outcomes based approach as a means of improving performance, accountability and consistency in service provision.

Throughout public service, for example, with the publication of *Every Child Matters: change for children* (HMTreasury, 2003) and *Our Health, Our Care, Our Say* (DH, 2006), it is clear that an outcome focus now represents a cornerstone of government thinking about how we define what services should be on offer and how we measure performance:

'Responses to the consultation on *Independence, Well-being and Choice* (DH, 2005) strongly supported the proposed outcomes which it set out for adult social care services, based on the concept of well-being.

These were:

- > improved health and emotional well-being;
- > improved quality of life;
- > making a positive contribution;

- > choice and control;
- > freedom from discrimination;
- > economic well-being;
- > personal dignity.

These outcomes are important to all of us, whether or not we receive social care services. The Commission for Social Care Inspection (CSCI) is already developing indicators to support these outcomes in social care. We endorse them as outcomes towards which social care services should be working, with their partners. We will build on them to develop outcomes that apply both to the NHS and social care. We will also use this set of outcomes measures to structure our goal-setting for health, social care and related activity in the Local Area Agreements negotiated over the next two years.'

Department of Health (2006)
Our Health, Our Care, Our Say

In spite of the promotion of outcome based commissioning and contracting in the UK, clear models as to how to contract for outcome based services are few, and there have been very limited attempts to evaluate the approach.

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definitions

Outcomes refer to the impacts and end results of services on service users. They may be general, eg. improve the health of older people, or individualized and person-centred, where they are based on the priorities and aspirations of individuals. Whether or not outcomes are perceived as successful may thus depend not just on the activities and skills of service providers and care managers, but also on the goals and expectations of service users.

Outcome based commissioning can be defined as any commissioning that links investment to outcomes, which may include shaping and facilitating the market for services. It moves the focus to results that may be achieved for individuals served by programmes and services.

Outcome based commissioning involves the overall setting of strategic goals, while **outcome based contracting** concerns individual arrangements with a particular provider about how they will deliver the outcomes that have been negotiated between the commissioner or purchaser and those with whom they are contracting.

Table 1 illustrates the distinction between outcomes, outputs and processes in terms of commissioning and contracting.

Table 1 Outcomes, outputs and processes

Source: Commissioning News

	Outcomes	Outputs	Processes
Commissioning	Defining the overall strategic direction and targets for a range of provision through the benefits that will be delivered to the people and/or community the commissioning organization serves	The range of services that will be purchased, and for which groups of people	The processes by which the services required will be delivered
Example	We will reduce the proportion of people coming into care homes with a continence problem	We will reduce the number of care beds used by the authority	We will de-commission Sunnyside
Contracting	Defining the investment to be made with a particular organization in terms of the outcomes it will deliver to the people with whom it is contracted to serve	Purchasing volume or amounts of provision in anticipation that it will meet need	Defining the routes and mechanisms by which individual services will be delivered
Example	Care services will ensure that less than 10% of the population they serve will have an untreated continence problem	Care services will provide a specialist continence service	Care services will provide a continence service on a Thursday

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Outcomes may be derived from a variety of sources:

- > National policy and requirements
- > Local policy
- > Research
- > Past practice
- > Evidence of need
- > Consultation with service users

Three types of outcomes were identified by SCIE (2006) which may serve as the basis for commissioning and contracting:

- > Change
- > Maintenance and prevention
- > Service process

To illustrate this, the social care outcomes desired by older people are categorized according to the type of outcome in **Table 2**.

However, service process outcomes are qualitatively different from change and maintenance outcomes in that they relate to how a service is delivered rather than what the service achieves. Change and maintenance outcomes will be specific to individual service users. Process outcomes reflect best practice in how services are delivered, applicable to contracts for all service users.

Table 2 Summary of social care outcomes desired by older people

Source: Commissioning News

Outcomes involving change

- Changes in symptoms and behaviour
- Improvements in physical functioning
- Improving morale

Outcomes involving maintenance or prevention

- Meeting basic physical needs
- Ensuring personal safety and security
- Living in a clean and tidy environment
- Keeping alert and active
- Access to social contact and company
- Having control of everyday life

Service process outcomes

- Feeling valued and being treated with respect
- Being treated as an individual
- Having a 'say' and control over service
- Value for money
- A 'good fit' with informal sources of support
- Compatibility with, and respect for, cultural and religious preferences

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early developments towards outcome based commissioning and contracting in the UK and from the USA and Australia

Outcome based commissioning and contracting of public services is not new. Some UK local authorities tried to develop outcome based contracts in the 1990s under Compulsory Competitive Tendering. There are precedents in developing such contracts in drug and alcohol services in the UK (eg Bolton and Bristol), the US and Australia; foster care services in the US (eg New York City); and employment and training programmes.

These service areas have clear and measurable maintenance and change outcomes, eg addicts stop taking drugs, children are safe from abuse, trainees are placed in employment. The availability of measurable indicators and data may explain why outcome based commissioning originated in these areas.

Outcome based commissioning and contracting has emerged from two parallel developments: the contracting out of public services and the spread of performance management. In the past, contracting of publicly funded services focused mainly on inputs, activity and outputs, for example, numbers of clients or number of hours.

The rationale for outcome based commissioning and contracting has variously been to:

- > refocus attention on the goals of social care services
- > provide greater opportunities for flexibility and responsiveness
- > give greater control to service users
- > encourage creativity and diversity
- > improve quality
- > foster change
- > improve service user satisfaction
- > increase efficiency and effectiveness.

what success has the outcomes approach had in delivering changed end results for service users?

The approach lends itself well to service and programme areas with single issue change outcomes, where it is relatively easy to define and measure outcomes. For example, drugs and alcohol treatment services may involve a process where clients come into contact with the service, are treated (hopefully), and leave.

As a result outcomes may be easier to identify than with an ongoing, maintenance or prevention focused service. In addition, there is a clear baseline to measure against.

A study by the Social Care Institute for Excellence (SCIE) in 2006 identified only seven outcome-focused initiatives that had been established for three years or more in relation to services for older people. Three schemes were concerned with outcome based commissioning and contracting.

Researchers in the US have found that outcome or 'performance based' contracting leads contractors to focus more on performance (Martin 2005), stimulates re-evaluation of service delivery models and improves effectiveness (Gates et al 2004 and 2005). In the UK, there are indications that the approach has resulted in: increased staff recruitment, retention and continuity in home care services (SCIE 2006); more person-centred services; provided a positive means for promoting independence; and supported evidence-based planning for continuous improvement, eg Thurrock. However, in the area of older peoples' services, there is a lack of evidence on the effectiveness of an outcomes focus on improving user outcomes.

A study of the Maine Addiction Treatment Service (Shen 2003) concluded that performance-based contracting gave providers a financial incentive to treat less severe clients in order to improve their performance outcomes, highlighting the need for robust monitoring and evaluation. This latter point is also made by Heinrich (2002). Concerns have also been raised that outcome based commissioning and contracting may disadvantage small community based organizations (Smith and Grinker 2004).

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scope for moving from an output to an outcome basis for contracting for mainstream services

There is scope to introduce outcome based contracting, particularly where measurable change outcomes are sought, for example, intermediate care and re-ablement. Where the desired goal is improvement, particularly if it can be measured objectively (for example with clinical tools), the scope for outcome based contracting is greatest.

Three approaches to outcome based contracting have been suggested by contributors to the Better Commissioning Learning and Improvement Network (SCIE 2006):

- > care managers allocate a block of hours to providers for a group of service users; providers have autonomy to allocate these to individual service users depending on their circumstances and priorities
- > care managers specify the number of hours normally to be received by each service user, but providers have flexibility to move hours between people according to need
- > care managers allocate a specified number of hours to each service user who has freedom to use these in whatever way they wish.

A more fully developed approach to outcome based contracting would involve care assessors or managers defining outcomes; and providers working with service users to define what would be required to achieve those outcomes.

An evaluation of the Department of Health's Drugs and Alcohol Specific Grant (Scott et al 2000) concluded that it appears that outcome funding is most applicable when:

- > it replaces a relatively underdeveloped bidding process
- > the services it supports are easily identifiable and relatively separate from other fields or services
- > the outcomes sought are easily defined
- > the treatment of the client group has a chance of positive success
- > the time of the intervention is limited, and
- > those involved in the administration of the grant are committed to the outcome funding concepts and have acquired the necessary skills to implement them.

A number of factors may hinder the implementation of outcome based commissioning and contracting:

- > regulation and inspection requirements may reinforce an emphasis on activity by focusing on compliance standards and activity-based performance measures
- > output-based government indicators and reporting requirements
- > constraints on resources including finances, time, and staff, and
- > lack of IT capacity.

There is a danger too that an outcome focus will become mainly a change outcome focus to the detriment of maintenance, prevention and process outcomes. This is of concern for some groups, eg people with dementia (SCIE 2006). Measuring issues are a particular challenge for monitoring maintenance, prevention and process outcomes because of the difficulty of identifying appropriate criteria. In addition, maintenance outcome based contracts with, for example, home care providers, require high levels of trust, open communication, and appropriate performance and financial management systems.

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key issues for commissioners of services who wish to develop an outcomes based approach

Moving to an outcomes based approach means greater clarity about what commissioners are trying to achieve for the populations they serve, the rationale that underpins that clarity, and the evidence base for potential service provision that will demonstrate that the outcomes can be achieved.

There will inevitably be tensions in developing an outcomes based approach, for example the need to find a balance between the goal of flexibility to respond to users and their changing needs; the need to maintain predictability in work loads, expenditure and income; and the need to keep audit and payment arrangements simple.

A number of key issues are of particular relevance to the development of an outcomes based approach:

Service configuration and boundaries

Currently output oriented services are configured around tasks and the time required to carry out the tasks. When an organization moves to outcomes based commissioning, traditional service boundaries may not work well, because the range of tasks required for an individual may vary and span across different services. Many outcomes desired by older people do not derive from interventions that currently fall within the remit of social services, for example, continuing to participate in social networks. Home care, residential and other services may need to be redefined.

Switching costs

As Scott et al's evaluation (2000) reported, there may be considerable set-up costs in moving to outcome based commissioning and contracting with demands on staff time and the cost of training commissioners and providers. It may be necessary for providers to employ additional staff given the uncertainty at the outset of what will be required in terms of time inputs to achieve specified outcomes. There may also be significant costs associated with developing the appropriate IT and financial systems to support the change.

How to determine price and charges around outcomes

Currently, a fair price is based on the cost of providing a service output and an appropriate profit margin. The introduction of outcome based commissioning and contracting involves a move away from contracts based on the volume of work in terms of inputs (such as hours and numbers of people) and outputs to contracts where the volume of inputs and outputs required to achieve the specific outcome is not known. Hence, it may not

be possible to set either a fair price or a realistic charge to the service user for a specific outcome in advance.

Table 3 illustrates how the currency of contracts might change.

Determining prices and charges for outcomes may follow past activity or input based costings. However, some flexibility particularly at the beginning may be necessary and resources for financial incentives are often used.

Table 3 A range of outcome currencies

Source: Commissioning News

Inputs	Outputs	Outcomes
Number of people who attend for training	Number of people who complete training	Number demonstrating changes in knowledge, attitudes and behaviour
Number of people starting drug treatment	Numbers completing at 12 weeks	Numbers stopping or reducing drug use
Number of people who sign up for job finding course	Number of people who attend and complete course	Number of people who obtain jobs and are still in them after one, six, and 12 months

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Baseline information

The availability of baseline information on costs, other inputs and current outcomes is needed to provide a benchmark for monitoring and measuring improvement in achieving outcomes.

If suitable baseline information is not available, then it will not be possible to measure either maintenance or improvement outcomes. It may therefore be necessary to collect new or additional data, for example, current level of well-being, or sense of security.

Contracts and indicators

Indicators are needed which reflect the goals of the service. They need to be:

valid - do they measure what they are supposed to be measuring?

reliable - if you repeated the measurement, would you get the same result?

feasible - is it possible to collect the data at a reasonable cost?

amenable to audit - is it possible to collect the data regularly?

Indicators may be **subjective** - the service user feels more in control; or **objective** - the service user can dress him or herself unaided. The challenge is to avoid indicators which reflect the impact of other factors outside the providers' control, or result in unintended outcomes, for example, bullying of 'difficult' service users.

In developing suitable indicators, there is a need for a partnership approach between commissioners and service users, for example, a service user may not wish to increase their level of physical activity. A commissioner may therefore need to negotiate with the service user about appropriate outcomes.

There is a danger that the potential difficulty of designing appropriate milestones and indicators for an outcome based contract may divert attention from the outcomes it aims to achieve. In addition, longer-term contracts may be more appropriate given the time that may be needed to properly evaluate the impact of a service, whether or not it is achieving the desired outcome.

Trust

Existing research (Sawyer 2005) has demonstrated the need for well-established relationships of trust between commissioner and provider for outcome based commissioning and contracting to work. This is vital given the shift that the approach requires involves a loss of control from the commissioner to the provider. For example, if the provider now determines what service is to be received, where previously this was decided by care managers themselves, trust between the two parties becomes important. Good communication and mechanisms such as open-book accounting may reinforce trust between commissioner and provider.

Potential routes for gaining provider co-operation

Provider co-operation is most likely to be achieved where they are consulted at an early stage in the commissioning process; efforts are made to develop relationships with them; and training and support is provided to provider managers and care workers (Sawyer 2005). The availability of additional resources and a willingness to share information and communicate with providers may also encourage co-operation. In Thurrock, the development of a Service User Plan facilitated clarity between commissioner and provider about the approach.

The potential relationship between individual budgets/self directed care and outcomes

Individual budgets and self directed care aim to empower individual service users and enable them to achieve their desired outcomes. Potentially, the two developments should work in parallel with outcome based commissioning and contracting. Within an outcome based care planning framework, individual service users would give feedback on quality, satisfaction and outcomes achieved for themselves.

Potential impact of an outcomes based approach on care planning and assessment

Research for SCIE found that commissioners have had difficulties incorporating an outcomes focus into the Single Assessment Process (SAP). However, solutions included:

a clear distinction between assessment and care planning - listing 10 quality of life outcome domains and four rehabilitation outcome domains in the care plan for social workers to indicate the aim;

introducing outcomes into the care plan - first identifying the outcome, then the type of support required, and then recording the need in the SAP;

adapting the EasyCare version of the SAP contact assessment form to seek users' views on 'outcomes

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we can support you in achieving, how these outcomes might be achieved (your care and options), your preferred choices from these options’.

The evidence indicates a need for staff to be willing to help service users turn their needs into desired outcomes that can be met by a care plan; a care plan format which can capture the desired outcomes and detail of activity required to meet the outcomes proposed; effective and responsive services; a review process which captures achievements; reviews being done; a system for collecting and collating individual assessments; integration with the introduction of joint care and treatment planning.

A model for outcome based contracting

A model for outcome based contracting developed by the Institute of Public Care identifies three elements to support successful implementation: establishing the environment; putting the process in place; and making the arrangements.

Establishing the environment - encompasses identifying the vision, aligning organisational and individual aspirations, redefining the purchasing relationship, changing organisational culture and attitudes of staff (particularly care managers), service users and carers.

Local leadership, effective partnerships and the availability of additional resources for investment may also contribute to providing the environment to support outcome based contracting.

Putting the processes in place - involves thinking about the implications for care planning and assessment; how to measure and monitor outcomes; the fit with other strategies and initiatives, such as Individual Budgets and Partnerships for Older People Projects (POPPs); service design, methodology and processes; staff skills and readiness; and developing the purchasing mechanisms for individuals and agencies.

Making the arrangements - covers agreeing the detail of contracts, service delivery arrangements, costs and the relationship of charging to outcomes.

While the model identifies context and tasks involved in outcome based commissioning and contracting, **Table 4** provides a summary of some key principles for successful outcome based commissioning and contracting.

Table 4 Key principles of outcome based commissioning and contracting

Source: Commissioning News

The market operates within an outcome based commissioning and contracting framework.

The language of outcomes firmly underpins contracts. The distinction between inputs, outputs and outcomes is widely accepted.

Providers take responsibility for stating what they will accomplish for the people they serve and for showing evidence of those changes in behaviour, condition and satisfaction.

Users, patients and carers can express individual outcomes to be achieved and be party to the verification process that has been achieved.

The key question shifts from ‘how many people did we get into services/treatment?’ to ‘how many people benefited and how does that compare with what was projected?’

Commissioners and providers see themselves as active partners, where each party depends on the other for success. Competition and conflict are reduced as mutual co-operation becomes the main mechanism to integrate the system.

Investment decisions clearly take into consideration past data on outcomes achieved and are seen as fair and equitable.

Contracts have modest increases to ensure that providers put in place outcome monitoring systems that give them usable data to manage their services and treat their clients.

Commissioners are investors, rather than funders who passively fund year-on-year; seek a return on investment, and have proof that they have delivered this for tax payers.

Commissioners are held to account for their public promises and the return on investment they bring about in terms of health and social gains.

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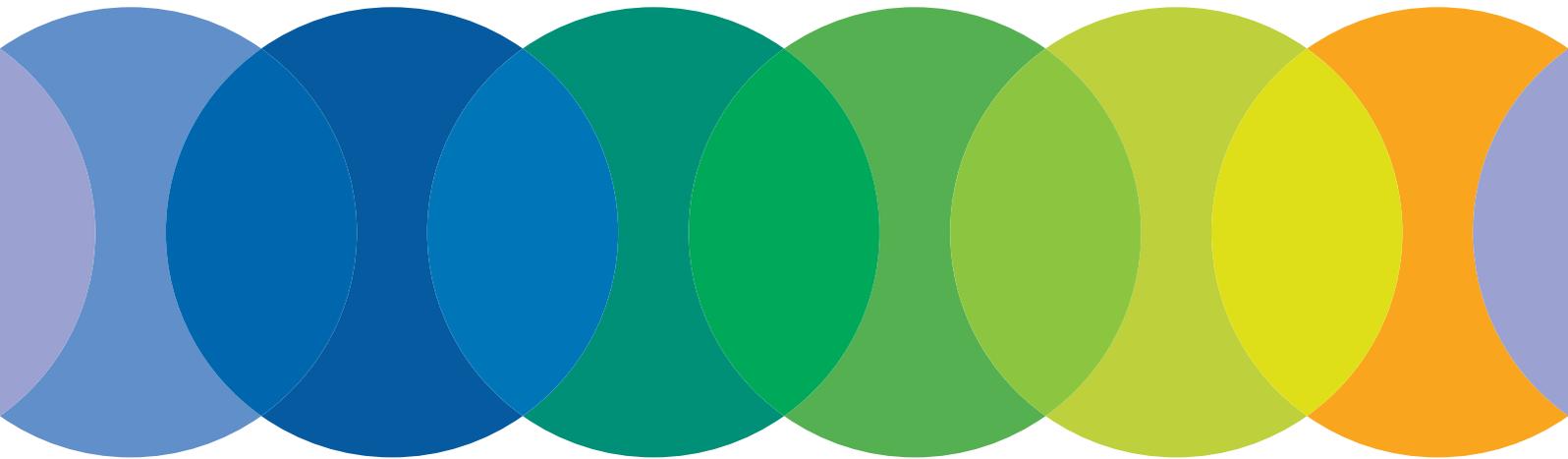
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