TRANSFORMING THE MARKET FOR SOCIAL CARE

Changing the currency of commissioning from outputs to outcomes

4

One in a series of seven papers on market facilitation

institute of
public care

JUNE 2009

OXFORD
BROOKES
UNIVERSITY

PREAMBLE

Government activity since the publication of the 2006 White Paper *Our health, our care, our say* has increasingly focused on the demand side of the social care transformation equation. It has done this by encouraging better estimates of demand through the new local joint strategic needs assessments (JSNAs) and through promoting a shift in who acts as the purchaser of care via direct payments and personal budgets.

However, recognising that accurate estimates of demand are important and giving people greater control over the services they receive can be both empowering and ethically sound, it also needs to be recognised that if social care is to be transformed then the supply side of care also has to change. Some believe this will occur through users flexing their new purchasing muscles, others argue that this has not been true in the past and in a market where increasingly demand is chasing static or diminishing supply, combined with diminished government funding, then this is unlikely to be true in the future.

Consequently, the importance of local authorities influencing supply is increasingly recognised. The government circular *Transforming Adult Social Care* lays down a requirement that authorities develop a clear approach towards the social care market.

"Councils will also be expected to have started, either locally or in their regions, to develop a market development and stimulation strategy, either individually or on a wider regional basis with others, with actions identified to deliver the necessary changes."

This set of papers lays out an approach designed to underpin the market development and stimulation strategy sought by the transformation circular, and in the context that the future role of the local authority towards the market should be one of 'facilitation'. The seven papers outline the following.

- The background to market facilitation.
- A model of market facilitation.
- The views of local authority commissioners and providers towards the market and current policy issues.
- An exploration of whether the focus of the relationship between commissioners and providers within the market should be on outcomes or outputs.
- An improved approach to contracting where the local authority still acts as a purchaser.
- A set of principles by which individuals may contract for services.
- An annotated bibliography detailing some of the key documents relevant to the development of the social care market.

Each of the papers is designed to be free-standing but contribute overall to a new approach to facilitating the social care market.

The views expressed in the papers are entirely attributable to the Institute of Public Care. They are not necessarily the views of the Care Services Improvement Partnership or the Department of Health or those of the local authorities that participated in the activities that have led to their publication.

Commissioned by the CSIP Commissioning Programme in 2008, published 2009

Care Services Improvement Partnership **CSIP**

1. INTRODUCTION

This paper is based on a project managed by the Institute of Public Care that took place during 2007/08, funded by the Care Services Improvement Partnership, Research in Practice for Adults[1], five local authorities and one provider organisation. The work initially focused on the development of an outcome-based approach to procuring services[2]. Its aim was to provide a model by which authorities could move from a purchasing process based on buying a volume of provision, ie hours, days, beds etc, to a purchasing process based on a provider delivering a set of pre-determined outcomes.

Implicit within this aim was also a test. While it had been shown in the past, by a number of projects, that an outcome-based approach to service purchase could be achieved by specialist services, eg substance misuse cessation projects, it remained to be seen whether the approach could be applied to a mainstream care service such as home care.

The intention was that an outcome-based procurement model would be developed through a series of mini-projects with five local authorities and a provider organisation. It was recognised from the start that this was not likely to be a simple process given that the participants were all at different stages of development in their thinking. Consequently, the plan was not to try and start from a single approach, but to work alongside the local initiatives and from them build the differing strands of work into a more substantive approach.

Overall, the only single consolidating factor between participants was a desire to shift towards an outcome-based approach to purchasing. The majority of projects planned to do this through making significant changes to the procurement of home care. Examples of the range of projects included:

• support in developing outcome-based documentation (assessments, information leaflets) and in helping build the local model ready for roll-out across the authority
• a toolkit for outcome-based working for domiciliary care teams
• supporting the necessary changes in culture by delivering initial training and workshops for a range of staff.

As the projects developed, a number of important issues emerged.

• The policy context of procurement of social care services by local authorities was rapidly shifting, from organisations that purchased on an individual's behalf to individuals purchasing their own care as local authorities began to address the emerging personalisation agenda.
• Moving to an outcome-based approach requires considerably more effort than a straightforward refocusing of the contracting process. For example, delivering a different financial basis to the relationship between provider, service user and funder requires changing not just contracts but assessments, care plans and reviews as well. This then has an impact on other stakeholders, from local authority legal and financial services through to inspection regimes.
• The process of purchasing by cost and volume is entrenched within social care, as much from service users as from providers and commissioners, despite its limitations widely being recognised by all parties.

In responding to these issues, the project had to take on a wider focus than that originally envisaged. Consequently, this document not only describes a new approach to purchasing social care services but sets it in the context of delivering the level of change envisaged by the government in its circular *Transforming Social Care*.[3] However, the nature of the change proposed by an outcomes-based approach goes beyond the personalisation cornerstones of individual budgets and direct payments and into the configuration and purpose of the services available. As a lead manager in one of the participating authorities put it:

"If we think that transforming social care is simply an issue of who controls the purchasing process or of allocating a notional value to services that users can spend then we are mistaken. Transformational change means not only changing who buys, but what it is they are purchasing. Personalisation, without outcome-focused assessment and service provision, is merely moving the deckchairs on the Titanic."

---

1 | Research in Practice for Adults www.ripfa.org.uk
2 | There is a lot of loose use of terminology in purchasing in social care. For the purposes of this paper the term commissioning is used to embrace the wider understanding of need and supply that local authorities require in order that the former may be met by the latter. Procurement is therefore a sub-set of commissioning and is the purchase process which facilitates the obtaining of a service to meet an

identified need. Contracting is then used to describe the legal negotiation and contract by which those services are purchased. However, use of the term commissioner is taken to mean individuals who cover any or all of the above functions.
3 | LAC 1 (2008) Transforming Social Care Department of Health 2008

1. INTRODUCTION

Section A of this paper looks at how thinking about outcomes has gradually become more prominent in social care. Section B describes the work of the individual projects. Section C looks at how an outcomes approach might be implemented and how it can be integrated with the personalisation agenda.

2. THE ANTECEDENTS OF AN OUTCOME-BASED APPROACH

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 an approach in drug and alcohol services in the UK, the USA and Australia, foster care services in the USA, and employment and training programmes. An outcomes movement in health care has developed from an interest in the impact of different treatments on health status. However, in general, the development of outcome-based contracting has tended to be limited to areas where outcomes are easily defined and measurable, for example, drug and alcohol treatment services.

Researchers in the US found that outcome or 'performance-based' contracting leads contractors to focus more on performance, stimulates re-evaluation of service delivery models and improves effectiveness. However, a study of the Maine Addiction Treatment Service 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. There are some suggestions that outcome-based contracting may disadvantage small community-based organisations.

In the UK, a study by the Social Care Institute for Excellence (SCIE)[4] in 2006 identified only seven outcome-focused initiatives that had been established for three years or more in relation to services for older people. However, from that work there were positive results. There were indications that the approach had resulted in increased staff recruitment, retention and continuity in home care services and more person-centred services, provided a positive means for promoting independence, and supported evidence-based planning for continuous improvement, eg Thurrock[5]. Most of the work that had been undertaken tended to have been in small-scale pilot projects. While this had been seen as successful by both provider agencies and service users there was still a lack of evidence on a larger scale of the effectiveness of the approach. The kinds of results the above projects described included the following.

Benefits
• Greater service user satisfaction.
• Greater flexibility of service provided.
• Some care staff and some providers feel liberated by a more flexible approach to what they can offer.

Issues
• Uncertainty as to whether it promotes higher costs.
• Greater need for staff training than initially envisaged.
• Hard to work out a good basis for charging for services.
• Care managers find it hard to give up control to providers.
• Some frontline care staff reluctant to change their hours to more of a 'what it takes' approach.

The SCIE project from which these results were obtained also delivered valuable work in terms of conceptualising what an outcome-based approach might encompass. The 2006 SCIE report identified three typologies of outcomes:

• outcomes involving change, eg, improvements in physical symptoms
• outcomes involving maintenance or prevention, eg, keeping alert and active
• service process outcomes, eg feeling valued and respected.

While it may be doubtful whether the last category truly comes within the definition of outcomes, given that it focuses more on how a service is delivered, the framework is nonetheless valuable in terms of distinguishing between outcomes and outputs.

Therefore, although there has been a limited application of contracting by outcomes at local level there has nationally been a substantial shift towards defining the goals of policy in terms of outcomes. For example, there are clear national objectives for children's services:
• **being healthy:** enjoying good physical and mental health and living a healthy lifestyle
• **staying safe:** being protected from harm and neglect
• **enjoying and achieving:** getting the most out of life and developing the skills for adulthood

---

4 | Outcomes-focused services for older people Social Care Institute for Excellence 2006
5 | Sawyer LA, An outcome-based approach to domiciliary care Journal of Integrated Care
   Vol 13 Issue 3 June 2005

2. THE ANTECEDENTS OF AN OUTCOME-BASED APPROACH

- **making a positive contribution:** being involved with the community and society and not engaging in anti-social or offending behaviour
- **economic well-being:** not being prevented by economic disadvantage from achieving their full potential in life.[6]

Similarly, in adult services there are outcome-based objectives as defined in both the Green Paper *Independence, well-being and choice* and in the *Transforming social care* circular. This shift in thinking is not confined to the UK as a variety of governments around the world are looking at how policy can be moved from outputs to outcomes.

While policy goals may be phrased in terms of outcomes, the actions that sit underneath these often still relate to services and hence many of the measures of performance are based around whether services are delivered or delivered to a given standard. Too often measuring services is used as a proxy indicator of outcomes being achieved rather than measuring the outcomes themselves.

A clear example of how this can become dysfunctional can be seen in rail services. The government desires an improved train service because the public tells it the train service is poor. One indictor of improvement is reliability and within that, more trains running to time. The rail companies are then told if they do not improve their performance in running more trains to time their contracts will be terminated. Because this then becomes 'mission critical' the train companies slow down all trains to give them a bigger margin of error if delays should occur. Consequently the train from Bath to London which took one hour, 12 minutes in 1977 took one hour, 31 minutes in 2008. Thus the service is more reliable – reliably slower.

Therefore, the need is not just for strategic commissioning goals to be outcome-focused but also the interventions that flow from these goals. The currency of the relationship between commissioner, provider and service user needs to shift from one of payment for, and measurement of, predetermined

volumes of services to meet needs, to one where payment is based on achieving a mutually agreed set of measures of outcomes achieved.

It was in response to the lack of evidence as to the viability of an outcome-based approach to care across mainstream services and to test whether it was possible to shift the commissioner, provider and user relationship from outputs to outcomes, that this project was conceived. It was decided from the outset that it should focus primarily on home care as an example of major and significant provision. This choice was helped by one or two authorities participating who had attempted some pilot projects in the approach.

Home care as a concept has no fixed boundaries, other than obviously it is about the delivery of care at home. Consequently, it can embrace everything from casual cleaning through to virtual residential care. In terms of state-commissioned provision then currently this tends to be based around a contract between the local authority and a group of registered providers via either a single purchase (spot contracts) or an agreement to purchase a fixed volume of care across a number of individuals (block contracts). The service user has an assessment where a determination is made of the amount of home care to be provided and when and what tasks will be delivered. This process will normally then be described in a care plan, which will be subject to periodic review. The outcomes to be achieved by any proposed intervention, while sometimes stated in care plans, are rarely the basis on which the amount and type of care is purchased.

In general home care can be characterised in a number of ways.

- It operates in a largely fragmented market with over 4,600 domiciliary care agencies (80% of which are in the private and voluntary sector), providing care to around 350,000 households at any one time, at a cost to the state of some £1.7 billion.[7]
- In addition to local authority-funded home care it is estimated that a further £417 million is purchased by private individuals from registered providers. It is likely

---

6 | Every Child Matters Department for Children, Schools and Families 2003

7 | Time to care: An overview of homecare services for older people in Englend Commission for Social Care Inspection 2006

2. THE ANTECEDENTS OF AN OUTCOME-BASED APPROACH

that an even greater volume of informal care is purchased from individuals and paid for outside formal employment processes or under other guises, eg cleaning, gardening.

• Local authority funding increasingly concentrates on higher level packages of care at a substantial and critical level of eligibility.[8]

Overall, home care has substantial support from those who use it although there are still criticisms of certain aspects of the way in which the service is delivered. As the Commission for Social Care Inspection reported:

"The conclusion here is that alongside apparently high levels of satisfaction with home care in England there is a considerable amount of dissatisfaction".[9]

This dissatisfaction appears to arise from an increasing discrepancy between what older people say they want from a home care service and what home care is funded to deliver. While the service is clearly valued, complaints centre on factors such as poor punctuality, early bedtime care where help is needed and weekend care arrangements.[10] Ironically what people seem to most want additionally from a home care service are the things that are outside its perceived primary function, eg care workers who will carry out extra tasks like engaging in social support, such as visits to shops or help with managing finances. Consistency of care workers with whom a relationship can be established is also highly valued. Consequently, the service presents a number of contradictions.

• Care staff are generally strictly limited in the time they can spend with individuals, with some local authorities monitoring payment down to quarter-hour blocks or even minutes. Yet service users prefer care staff who are flexible in their allocation of time, do not appear to be always rushing away and with whom they can build a relationship, ie make it less of a cared for/carer relationship.

• While a person's needs may vary on a day-by-day basis the process of assessment and care planning does not readily encourage the flexibility that users want, with financial restraints further encouraging a tight definition of the tasks and activities to be delivered.

• Because an initial assessment sets the volume and timing of care to be delivered, it is quite possible that some days too little care may be available, leading to a potential deterioration in the service user's well-being, while on other days care may be delivered which is not needed – wasteful in a world of diminishing resources.

• However, if access to care is made to appear difficult and restricted through eligibility criteria and assessments, it is of little surprise that many service users appear reluctant to give up care that they might not need on given days or for periods of time. Giving up on care hours, unless it is within a programme or regime that encourages flexibility, may mean care is harder to come by when it is needed.

• The skill of care workers may be critical in determining how long an individual can be maintained within the community, yet their employment circumstances do little to support this. Pay is low, often travel time is not covered and workers are discouraged from undertaking extra tasks that are important to service users.

• In those services that are tightly defined by time and task, in addition to the cost implications, health and safety concerns and 'risk' are often advanced as reasons for not extending the tasks that service users want. However, the risk to the agency or care worker is rarely balanced against the risk to the service user if these activities do not occur.

• Current contractual arrangements focus on a provider winning either a block or an individual contract to provide a service. However, once the contract has been won there are then few incentives to deliver anything beyond the volume and quality of the service as agreed. Yet if the need is to maintain more people in the community, home care services need to be offered incentives to reduce the level of need and to lessen dependency.

Many of the above arguments sound like good reasons (which they are) for giving people their own budget and allowing the relationship and contract to be negotiated directly between service user and provider. However, it is also important to recognise that the restrictions placed

8 | What councils are reporting on their progress in delivering services to adults with social care needs Commission for Social Care inspection 2007

9 | Time to care: An overview of home care services for older people in England Commission for Social Care Inspection 2006

10 | Palmore C, McNulty A, Making home care for older people more flexable and person-centred Social Policy Research Unit 2005

2. THE ANTECEDENTS OF AN OUTCOME-BASED APPROACH

on home care have not come about because of pernicious or uncaring local authorities. Tighter contractual relationships between commissioners and providers, and providers limiting the activities of their care staff, invariably come about because of financial pressure, something that is likely to increase rather than diminish.

At the heart of this dichotomy between flexibility and control is the relationship between identified needs or problems and a volume of service funded, not to diminish or remove need but to meet it (whatever that might mean). As a consequence, success, from a local authority and a provider perspective, means delivering a service for a given price rather than achieving improvements or diminishing the need for care and support. Improvement may occur but it is essentially a bi-product of the needs meeting process. Therefore, while service users want greater control, quality and flexibility from their services, this has to be achieved within a climate of, at best, maintained spend per head of population.

Personalisation as currently conceived could potentially meet the service user requirements in home care listed above, but not necessarily cost less, neither would it automatically diminish the volume of health care or intensive social care support required. To make that change means introducing a third dynamic – what outcomes are services able to deliver? This means changing not only who makes the purchase, how and with what volume of funding, but defining what is needed to improve health and well-being to maintain older people within the community, as well as configuring and incentivising providers to achieve that goal.

3. SUMMARY

- While commissioning strategies at both a national and a local level are increasingly phrased in terms of outcomes, few organisations have made the shift to contracting on a payment-by-results basis.
- As outlined at the start of this section, the need is to shift the debate about outcomes from a method of defining strategic goals to one where it defines the practical relationships between service users, commissioners and providers.
- Most of the projects in the UK have either been small scale or have focused on substance misuse services.
- There are a number of features of home care services which encourage moving away from a focus on outputs and delivery and onto outcomes and their consequences, not least of which is the discontinuity between what older people say they want from a home care service, and what they receive.
- The individual budgets and direct payments of personalisation will work for some people who currently receive home care in driving forward a better service, but are unlikely to work across all older people. The need is to break the link between need and resource, and to add a third dynamic of testing what outcomes the application of resources can achieve.

1. THE BACKGROUND

As outlined in the introduction, the outcome project on which this paper is based began in September 2007. It aimed to develop a practical model for social care commissioners and providers where they desired to move from an outputs to an outcome-based approach to contracting, ie contracting not by beds or days or hours but by the outcomes for the service user that the provider agrees to deliver. Overall, the project had three particular objectives.
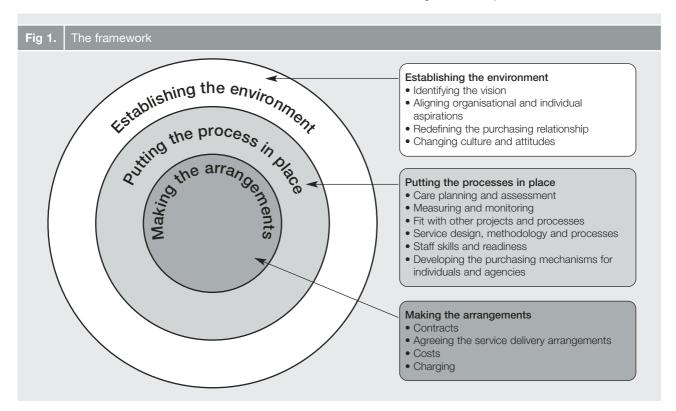
• To provide a background rationale for commissioners as to why the development of outcome-based contracting may prove beneficial.
• To develop a model that commissioners could use to develop outcome-based contracting within their local areas.
• Through a series of mini-projects with participating organisations, to develop or strengthen the practice of local outcome-based contracting.

The following bodies were involved in the mini-projects:
• North Yorkshire County Council
• Bath and North East Somerset Council
• Somerset County Council
• Hartlepool Borough Council
• Care UK
• Thurrock Council

It was recognised that all participants were at a different stage of development in their work and thinking about outcome-based contracting. Consequently, the intention was to not try and produce a uniform approach but to engage in small-scale projects, which, for example, could:
• evaluate work that had been undertaken to develop a local outcome-based model
• work on clarifying and improving particular aspects of the approach for participants that had already piloted projects
• support other participants through the early stages of their thinking and development.

Fig 1.	The framework

Establishing the environment
• Identifying the vision
• Aligning organisational and individual aspirations
• Redefining the purchasing relationship
• Changing culture and attitudes

Putting the processes in place
• Care planning and assessment
• Measuring and monitoring
• Fit with other projects and processes
• Service design, methodology and processes
• Staff skills and readiness
• Developing the purchasing mechanisms for individuals and agencies

Making the arrangements
• Contracts
• Agreeing the service delivery arrangements
• Costs
• Charging

1. THE BACKGROUND

During the early stages of establishing the projects, a number of fundamental questions began to emerge which quickly illustrated that delivering outcome-focused social care was more than just changing the basis of care purchasing. These questions helped to formulate an initial framework for identifying, under three categories, the various principles and arrangements that needed to be in place across commissioning and provider organisations to support an outcome-focused approach. The framework is as shown at Figure 1 with the questions that underpin it in the table below.

Establishing the environment

1. Can we define overall, what an outcomes-driven approach to social care might look like for:
   • commissioners
   • providers
   • service users/carers?

2. Is there an understanding of the difference between the outcomes as described by commissioning strategies, as compared to purchasing care on the basis of the outcomes it might deliver?

3. Who needs to be brought on board?
   • What are service users' and carers' attitudes to buying on the basis of outcomes, as distinct from buying services?
   • Are providers ready or resistant?
   • Are staff attitudes and approaches already outcome-driven? If not, what change in thinking needs to take place?
   • Are there other stakeholders to be involved at an early stage, eg elected members, financial management staff, service user organisations?

4. What might be the range of contractual relationships which need to change, eg block contracts, spot purchases, care arrangements brokered by the local authority? Where service users purchase their own care, how can that be re-defined into an outcomes framework?

5. What might be the potential resource implications of changing the basis of social care procurement?

6. How does re-defining social care interventions on the basis of outcomes relate to national policy and performance? What will be the care regulator's attitude?

7. Does the existing configuration of services look to fit the outcomes to be achieved or will the process encourage or require re-definition of organisational boundaries?

Putting processes in place

1. What are the implications of an outcome-based approach for assessment and care management/care planning processes and documentation?

2. How might outcomes be measured and monitored?

3. How does this initiative link to others such as In Control, direct payments, individual budgets, self-directed care etc

4. What audit, legal and procurement permissions may be required?

5. What evidence can providers offer, or be expected to deliver, to show that what they provide will meet desired outcomes?

6. What retraining will be necessary for both commissioners and providers/carers?

7. What changes will need to be made to current technology and financial systems and procedures?

1. THE BACKGROUND

Making the arrangements

1. How do we link personal budgets and direct payments into assessment, and measuring and monitoring around outcomes?

2. How should care managers assess for outcomes and what is the knowledge base required to deliver this?

3. Will providers be able to provide a range of responses delivered flexibly in order to achieve outcomes?

4. What will be the basis of payment to the provider?

5. How will we set charges for service users against outcomes?

The following pages describe the work undertaken with the participant organisations and the shape of thinking that this eventually led the project towards.

North Yorkshire

Background
In September 2007 North Yorkshire County Council (NYCC) was at the beginning of the process of implementing an outcome-focused approach. During the period of the project they worked to develop an outcome-focused specification and completed a tender process for this service. NYCC felt that the immediate issues that challenged them were:

• to nurture and support a change in culture and behaviours within the local authority so that the design and implementation of all care assessment and management processes are outcome-focused
• to develop better relationships with providers by creating forums for discussing and solving problems together
• to develop fair and equitable charging
• to develop an outcome-based contract.

Project task
It was agreed that the Institute of Public Care (IPC) would focus on supporting the changes in culture by designing and delivering initial training that ensured the development of a consensus in the organisation on what is meant by 'outcomes' and why it is important. This took the form of workshops that involved staff from the NYCC assessment team, staff from the in-house provider and staff from the private provider who had won the tender. Alongside this the Institute of Public Care (IPC) pulled together a range of information and tools on outcome-focused assessment and contracts.

Results
1. The workshops highlighted that there was some way to go in terms of developing the knowledge and skills of all staff. This was not something that had previously been fully appreciated.

2. There was a realisation that the task ahead was huge and therefore a need for an incremental approach to change was required.

3. Having workshops that involved NYCC and private provider staff worked well. It was clear that perceptions were beginning to change and there was a real willingness to work together.

The impact and issues for the project
• Wherever you start within the development framework, ie 'establishing the environment' or 'making the arrangements', it will inevitably result in having to make considerable organisational changes.
• While the staff involved in the training workshops understood what is meant by 'outcomes' they still needed to acquire additional skills to work in this way. Developing such skills probably needs to involve practical coaching rather than further classroom-style training.
• Staff are only going to work in an outcome-focused way if they are reinforced in doing so. Therefore, they need to be inspected and audited in relation to outcomes rather than time and task; supervision, appraisal and promotion needs to be outcome-dependent/focused; the organisational commitment to

1. THE BACKGROUND

outcomes needs to be transparent and transcend all departments and activities.

Action points
NYCC decided to start by changing their assessment and support plan documents, setting up a working party involving a range of staff (both NYCC and private provider). Once the documents were finalised they needed to ensure that staff had the skills to use them effectively so that outcomes were phrased in a specific and measurable way. Finally, the authority did further work on designing an outcome-focused contract.

Bath and North East Somerset

Background
There were three motivations by Bath and North East Somerset (BANES) Council to examine an outcome-based approach.

• The authority had for some time been part of the individual budget pilots and as part of this had begun to look at outcomes.
• There were pockets of work that were being undertaken on outcomes (for example, intake teams). However, it was felt by the authority that this had not been undertaken in a 'whole systems' way.
• The authority was about to undertake a formal tendering process for the delivery of home care services in an outcome-focused manner. As part of this initiative there was a need to achieve a culture shift across both assessment and provider services to focus on outcomes and have more active involvement from service users.

Project task
The key products desired from the project were:
• to continue to develop a framework and tools for measuring and monitoring of outcomes
• to receive feedback from providers on how individual budgets were working and how providers were delivering more outcome-focused services.

In order to develop effective monitoring tools, the tools needed to be aligned with current assessment tools.

However, in reviewing these, it became clear that the assessment tools were not outcome-focused. BANES agreed that these needed to be redesigned. Therefore, IPC and a number of BANES staff were involved in developing the following:
• a block contract monitoring tool
• an outcome-focused resource allocation system
• an individual assessment tool
• a support plan
• an individual monitoring/review tool.

Two provider organisations were approached by BANES and asked if they were willing to be interviewed about individual budgets and outcome-focused services. IPC conducted interviews with a variety of staff, ranging from senior managers to care staff, from each organisation. The findings were then compiled into a report which was discussed at a meeting involving all parties and facilitated by IPC.

Results
• There was a realisation that care managers were still being too prescriptive in the packages of care that were being agreed with service users. It was felt that one way of tackling this was to involve providers in the discussions with service users about their support plans.
• It was recognised that service users were confused about what was meant by outcomes and how individual budgets work and that providers had incurred hidden costs in terms of spending time explaining this to their clients.
• Both the authority and provider staff agreed they needed further training/support in understanding how outcomes should be phrased, assessed and monitored.
• It was recognised that there was a need to rethink some of the protocols around assessment and monitoring. This needs to incorporate the new tools but also what information is recorded on databases and who is involved in the assessment and monitoring.
• In conjunction with the point above, there is a need to design new database systems.

The impact and issues for the project
• There was a need to work with CSCI in order to shift

1. THE BACKGROUND

the emphasis of inspections from outputs to outcomes. For example CSCI required support/care plans to document exact times and tasks. This did not allow for flexibility.

- If staff and service users are unable to phrase outcome statements so that they are specific and measurable, it is impossible to accurately monitor and measure them. This requires making sure that the lessons learnt in training are well rehearsed in practice.
- There is a growing need to have IT systems that can help in recording and monitoring outcomes rather than just measuring outputs and processes.
- Discussions about paying by outcomes focused on the need for there to be some form of sliding scale to payment, based on the degree of difficulty surrounding the outcome to be achieved.
- For providers, delivering flexibility may also require staff to be salaried rather than paid by the hour.

Action points
Essentially the challenge is to consider how to implement a more widespread approach to working in an outcome-focused way. There are three main elements to this:

- to develop understanding and skills of their own and provider staff through joint training
- to develop an approach to support service users to understand an outcome-focused approach, including providing improved information leaflets
- implement appropriate systems and protocols to support the approach. This must include reviewing the current IT/database systems.

Care UK

Background
Health and social care provider Care UK had already conducted a number of pilots in outcome-focused home care. In particular their work in Lancashire had attracted some national attention. However, to move beyond a pilot approach Care UK recognised that they needed to look at their organisational culture and work processes and to explore how a provider can drive forward an approach particularly when tender responses may require that they are phrased in terms of outcomes.

Project task
Care UK wished to make use of their early experiences by sharing what they had learned about changing to outcome-based care with other branches within the organisation through the development and implementation of a toolkit for use by managers and care supervisors. The aim was that the toolkit should contain the following.

1. A description of the change process and the key staff to be involved.
2. A programme of interactive learning team meetings.
3. Aims and objectives for each team.

Results
The Care UK toolkit focused on a training and development process for introducing frontline staff and managers to an outcome-based approach. Its basis was on team creation through:

- establishing an informal and positive working culture among staff
- providing staff with the skills they needed to take on the additional responsibilities that outcome-based care gives them
- enabling staff to approach their new roles with confidence and enthusiasm.

This process required considerable staff time and resources. To start the process Care UK needed care staff to attend a sequence of team meetings initially at weekly intervals. Once the team had demonstrated it was fully trained and competent in delivering outcome-based care, team meetings continued in a fortnightly cycle. The initial weekly meetings typically required around ten weeks' input.

Given the structured approach to development, the change process was gradual, with teams and branches in a region changing in a 'chain reaction' process as more staff become experienced in outcome-based care and were able to take part in training other staff.

The impact and issues for the project
- Moving to an outcomes approach has as much, if not even greater, impact on care providers as commissioners. Not only are changes to staff

1. THE BACKGROUND

processes required but the reasons for change have to be argued through the organisation in terms of the impact on profitability and the likelihood of winning contracts both at an individual as well as at a local authority level.

• Even where providers are willing and able to change their approach this still takes considerable time and resources. For example, the overall time period for managing the change from a branch delivering traditional home care services to one based on teams, each of which was fully trained and competent in delivering outcome-based care, is believed by Care UK to be in the region of six months.

• While the toolkit focused on the introduction of a number of new processes and operational arrangements, carrying out greater responsibilities also required improved background processes, eg the requirement to produce outcome-focused support plans, care notes and reviews introduced new expectations for the quality of these written materials.

Action points
Care UK reviewed all its assessment and reviewing documentation before finalising the details of the toolkit for its branch managers and care supervisors. The organisation aims to introduce the methodology described in the toolkit as each new outcome-based contract is developed.

Hartlepool Borough Council

Background
Hartlepool Borough Council (HBC) have over the last four to five years made good progress on developing an outcome-focused approach to their work. A significant contribution to this progress has been the development of an outcome-focused home care contract and their involvement as one of the In Control pilots for self-directed support. At the time of commencing work the authority was looking to review its existing contract specification for extra care housing. It was felt that there was the potential to move to a better outcome-monitoring process and moving towards paying providers by outcome.

Project task
In order to support these developments, Hartlepool acknowledged the need to address not only changes to assessment and care management but also to the culture, mindset and skills of both the local authority and provider workforce. To help with this IPC were asked to conduct a series of workshops. The first of these was attended by care managers from the authority, the second by private providers and the third and final session by both care managers and providers.

The aim of the programme was to introduce and gain a consensus on defining the key processes, arrangements and skills needed across care management and the provision of services that ensure that the approach is outcome-focused. During the all three workshops, the participants contributed to a range of discussions and exercises using anonymised support plans from HBC to critique and improve:

• support plan format
• the identification and phrasing of outcomes in the support plan
• methods for reviewing outcomes.

Results
• The workshops highlighted that further work needed to take place with care managers in order to make care management processes tighter, for example how to write outcomes into plans and what is meant by monitoring.

• Providers felt that while working to an outcome-based approach may take longer there was a need to develop a local contract and through negotiating that process the real issues would emerge.

• The department needed to give a strong message about how it would introduce outcomes in a whole systems way – what does outcomes mean in this context and what are its expectations for the design of its processes, the skill of its staff and the development and engagement of its providers?

The impact and issues for the project
• There is a need to review how organisations performance manage the outcomes agenda within local systems, eg how to ensure that individual

1. THE BACKGROUND

outcomes feed into the authority's wider strategies, and externally, eg how organisations engage care regulators in this process.
- This work highlights the importance of the fit for purpose state of the care management processes and in particular the need for variation across service users groups, eg what works for learning disability may not necessarily work for older people.
- Providers highlighted the new skills they require in developing care plans, and in managing and quality assuring their support workers if they are being more flexible.

Action points
As a result of the workshops, HBC is working to address the following issues.

- How to meet regulator expectations in respect of providing performance information in an outcomes environment.
- How to link individual outcomes to broader performance management issues that may influence star ratings.
- How to develop an outcome-focused specification and monitoring arrangements for a pilot contract.

Somerset County Council

Background
At the beginning of the project Somerset described the focus of its work as wanting to move to an outcome-based model of support which did not focus on a single area of provision such as home care but which supported the whole care marketplace to move to an outcomes approach.

To help achieve this Somerset intends to bring existing work across the service areas of mental health, learning difficulties and adult social care into a single workstream.

Project task
A range of discussions were held with lead managers about the type of outcomes approach the county might wish to adopt. In order to move to this position, two consultation sessions with a broad range of stakeholders

were conducted in order to undertake testing of an outcomes approach against a number of prototype frameworks. The consultations aimed to look at how service users, carers, care managers, commissioners and providers needed to work together to develop an approach to outcome-based contracting.

Results
It became very apparent during the discussions that there was a need to initially establish a whole range of interdependencies that would enable commissioners and providers to design an outcome-based contract. These included not only contract design issues, but fundamental strategic goals, care management structures and processes, ongoing provider relationships and the development of the care services market.

A common theme in both workshops, expressed particularly by service providers, was the need to review the traditional basis of the relationship between commissioner and provider. Phrases such as 'letting go' and 'trust' typically described the wish of many providers who felt that in order to provide more flexible services, commissioners need to review the details of contract specifications and monitoring requirements. Many comments expressed the need to strengthen the relationships between commissioners and providers, particularly around the development of training and evidence-based service design.

Providers also expressed a strong view that they would want to be involved in the design of the specification and contracting frameworks of the outcome-based approaches.

The impact and issues for the project
- Adopting a new approach across an authority in one go calls for a significant investment in project leadership and management.
- If providers are to have confidence, there is a need for absolute clarity in articulating service and individual outcomes and the basis for their payment. While the workshops only discussed the principle of introducing incentives/bonus there were many comments relating to minimising the level of risk for the provider and

1. THE BACKGROUND

availability of the appropriate level of upfront funding that would continue to allow the business to function and develop.

Action points
Somerset is extending its whole systems approach to developing outcome-focused service delivery and acknowledges that this requires developing a structured approach over time. The following represent some of the activities the authority is developing.

• Review care management and assessment processes to assess how much they genuinely focus on outcomes and what the consequences are of not doing this (if that is the case) for service users.
• Stimulate as part of the transforming social care discussion a debate about how to ensure social care funding delivers the outcomes that your client base wishes and needs.
• Ongoing work with providers to ensure that service design and delivery are aligned with user outcomes and requirements.

Thurrock

Background
Thurrock Council has been one of the national leaders in developing their approach to outcome-based contracting, having run an extensive pilot in home care. The authority now feels the time has come to mainstream the approach across all its care management and home care functions.

Project task
IPC's task was to work alongside staff in the authority and the lead manager in promoting the approach and critiquing key documents designed to help deliver the changes required. There was also a meeting with key providers of home care. Thurrock was working to not only implement its outcomes approach but also to incorporate that within the personalisation agenda delivered through a much altered care management process. As the work developed it increasingly focused on how far the change may actually go and how to put boundaries around the move towards outcome-based contracting.

Results
Considerable work has taken place during the project to put in place new assessment and care planning processes, together with documentation for staff and service users. Changing the basis of payment for care has also been agreed with an element of outcome-based incentives being put in place.

Impact and issues for the project
Thurrock has helped to clarify the extent of change which a true outcome-based approach may entail and some of the obstacles to delivery.
• At the heart of the process is a user-led self-assessment phrased in terms of outcomes to be achieved as compared to services to be delivered.
• The traditional care management role needs to radically change to one of both advisor/broker but also potentially an intermediary between the provider, with whom the user contracts, and the user themselves.
• Outcome-based thinking needs to permeate the approach of the local authority even before a service user gets to an assessment, eg there needs to be a change to front desk services so that people are not immediately defined in terms of their potential eligibility for a service.
• In terms of obstacles the major test has been whether it is possible to deliver a true outcome-based approach if providers are still funded on the basis of hours delivered.

Action points
Thurrock is implementing its outcome-based approach by continuing to reconfigure its care planning and assessment documentation, re-defining its relationship with its key providers, changing its approach to care management and monitoring the impact of change on service users, and continuing to explore the financial basis of payment and charging for services.
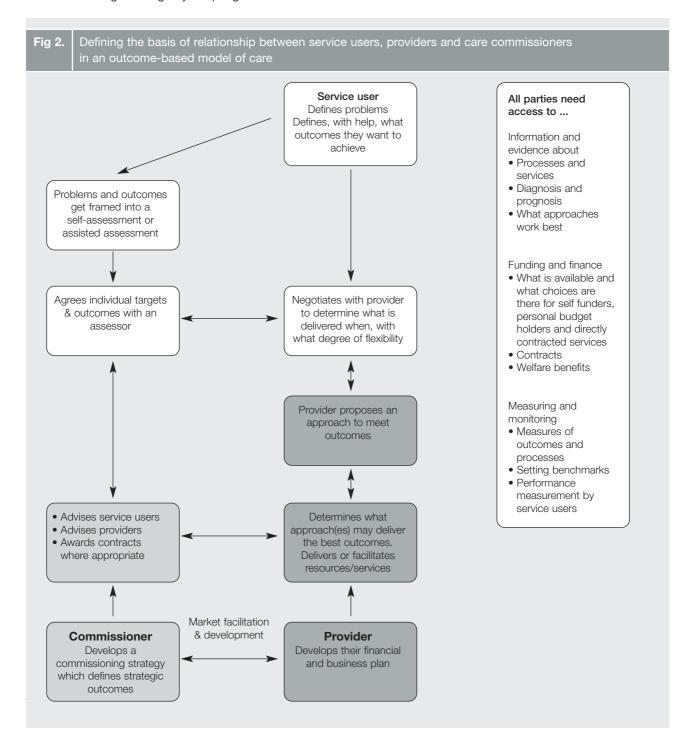
2. SUMMARY

- Outcome-based thinking is a whole systems approach and therefore needs to permeate through the social care function and through providers. Like all major change projects this requires significant investment in project leadership, management and time.
- Despite this, most of the local authorities in the project felt that the approach was best progressed through small localised projects, for example the introduction of an outcome-based specification in a discrete geographical area, or for a new service. It was recognised by all that fundamental to the success of any pilot was a good working relationship between provider and commissioner and a willingness to be flexible and share risk.
- Commissioners and providers were tentatively exploring whether there was a half way stopping point en route to a true outcome-based approach, ie with providers still funded on the basis of hours delivered. In taking this perspective commissioners felt they could minimise the level of risk for the provider by ensuring the availability of the appropriate level of upfront funding, but with some financial incentives.
- The traditional care management task needs to radically change in order to permit both staff and processes to be truly outcomes facing. While some care managers felt confident in this task, there were many who felt unsure about their capacity to identify outcomes, about personalisation in general and new care planning and assessment processes in particular.
- Both commissioners and providers were not confident that their current performance management arrangements had the ability to record and monitor outcomes. In addition, local authorities and providers would need to review how they could evidence their outcome-based performance to inspectors.
- Providers highlighted the need for new skill ranges in their staff to develop outcome-focused care plans and in managing and quality assuring their support workers. Additionally where care staff work flexibly to deliver outcomes, providers may also require staff to be salaried rather than paid by the hour.
- Nonetheless there was an increased determination, by commissioners, to progress an outcome-based approach and extend this into payments.

1. INTRODUCTION

Based on the outcome project, this section on implementation looks at the various key stages of the care process from an initial enquiry through to receiving services and explores issues with the current system and how this might change by adopting an outcome-based approach. Fig 2 diagrammatically displays some of the elements of the relationship between service users, providers and care commissioners in an outcome-based system.

Fig 2. Defining the basis of relationship between service users, providers and care commissioners in an outcome-based model of care

Service user
Defines problems
Defines, with help, what outcomes they want to achieve

Problems and outcomes get framed into a self-assessment or assisted assessment

Agrees individual targets & outcomes with an assessor

Negotiates with provider to determine what is delivered when, with what degree of flexibility

Provider proposes an approach to meet outcomes

• Advises service users
• Advises providers
• Awards contracts where appropriate

Determines what approach(es) may deliver the best outcomes. Delivers or facilitates resources/services

Commissioner
Develops a commissioning strategy which defines strategic outcomes

Market facilitation & development

Provider
Develops their financial and business plan

All parties need access to ...

Information and evidence about
• Processes and services
• Diagnosis and prognosis
• What approaches work best

Funding and finance
• What is available and what choices are there for self funders, personal budget holders and directly contracted services
• Contracts
• Welfare benefits

Measuring and monitoring
• Measures of outcomes and processes
• Setting benchmarks
• Performance measurement by service users

2. OUTCOMES AND THE 'FRONT DOOR'

Care services tend to present something of a conundrum. On the one hand people are deterred from coming forward for services through mechanisms such as means testing and eligibility criteria, yet if demand for intensive health and care provision is to be diminished certain populations need to be encouraged to receive services earlier. Often people can be deterred long before they ever see anyone from social care. This might be by public perceptions of services as being inappropriate or stigmatising or by re-signposting at a local authority front desk or GP surgery. There are a number of consequences to this which fundamentally underpin attitudes to service provision.

"Attempts to manage demand typically take the form of rationing by diversion, particularly through the use of 'signposting' to send people to seek help elsewhere. Often this is for help with those essential areas of daily life pejoratively viewed as 'low-level' need – help with keeping the house clean and tidy, managing the garden, help with shopping, and access to companionship and social opportunities. Often such directions lead down cul-de-sacs, and councils fail to check on the value or success of these diversionary tactics in meeting people's needs."[11]

Older people in the past have frequently complained of having to go from one department or organisation to another. As a consequence people not only fail to get services to which they are entitled, but do not get provision that is needed if more intensive interventions are to be avoided. From the provider perspective it creates an approach of 'not our problem' if the need is not matched by what that particular organisation has on offer rather than a 'we will sort it' perspective.

While not unique to refocusing thinking around outcomes, a changed approach needs to start from a generic, and somewhat wider, front door to health, care, accommodation and benefits. It might start from asking the person to describe in general terms what they want and what they might want it for, before leading onto a discussion of how a particular problem or issue might be overcome, what resources the person has available to them and a combined initial assessment by the older person and a broker/advisor of current and future risk.

The approach should be one that encourages discussion of problems and focuses on their resolution alongside the capacity to analyse risk and recognise early warning signs of potential difficulties. It should not be focused on services.

This discussive approach is particularly pertinent for older people. As we age, albeit at different rates and timescales, we tend to become more infirm and lose intellectual capability plus there are increasingly frequent reminders of mortality and morbidity amongst friends and family. In short our natural fortitude diminishes and the struggle becomes greater. Consequently, if access to care and support is made difficult but its acquisition is necessary then gaining help becomes an additional problem rather than a benefit. From this point any number of precipitating factors may accelerate that initial 'shove' down the path towards a hospital admission or a care home.

"The needs most frequently excluded by FACS eligibility criteria were those associated with domestic support and practical help. People care about the state of their homes and gardens; when their world is reduced to little more than their four walls these issues become disproportionately important. Denied help from the council, and often unable to access alternative help through signposting, the risk is that these low-level needs can escalate as people try to cope unaided and may have accidents in the process."[12]

A much more 'on demand', non-service-specific approach which looks to jointly review need, assess risk and define outcomes to be achieved may not lead to any state-funded service or any service at all. Indeed the approach may be configured to assess every possible way to resolve a problem without access to state-funded resources. However, at its heart is access to information and good quality help when needed. For those needing greater help who do not have the resources to access it now or who have a number of risk factors, this approach can offer a personal stocktaking and problem resolution service which can act not only as a gateway to assessment, but also to identify potential future risk.

---

11 | Checking the FACS The Guardian 13 February 2008
12 | Lost to the system? The impact of Fair Access to Care Commission for Social Care Inspection 2008

2. OUTCOMES AND THE 'FRONT DOOR'

Key features of an outcome-focused approach to access

- An advice and information service that is not seen as a public sector service and can offer advice and help based on the concerns of older people across all sectors.
- It goes beyond signposting and employs staff as problem solvers designed to identify risk and produce solutions in co-operation with older people.
- It does not rely on leaflets but is available in person, by telephone and via the internet.
- The outcomes such a service might deliver for older people should be closely monitored both in terms of promoting well-being but also in avoiding increasing the need for care and dependency.

3. ASSESSMENT

In the last 10 to 15 years in social care much attention has focused on the assessment process. If only we could assess better and jointly with other agencies we could save time and offer more effective interventions. Yet despite attempts to make assessment more structured and scientific and to develop single assessment processes most service users feel that little gain has been achieved. Older people still complain about the number of times stories have to be repeated and about the plethora of different people who deliver services. There is still a sense of assessments emphasising what people cannot do rather than what they can and what they might need assistance with. If an assessment focuses on incapacities it is only a short step from there to underlining dependency rather than independence.

An outcome-based assessment process should try to focus on what is the desired end result the person wants to achieve rather than what can they can or cannot do or who holds the power in completing the assessment. While both of these other factors are important they are only contributory influences to the main aim of making sure that the assessment focuses on the benefits or outcomes to be achieved.

In this environment the test is not about crossing a threshold of need or incapacity, neither is it necessarily even about what people want (in terms of services) but what outcomes are necessary and desired to improve this person's health, well-being and quality of life. The process should separate out the business of assessing what outcomes are sought from the services that might deliver them, the latter becoming a planning process between service user and provider.

Therefore, either the service user or the service user with help from a relative, a care broker or care assessor completes an assessment process which is focused on the outcomes the individual wishes to achieve and why. These may represent improvements in or maintenance of their current situation although they may not reflect a return to full health, eg for someone with dementia the outcome may be about maintaining a set of activities for as long as possible or about the way in which they wish their condition to be managed.

Key features of an outcome-focused assessment process

- Overall, a good outcomes assessment comprises three components.
  - It starts from a service user's perception of the outcomes they wish to achieve.
  - Alongside the assessment of outcomes desired, runs an assessment of risk – what might happen now or in the future if these outcomes are not achieved.
  - Finally, the process does not devalue expertise, it encourages discussion and dialogue about what might be possible between not just the care assessor but any other knowledge source that either the service user or the care assessor might wish to bring to the table.
- The assessment is completed by the service user but with advice and help from a care assessor or care manager where necessary and appropriate. If the desired outcomes are simple and straightforward and do not involve high risk now or in the future to the service user then the user can choose whether to involve the local authority further in procuring a service or do that for themselves.
- If the assessment calls for delivering more complicated outcomes or there are high risk factors present then once the assessment is agreed it is passed to a care provider of the service user's choice to agree a plan for provision.
- The assessment also needs to encompass people's wider resources so that when a care plan is discussed it can look for solutions that are not just about state-funded services but how existing sources of care and help can be additionally supported.

4. ELIGIBILITY

"Deciding to seek help from social services is rarely made lightly or frivolously. People typically seek help only as the result of a crisis and when they have exhausted all other possible avenues. For people who fail to meet the eligibility criteria of FACS the experience of assessment is one of frustration and disappointment that they can be offered no help. For people who are just about coping, but with considerable difficulty, the situation is bewildering."[13]

Currently access to services is based on a level of need or problem relating to a degree of risk which then gives proportionate access to a level of service provision. Fair access to care services (FACS) is designed to ensure that fairness is about making sure there is an equivalent level of resource available to people with roughly equal needs. Individual budgets take a similar perspective in translating a notional level of service into funding via resource allocation systems (RAS).

There are two main problems with this process. First, while Department of Health guidance[14] talks of 'presenting needs' from which 'eligible needs' can be disaggregated it decouples this from risk. Whereas it is risk or incapacity (as the substantial/critical framework) that then determines whether the individual is eligible for resources. Secondly, the process then fails to identify why or how the availability of resources might diminish or lessen the risks presented. As mentioned earlier the only requirement is to 'meet need' rather than alleviate or diminish it.

In effect this process puts care and support into the same bracket as entitlements and benefits, where a given level of incapacity equals funding or access to resources. However, there is nothing within the process that then specifies how the availability of those resources will diminish the risk that led to their acquisition. Therefore, the additional ingredient to be added to the eligibility process, is what outcome does the individual desire to achieve that will meet their needs and lessen risk and what activity delivered, funded or facilitated by the local authority might help to achieve that.

Interestingly, taking outcomes into account has long been implicit in the government's perspective of eligibility criteria although not always evident in its application. For example the FACS guidance states:

"What is important is for people with similar needs to be assured of similar care outcomes, if they are eligible for help, irrespective of the services that are provided to meet eligible needs.

"Assessment should be carried out in such a way, and be sufficiently transparent, for individuals to:
- *Gain a better understanding of their situation.*
- *Identify the options that are available for managing their own lives.*
- *Identify the outcomes required from any help that is provided.*
- *Understand the basis on which decisions are reached."*

Consequently, developing outcome-based eligibility criteria may not call for a major overhaul of the eligibility system but rather its refinement and improved application. To achieve this the process needs to overcome three key hurdles.

- By tightly linking needs with resources the eligibility process discourages other forms of help being brought into the package.
- Eligibility tests discourage a preventative approach because if people do not cross the threshold at the time of assessment they are not eligible for resources even though the acquisition of help now may prevent later poor outcomes. While the FACS criteria talk of future need in reality the impression is that this appears to be rarely considered.
- By making the eligibility threshold increasingly hard to cross it encourages people to hold onto resources once obtained and hence provides no incentives for improvement either by the service user or the provider.

---

13 | Lost ti the system? the impact of Fair Access to Care Commission for Social Care Inspection 2008
14 | Fair Access to Care Services: Guidance on eligibility criteria for adult social care LAC (2002) 13 Department of Health 2002

4. ELIGIBILITY

Key features of an outcome-focused approach to eligibility

- The process needs to start from a determination of four factors.
  - What are the risks to the individual now and in the future if some intervention from somebody does not occur?
  - What are the outcomes that the individual desires which would lessen the degree of risk?
  - Are these outcomes achievable by the application of some resource or intervention?
  - Do the outcomes lie within the legislative requirements of the state to fund, facilitate or deliver?
- There needs to be a much better appreciation of future risk and an identification of which early intervention really does achieve the outcomes desired, eg 'if these mobility issues are not addressed now what does research and past practice tell us is likely to be the outcome for the individual'.
- Defined outcomes need to be focused on improvement, re-ablement and a better quality of life, even where an individual's physical or mental health may inevitably deteriorate. To achieve this it needs to be made clear that resource investment may vary but that it will always be available to meet the agreed outcomes. The commitment is to helping meet the outcomes not to a level of resource.
- The release of funding is then not constructed around a set of needs being met by a package of actual or notional services but around the degree of difficulty, given the risks for that individual, of achieving the outcomes that are desired and agreed.

5. CARE PLANNING AND SERVICE DELIVERY

Currently, like assessments, care plans tend to be static documents that are periodically reviewed and revised. The plan should of course be a statement about what services are required, in what frequency, to meet the needs identified through the assessment. There are a number of problems with this process.

• A plan produced at a fixed period in time can make it difficult to reflect needs that may change on a day-by-day basis.
• All too readily both planner and planned-for may be aware of a limited range of services to meet needs, so both covertly conspire to fit the problem to the service rather than the other way around.
• Plans and assessments may not always be given the time needed to reveal the depth of issues and problems facing older people. Issues, for example, such as incontinence, people may not find easy to talk about, particularly if other relatives are present, or they may not be recognised as a treatable problem if they are discussed. The danger is that a plan is then formulated which tackles the visible issues defined by what service is available rather a wider discussion of how needs might be resolved.
• The provider may not be present at the formulation of the care plan, so the person or individual that is responsible for meeting needs is not a party to the discussions that formulate what is required. However, in a world where commissioning and provision is separated it is the latter who may have much expertise about how needs might be met.

Assuming the provider community has been fully prepared for the approach, and after either the service user or the local authority has selected who they might wish to have work with them, the provider then negotiates with the service user how their outcomes might be achieved and how their achievement will be measured. So how might this process actually work? Suppose a hypothetical service user has a problem with mobility which is also contributing to their social isolation and increased risk of both falls and a care home admission.

• The assessment should provide an overview of the problem, the outcome that is desired, the risks involved and the degree of difficulty. Eligibility tests would be applied at this point.
• The provider would then negotiate and discuss with the service user how this outcome might best be achieved and agree any milestones and measures along the way.
• The provider then develops the plan; outcomes to be achieved, the range and flexibility of the activities to be adopted to deliver this, the preferred approach, the evidence underpinning why this would work and the end point to be reached.
• The provider may seek to use the funding to provide services themselves, to commission from a third party or to use money to provide additional support to current carers.
• The provider is incentivised by the process to find the best/quickest/cheapest route to delivering the outcome rather than as now where once the contract has been won there is no incentive for the provider (and indeed every disincentive) to lessen the dependency of the service user.

The above only represents an overview, there is of course much more detail that needs to be built into developing the approach as well as safeguards to ensure that appropriate methodologies are used, risks minimised and service users safeguarded. Boundary issues between health and social care needs and the potentiality of one to contribute to poor outcomes for the other still need to be resolved.

Nonetheless the virtue of the approach is that it gives those that deliver the service incentives to achieve improvements for service users and to use their day-to-day knowledge and expertise of older people's circumstances to deliver services that are much more flexible in defining how needs might be met and outcomes achieved. Therefore, in the example, above, the provider might find a volunteer to walk with the service user, podiatry issues might be better addressed, advice from the provider's own physiotherapist might be used as to how the care service could improve gait and balance and hence increase confidence in walking. The key is in delivering what is needed now to achieve the outcomes required.

5. CARE PLANNING AND SERVICE DELIVERY

Existing research[15] has demonstrated the need for well-established relationships of trust between commissioner and provider for outcome-based contracting to work. This is vital given that the approach as outlined here involves some 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, trust between the two parties becomes important.

Key features of an outcome-focused care planning and delivery process

- The care provider offers a series of differing approaches to achieving the outcomes desired, agrees when and what services will be delivered and the degree of flexibility that the service user desires.
- Where the local authority is funding the outcomes it might work with providers to explore in advance the range of options available for meeting typical outcomes and the methodology that might underpin their success.
- The care plan embraces what is needed to achieve the outcomes for the service user including what others might additionally provide. Because the care provider is responsible for delivering the outcomes and is paid accordingly they will be incentivised to co-ordinate the range of provision and make sure it works well.
- If there is a disagreement about the services to be provided or about the flexibility of their delivery then the care assessor can act as a mediator.
- The care assessor needs to have expertise in understanding what outcomes may be possible and the evidence to support this. The assessor works with the care provider to encourage innovative ways of meeting the service user's outcomes.

15 | Sawer L An outcomes-based approach to domiciliary care Journal of Integrated Care
Vol 13 Issue 3 June 2005

6. PAYMENT AND CHARGING

At the heart of the outcome-based approach is shifting the basis of payment from outputs and processes to results. While it is possible to define existing processes such as the assessment, the care plan and the interventions, the real shift in provision is only likely to take place, and be sustained, when providers are paid by the results that they deliver. Without this the danger is always that the provision of a service gets used as a proxy indicator for achievement and that the whole process focuses around this rather than the outcomes for the service user.

However, in developing the approach it needs to be recognised that in the case of home care demand (if not funding) outstrips supply and providers have to resource services upfront to even be able to contemplate the outcomes they might deliver. Therefore, in all likelihood, the question is how can a gradual shift be made to outcome-focused social care without the risk that it makes providers vulnerable or builds in its own downfall by still keeping payment based around volume.

The approach suggested here is one of a step-by-step change.

The first stage in the process could be by defining the assessment and care plan processes around outcomes and then potentially setting a chargeable range within which providers can invoice, but leaving the flexibility of day-to-day allocation to be negotiated with service users. Where a block contract or guaranteed contract is used a variation on this approach could be to provide a guaranteed maximum payment against the delivery of a range of outcomes for an agreed number of individuals. At least both of these approaches shift the emphasis to the provider/service user negotiation, refocus thinking around outcomes and potentially offer flexibility in terms of the services provided.

West Sussex in their outcomes pilot[16] (although not a participant in this project) introduced a similar process by using a combined pot of hours over a four-week period and then letting providers and service users negotiate any increase or diminution in time needed during that period within the overall amount of funding.

Beyond this the next stage could be to gradually introduce payment by results. One approach might be to break the payment down into three parts.

- A guaranteed minimum for providing the service, eg 80% of the current contract value.
- A further 20% would then be available on the delivery of the agreed outcomes.
- Finally, an incentive payment could be achieved if a provider exceeded the anticipated outcomes and maintained more people in the community. The aim would be that this funding would be available on the basis of the greater savings made in more intensive provision.

There are of course similar issues around charging. Currently service users are charged based on their capacity to pay and the volume of service they receive. An outcome-based approach which still maintained charging by volume could introduce disincentives into the system. Someone may not wish or be able to pay a high price for a short period of time. Again the suggested approach would be to grade severity of desired outcomes into bands or tariffs. Each tariff then gets charged at a fixed price regardless of the volume of service received.

Key features of an outcome-focused payment and charging process

- The system needs to have at its heart a shift from payment by volume and services to payment by results and outcomes achieved.
- The move towards payment by results needs to be undertaken gradually with the risks to the provider's business fully researched and understood.
- The outcomes to be achieved and how they will be measured should be agreed in advance by all parties. The payment process will be contractually binding regardless of whether payment comes direct from the local authority or via a direct payment or individual budget.

---

16 | Outcome-based commissioning of home care: Evaluation of pilot programme West Sussex County Council 2007

6. PAYMENT AND CHARGING

- Charging will be based around the degree of significance and difficulty of the outcomes to be achieved, not around the amount of service delivered.
- Where elements of the agreement are contracted out to third parties payment will be the responsibility of the provider.
- In the initial stages of development there may be compensatory arrangements for providers where outcomes are not achieved.

7. OUTCOME-FACING PROVIDERS

In developing an outcome-based approach, as has been hinted at in the preceding section, the need to ensure that providers are on board and committed to this way of working is vital. As was discovered in the pilot project some providers will readily embrace the approach and see it as a logical next step in the development of home care. Others will be more cautious and may question what is the motivation for them to change in a market where demand is already high and current arrangements and service configurations serve them and their staff well.

It is also important to note that given an increase in self-funding, both from people's own resources and via direct payments, then the whole market needs to move in this direction not just those providers with whom the local authority contracts. For those services that the local authority still provides it may well be beneficial for the authority to lead by example in defining its own provision around outcomes.

Nonetheless the nature of the change for providers is substantial, and although having at its core payment by results it encompasses issues beyond those simply about how care is funded. For example, if a provider needs to obtain a significant element of their income from the achievement of outcomes then they will wish to have greater control over the resources and services that can deliver those goals.

Not only is home care a concept defined by the nature of the service it offers rather than what it might achieve, but if a broad outcome is to maintain a higher proportion of older people in the community then providers will rightly want to control the range of resources that can deliver that. Consequently, refocusing provider services around the outcomes to be achieved drives a reconsideration of organisational boundaries, which in this example may see home care, Supporting People, care and repair and assistive technology all being delivered in a co-ordinated approach through a single organisation. From there it is only a small step to bring community health services into the same structure.

In this way the approach begins to mirror the best of care delivered by spouses and sons and daughters, ie

the carer does what is needed to ensure the best outcome possible for the person they are caring for, rather than defining what they do by function, organisational boundaries or professional territory.

Implementing the approach also means considerable changes for the staff that care agencies employ. In complex care packages that cut across the range of existing services it is likely that both a greater breadth and depth of skills will be needed. Care may be delivered by micro teams of carers working with small groups of service users in order to provide the consistency and flexibility required. The basis of these arrangements already occurs informally when carers balance the time available to one person against the immediate need of another, giving slightly more to one at the expense of giving another slightly less. The problem is that such an approach is actively discouraged by both providers and commissioners where performance and funding is locked into time-based care delivery slots. As a consequence, the very flexibility that users desire becomes a covert, hidden and unrewarded activity.

Of course some elements of care may not change very greatly at all. For example, where the task to be performed is simple and straightforward, where it only offers a low risk now or in the future, and it is simply a self-assessment by the service user of what outcomes the provision of such a service will achieve for them.

Key features of outcome-focused providers

- The system needs to have at its heart a shift from payment by volume and services to payment by results and outcomes achieved.
- Provider organisations need to be able to understand what forms of provision will be best placed to deliver the outcomes desired, the risks involved in doing so and the underlying research or rationale that makes them think the approach will be successful.
- Providers need to be able to configure their service and staffing arrangements so that they can deliver a much more flexible service if the

7. OUTCOME-FACING PROVIDERS

outcomes people need and desire are to be
achieved.

- It is also likely that the range of services a provider
offers will change in order to best be able to meet
outcomes rather than such services being
configured around conditions or issues, as in
health care, or historical function boundaries, as in
social care.

- The home care workforce will change from hourly
paid staff to professional staff with wider skills and
working in more complex care arrangements as
micro teams.

- More simple low-risk elements of care and support
are unlikely to change greatly other than they will
still be assessed by the outcomes they can deliver.

8. MEASURING AND MONITORING

A key component of outcome-focused social care is the capacity to measure and monitor whether the defined outcomes are actually being achieved. This could entail making some major changes to existing measurement systems. Among the issues with the way in which home care is provided is that performance is currently measured by local authorities in terms of payment and in terms of performance by the care regulators.

Local authorities, based on ever-increasing pressures to drive down price and demonstrate value for money, rely on home care monitoring systems in order to determine whether performance is being met. The problem with systems are that while they may tell you when the carer arrived and departed they say little about whether the care delivered was what was necessary on that day, what were the consequences of late or early arrival, whether the care was delivered in the manner the service user desired and above all else, over time, whether the care delivers the outcomes needed and desired.

Even where time-based data is aggregated (and in many authorities it is not) the outcome only tends to be in terms of overall performance rather than in recompense to the individual for a service that was not delivered and hence damaged that person's quality of life. A care service for an older person that is late or does not arrive may not just mean a contractual variation around price but whether that person can or cannot get out of bed or get to the toilet or have their breakfast. The cost of failure to the service user is rarely identified and many still feel unable to effectively complain in a relationship where the consumer has little power.

Equally, there are problems with national minimum standards. Although regulators are taking steps to focus measurement more on outcomes the underlying tests still rely on measures of quantity, volume and standards.

Clearly, in terms of the government's transformation agenda, how success is measured will need to change. It would be hoped that in measuring transformation this does not stop with counting how many people have a direct payment or individual budget or even user satisfaction surveys but goes on to really test whether the money spent delivers the outcomes desired whether by central government, local authorities or service users. The Australian Government[17] offers some useful advice in suggesting three criteria to assess the quality of indicators.

- Is the selected outcome important and significant to the programme?
- Is the potential indicator a meaningful measure of outcome? Is it free from undesired side effects?
- Is the instrument valid, reliable, feasible and amenable to audit?

Key features of outcome measuring and monitoring

- Define what measures or indicators could be used to demonstrate whether the provider is achieving each outcome and how that monitoring would be conducted (by whom, how, frequency, etc)?
- Define how accuracy and impartiality be guaranteed in the monitoring process?
- Where service user opinion is being sought then this needs to be by a process that allows for commenting on poor delivery of outcomes without the user feeling vulnerable.

---

17 | Public health outcome funding agreements Commonwealth of Australia Population Health Division 1998

9. OVERALL SUMMARY

An outcome-based approach has a number of advantages
- It helps to focus services around results and goals to be achieved rather than about simply providing a volume of service.
- It encourages flexibility, a 'doing what it takes' approach to care and the achievement of measurable results.
- It means only the care that is needed is provided and moves the system away from mechanistic monitoring approaches which reduce care and support to a minimum of time needed to complete pre-determined tasks.
- It gives greater scope to service users to define what it is that they want to achieve and in doing so changes the balance of the relationship between carer and cared-for.
- It widens the scope of care agencies to define their role and task by what needs to be achieved rather than being defined by historical boundaries based on the service they provide. It also gives the knowledge that such agencies have gained proper recognition.

Without adopting an outcome-based approach to social care provision the danger is that the personalisation agenda will increasingly focus on who holds the money as the main driver of service improvement. While such an approach has some benefits, on its own it is unlikely to drive the changes needed without a consideration of what outcomes that funding can deliver. Such a consideration is vital if more older people are to enjoy a better quality of life and need less care support and health services in their final years.

Having described some of the advantages, it also needs to be recognised, as both the literature and the projects with authorities suggest, there are obstacles to be overcome:

- As a 2006 report found: "Users and carers were sometimes resistant to outcome-focused approaches. Problem included deference and a reluctance to articulate desired outcomes for fear of being unrealistic."[18]
- Providers have to be convinced that the benefits

outweigh the disadvantages and that this approach represents a better way in which to run and manage their businesses.
- Changes such as those envisaged in this paper are potentially threatening to the role of care managers, who see service users having a greater say in assessment and in managing their care and providers defining how and what care should be delivered via the care plan.
- Changing the currency of care from cost and volume has wide implications across local and central government in terms of finance and funding and in terms of measurement and accountability.
- Establishing effective and attributable outcome measures is not easy and is a task in which local authorities have had little practice.

Notwithstanding the problems, the need to change is considerable. As the demographic data suggests, if the existing basis of purchasing care does not change some local authorities within a comparatively short time will find their resources run dry. In such a climate funding by the outcomes a service can deliver may move from a desirable to an essential step.

18 | Outcomes-focused services for older people Social Care Institute for Excellence 2006

10. APPLYING THE APPROACH

The following table illustrates the application of an outcome-based approach and contrasts this with that of a more traditional assessment and service procurement process and then the same issues under a personalised agenda. Each activity is described in general terms and then offers a service user example to explore how the approach might be implemented.

Mr A, aged 86

Mr A has numerous health issues which include: general poor mobility; an enlarged prostate; urinary retention so he has had a catheter in situ for some time; irregular heart beat which impacts on breathing; high blood pressure; impaired hearing; recently experiencing headaches and dizzy spells. Additionally he has recently been diagnosed by his GP of having short-term memory loss which has exacerbated his continued feeling of anxiety.

Mr A is a widower, has three sons, one of whom lives locally and he has daily contact and support from. He currently lives on his own in a ground floor flat which is warden controlled.

Mr A feels that up until recently he was managing pretty well, however recently he has been feeling extremely tired and when he discussed this with his GP he was advised that his lethargy was age-related and advised to seek some form of more intensive 24-hour support.

Mr A has told his son that he does not like the idea of living in a residential home but does clearly understand that he does need more 'proper support' from someone.

Traditional	Personalisation	Outcomes
Assessment and identification of need		
• Two-stage assessment process of initial followed by comprehensive assessment led by care manager.	• Self-assessment the most likely route, although assistance from care broker available.	• Self-assessment the most likely route, although assistance from broker/care assessor available.
• Assessment focuses on need although in reality shifts to services fairly quickly.	• Assessment focuses on need.	• Assessment focuses on outcomes the person desires/requires and their achievability as compared to needs.
		• The assessment starts from looking at what resources the person currently has available to them to achieve those outcomes.
• Process is by and large led by the care manager.	• Process is by and large led by the service user, with the offer of help if needed.	• The care assessor's expertise is in helping the potential service user assess their current resources and capabilities and helping formulate desired outcomes that are achievable.

10. APPLYING THE APPROACH

Traditional	Personalisation	Outcomes
Assessment and identification of need		
• Information at this stage tends to focus on user rights and information about the assessment and care planning process. *Mr A's son has telephoned social services and was asked to describe his father's problem. The son detailed some of the health issues his father faces and what he feels would help him.* *A social worker visits Mr A and his son and completes a full assessment of needs.* *The social worker informs Mr A and his son that the information will be used to decide how much help he will need and how that help can be provided.*	• Information focuses on the range and quality of services available, together with information about how the assessment will be used to determine resources available. *Mr A has completed his assessment in conjunction with his son and a care broker. The discussion with the broker is still fairly structured and guided by a number of areas identified on the assessment form. These areas may include topics such as: complex needs and risks, meeting personal needs, learning and leisure etc.*	• Information available focuses on outcomes that may be achieved and how. *In this instance Mr A and his son asked for help with the assessment. The first task was for the care assessor to discover something about Mr A's perspective on his current situation, what he was previously able to do, what he does now and what he would like to be able to do in the future.* *It looks at what resources Mr A and his son have (including friends, neighbours etc) that could help.*
Eligibility for resources		
• Access to funding is based on presenting needs. • In most instances the needs have to be at a substantial or critical level to receive a service. • Little consideration of the relationship of needs presented now in the light of their long-term prognosis.	• Access to funding is based on applying a scale of need to a level of funding via a resource allocation system (RAS). • The calculation of points to funding is based on estimates of 'typical' care packages. • Amount of funding and the process for obtaining help is transparent. • Little consideration of the relationship of needs presented now in the light of their long-term prognosis.	Two initial tests are applied prior to any consideration of funding: • Do these outcomes fall within the wide remit of social care? • How great is the risk to the individual's health and well-being, either now or in the future, if these outcomes are not met? The desired outcomes are then considered against the following hierarchy: • Can these outcomes be met by advice? If not • Can they be met by others (eg

10. APPLYING THE APPROACH

Traditional	Personalisation	Outcomes
Eligibility for Resources		
Mr A's assessment confirms that his needs meet the eligibility criteria for service provision and that services will be arranged to meet these needs. Which services are provided, for how long and at what cost is dependent upon his individual needs and circumstances. *He is informed that he will be assigned a care manager who will work with him to arrange the most efficient and cost-effective way of meeting his needs.*	*Mr A's needs identified in his assessment are fed into the resource allocation system, which 'bands' the needs into pre-determined categories. Mr A has been informed that each of the bands is equated to a sum of money. If he wishes he (and his son) can be given this money to buy their own support. Advice is available if they need help in doing this.*	family, friends, community resources) providing a service? If not • Can they be met by others providing a service but with support from social care? If not • Can they be met only by social care providing a service? *Mr A has identified the following outcomes:* *I would like to feel better than I do now, I know that I will never feel like I did 10 years ago but I want to be able to get about a bit, maybe go out once in a while, do things for myself like everyone else.* *I think this may stop me feeling as anxious and worried about things – having something to do I'm sure will help.* *I would like to be able to look after myself better than I do, I've stopped caring about my appearance, stopped washing and looking smart. I think that I would like some help with this and maybe do some of the things around the flat I used to like doing every now and again, maybe make a nice shepherd's pie.*

10. APPLYING THE APPROACH

Traditional	Personalisation	Outcomes
The plan for care		
• Care plan is written by care manager after discussion with service user and carer.	• Support plan is written by the service user on their own or with the aid of a care broker.	• Support plan is written by the service user with their chosen care provider.
• Provider agency is chosen by care manager and contract agreed by the local authority with the provider.	• The support plan details how the service user's individual budget will be spent and with whom.	• The support plan identifies what the service user can do for themselves in order to achieve their outcomes and what contribution the service user's local services and community will make.
• The care plan specifies the volume and arrangements for the delivery of the service.	• Help is offered to identify a list of care agencies from which a provider might be chosen.	• It identifies what role the main provider agency will play, how they will co-ordinate what is needed and how what is to be provided will meet the outcomes of the service user.
The care manager meets with Mr A and his son both separately and together. Mr A's care plan states that his identified needs would require 15 hours per week that would be provided by a home care agency. The 15-hours support will include support with personal care, meal preparation, emptying catheter bag and also prompting the taking of medication.	*The care broker meets with Mr A and his son both separately and together to talk about the plan that Mr A and his son have devised. They have some discussion about which provider it might be best to use.* *The plan details the needs that the funding will meet and the basis on which that funding will be transferred to Mr A.*	*The main care provider agency meets with Mr A and his son both separately and together. A risk assessment is agreed about what factors could lead to Mr A giving up his independence and how this might be avoided.* *The provider offers a number of options about getting out more which will include help from their physiotherapist in putting together an appropriate exercise programme. Two days a week more intensive care will be provided to allow Mr A's son to have a complete break.*

10. APPLYING THE APPROACH

Traditional	Personalisation	Outcomes
Receiving the service		
• The service is commissioned by the local authority.	• The service user and the provider agree what volume/type of service will be delivered.	• The service user and the provider discuss the outcomes that need to be met and identify the most appropriate evidence-driven methods.
• The service user is not directly involved with influencing the design of the service.	• The service user and provider agree a schedule of visits.	• The service user and provider negotiate the scope for variation and flexibility in the schedule of visits and how any 'unused' time may be 'banked' for future visits.
• The service user is informed of the days and times of service delivery.		
In this instance Mr. A is informed of what services he will receive and the times he will receive them. Mr A, his son and the care provider are given a copy of the care plan. *Mr A's son has completed a financial assessment on behalf of his father and the contribution he must make to his care.*	*Mr A has now discussed his needs with a home care provider and they have reached an agreement based on the hours, tasks and times of their visits. They have agreed the amount of money this will cost and what amount Mr A will have to top up his care costs.*	*The provider care supervisor in consultation with Mr A and his son have met to discuss how the outcomes will be delivered.* *Mr A and the care supervisor have agreed a number of short-term outcomes, which has helped them to focus on what he wants to achieve and by when. The care supervisor and the carer begin to refer to these outcomes as improvement or change outcomes so that Mr A will know that things can begin to change for him and that they will be monitoring his progress in these areas.* *They also discuss how they can respond to Mr A's changing needs and agree how any banked time can be used creatively to meet his outcomes. Mr A suggests that he would like to maybe try a walk to the nearby park in a few weeks' time.*

10. APPLYING THE APPROACH

Traditional	Personalisation	Outcomes
Reviewing		
• The review is led by the care manager.	• The service user is encouraged to undertake their own review or can be assisted by a care professional.	• The service user is encouraged to undertake their own review or can be assisted by a care professional.
• The original assessment forms the basis of the review, the purpose is to ascertain if the service user's needs have been met.	• The review is intended to evaluate the service user's achievement against their care plan.	• The review is intended to evaluate the service user's achievement against a planned outcome and to determine any changes to the level of resources required.
• The period of review typically after the start of a care plan is conducted on a yearly basis.	• The review can be completed when considered necessary by either the service user or the care professional.	• The review can be completed when considered necessary by either the service user or the care professional.
Mr A and his son are told that the review will be guided by a questionnaire, and he is encouraged to respond to the questions as fully and honestly as possible. *The question on the review form is: "How does the service currently in place meet your identified needs in the following areas of needs:* • Self care • Mobility • General health care; • Emotional well being • Communication etc.* *In addition to the above they also discuss the performance of the provider – if they turn up on time, level of respect show etc.*	*The care assessor assists Mr A with reviewing his support plan. They discuss the suitability of the current care package in meeting his needs.*	*Mr A's review is based on a discussion to ascertain the following circumstances.* *Has Mr A improved his independence to an extent that he now requires less or no further resources to maintain his quality of life?* *Does Mr A require the same resources because his outcomes have yet to be achieved, or more resources and support as his health and well-being have decreased?* *If the above statements are the case, then a new set of outcomes may need to be agreed by the care assessor.*