

working for well run evidence-based public care

**John Bolton**

**Emerging practice in outcome-  
based commissioning for  
social care**

**Discussion paper**

**April 2015**



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## Emerging practice in outcome-based commissioning for social care

### Discussion Paper

#### 1 Introduction

This paper is a progress report exploring the lessons learnt from a variety of approaches taken by councils to “outcome-based commissioning” in adult social care (sometimes called payment by results<sup>1</sup>). It follows an earlier paper written by the author, John Bolton, on an approach to outcome-based commissioning taken by Wiltshire Council<sup>2</sup>. This paper considers some of the opportunities and risks that arise from taking this approach.

The paper puts the emerging practice in social care in a context with other developments within the public sector; explores current practices in social care from a small number of councils and looks at the advantages and risks in taking this approach. Suffice to say there are limited studies to this approach which has only emerged in the last five years. Those studies that have taken place are yet to demonstrate significant changes, yet there is an optimism in parts of the care sector (including some providers) that this must be the approach for the future.

The development of thinking in local authorities in recent times has shown a new emphasis on interventions that either prevent or reduce someone’s need for longer term care. This is supported by the evidence for the benefits from re-ablement for older people; the recovery model in mental health; and the emerging progression model in learning disability services. Outcomes based commissioning is, in part, a natural evolution of the way in which commissioning might take place when a council is seeking improved outcomes for its customers as a result of the resources it purchases or deploys. The overall expectation is that if a provider can produce outcomes for customers that may reduce their need for longer term care they should be rewarded. At the same time if fewer people need longer term care this will reduce the overall costs to the council. The benefits can then be shared between commissioners and providers of services.

At a time when resources for public funded care are reducing, one of the key questions for this approach is whether it will actually increase the overall costs of services – because of the greater requirement to measure

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<sup>2</sup> Wiltshire Council- Help to Live at Home Service – An Outcome-Based Approach to Social Care, Case Study Report- April 2012

what is happening in the service - or whether it will reduce the overall costs because the interventions that are being rewarded will help to reduce overall demand?

One example of why this might be important is the very variable outcomes that similar services obtain from one council to the next<sup>3</sup>. For example in Luton they achieve a rate of 66% of older people experiencing reablement not requiring further services whereas in other places the performance is around 45%. If all providers could be incentivised to improve their performance then councils may make further savings in these tough fiscal times.

The aim of this paper is to explore how councils might incentivise the behaviours for providers so that the services that are offered do more to help people maximise their opportunities for more independent living. The paper has drawn on the experience of the author and discussions with providers, commissioners and customers receiving services.

The following terms are used in the report<sup>4</sup>:

**Commissioning** is the processes which include assessing the needs of people in an area, designing and then achieving appropriate outcomes. The service may be delivered by the public, private or civil society sectors.

**Procurement** or purchasing refers to the process of finding and deciding on a provider and buying a service from them.

**Outcomes** are the perceived benefits to a person from the services they have received.

**Payment by Results** is the process whereby a service provider is rewarded financially because they have delivered pre-agreed set of outcomes for an individual or for a population of people in an area.

**Promoting Independence** is the process whereby a person is helped to be less reliant on state funded support in order to have their needs met.

**Prime Provider** – a single provider is procured by the council to deliver a set of services (at an agreed price). This provider then sub contracts work and manages the local supply in the market to deliver the required service.

## 2 Background

### 2.1 Early days and payment by results

The move to outcomes based commissioning in adult care has been slow. The work on outcomes defined in the English Children's Policy papers

<sup>3</sup> LGA Adult Social Care Efficiency Programme – The Final Report July 2014.

<sup>4</sup> Definitions are taken from the book "Commissioning for Health and Social Care" published by SAGE and IPC (Oxford Brookes University) in 2014

published alongside the Children Act 2004 and published in Every Child Matters<sup>5</sup> focused on 5 simple outcomes:

- Being Healthy
- Staying Safe
- Enjoying and Achieving
- Making a Positive Contribution
- Achieving economic well-being

These five key objectives set the strategic direction for children's services and they have been widely used for the last decade. There has been no parallel policy impetus from adults' services despite the publication of the Adult Social Care Outcomes Framework (ASCOF) Performance Measures in England in 2011 which specified four key outcomes from services.

- Enhancing the quality of life for people with care and support needs.
- Delaying and reducing the need for care and support.
- Ensuring that people have a positive experience of care and support.
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

These "outcomes" measures have not had the same traction in adult social care, although they set up a set of measures against which adult care might be monitored. It may be that the described outcomes are too general and wide ranging and that if an approach to commissioning is to be developed then it may be helpful for the outcomes to be more specific. One of the key considerations in this paper is: Do the outcomes that are being delivered help improve the recipients' independence in a way that they may need less on-going care? This is a theme to which the paper will return at various points.

In other sectors there was a move to Payments by Results following the 2011 "Open Public Services White Paper"<sup>6</sup>. This Government White Paper encouraged commissioners to focus much more on payment for outcomes achieved by providers of services rather than for the activity that was delivered by providers. This was particularly the language used in the NHS when it moved towards payment mechanisms for activity in hospitals (moving away from the previous capitation allowances for acute hospitals based on their population). This scheme pays on a tariff for different interventions that were offered in acute hospitals<sup>7</sup>. This scheme, however, actually pays for activity that is undertaken rather than the actual outcomes that are achieved by the interventions.

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<sup>5</sup> Every Child Matters – HM Government 2003

<sup>6</sup> Cabinet Office White Paper published in 2011

<sup>7</sup> A simple guide to Payments by Results in the NHS – Department of Health 2011

In part response to the White Paper in April 2012 the Audit Commission published its guidance on Payments by Results (PbR). The Audit Commission had positive messages around PbR but also advised commissioners to be aware of the risks.

*“At its best, PbR can deliver savings and bring in new resources at a time when budgets are under great pressure. It also defers costs to commissioners to allow time to realise the benefits of change and preventative work. PbR can provide sustained incentives for providers to improve outcomes, and to find new ways of doing so. It can encourage new ideas, new forms of service delivery and new entrants to service provision. Unlike other forms of contract, PbR aims to transfer financial and operational risks away from the commissioner, often onto the provider, or funding bodies. It can also provide clearer accountability for outcomes. However, PbR carries extra risks to securing value for money and requires higher level commissioning skills than more traditional approaches. Schemes that make a large part of the payment dependent on performance is, for the most part, untested and their overall effectiveness is not yet proven. PbR could increase costs for commissioners and others.”<sup>8</sup>*

## **2.2 Pilot Study on Payment by Results by Department of Communities and Local Government (DCLG)**

One of the government departments that responded to the Cabinet Office white paper was the Department of Communities and Local Government who in 2011 set up ten volunteer pilot sites from the former ‘Supporting People’ funded services. Their programme under the auspices of the former ‘Supporting People’ grant encouraged councils to pay providers based on the effectiveness of the services provided. These were evaluated over a three year period and a report of the findings was published in 2014<sup>9</sup>.

The councils involved were encouraged to take different approaches but the dominant approach was an 80% core payment for services provided with a 20% reward element that could be gained by the provider if agreed outcomes were delivered. Over time some of the councils increased the percentage of reward element. The models adopted reflected a series of factors, including:

- the ability of local authorities to fund payments above a fixed level;
- the perceived nature of incentive required to make Payment by Results a success;
- the nature of services within the pilot’s scope; and

<sup>8</sup> Local Payment by Results – Audit Commission Spring 2010

<sup>9</sup> Supporting People Payment by Results pilots – Final Evaluation Department of Communities and Local Government 2014

- understanding of experience and good practice from previous Payment by Results contracts (usually outside the local authority area).”<sup>10</sup>

Although in many cases, due to financial cuts, councils did not continue with the approach. The study concluded that there was much to learn both around how to set up contracts to focus on the outcomes expected and on how to measure the impact of the actions taken within the services to deliver the desired outcomes. One of the findings of the study was that this was an appropriate way to commission services when there were clear goals to help customers within the service to attain greater independence and be less reliant on state interventions in the longer term. Though the study did point out that even if a supporting-people service had a goal of supporting independence, but this was not supported by the rest of the care and support system, their work could be quickly undermined.

Other important findings of this study were:

- Both commissioners and providers need to recognise the resource intensive nature of Payment by Results contracts, specifically the monitoring and auditing requirements and the need to establish effective systems to manage this.
- Contract terms need to be transparent and easy to understand to include clarity of outcome measures, the implications of failing to achieve targets and the frequency of payments. All organisations should then carefully consider the cashflow implications and how they can be managed.
- Providers should be encouraged to take Payment by Results terms as an opportunity to innovate in the delivery of services, ensuring that the best approaches are taken to achieve the greater outcomes for clients.
- Outcomes should be applied that recognise client’s needs while still retaining a focus on overall service objectives.
- The monitoring burden can be reduced, and the transparency of achievements against targets improved, by focusing on a limited number of outcomes that reflect the core aims of the service. A distance travelled model is positive for service users but presents challenges for evidencing and later auditing achievements.
- Measures should be put in place to allow the full impacts of Payment by Results to be assessed, including to measure change in the level and nature of outcomes achieved, value for money secured and, if possible, change in client experience and the sustainability of outcomes<sup>11</sup>.

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<sup>10</sup> Supporting People Payment by Results pilots – Final Evaluation Department of Communities and Local Government 2014

<sup>11</sup> Ibid

In conclusion, there has been a policy shift towards examining outcomes. There have been some interesting approaches particularly within the DCLG pilots. However, the evidence is unclear as to whether this approach will sustain an improved set of outcomes for either individuals or subsets of the population. This is not yet the panacea for commissioners and yet there is a compelling case to explore this further. If local authority commissioners are going to work with providers to reduce people's care needs (where possible) then this approach is certainly worth exploring.

### **3 Outcome based commissioning in Wiltshire and other emerging approaches**

This next section explores the emerging practice from some councils who have described their approach as "outcomes-based commissioning". It appears that domiciliary care is a service that may be suitable for this approach. In the traditional way that domiciliary care is commissioned and procured councils require their providers of care to deliver a certain number of hours of care each day/week and they are paid at a rate for the agreed time they spend with each person (some contracts also include travel time between each customer).

There has been a growing critique of this approach. On the one hand, councils who have had to make savings in recent years have looked to reduce the costs of this service. Providers still bid for contracts but use a number of approaches to keep their costs down, including maximising the number of calls a care worker can achieve in their working day; seeking more help than was originally agreed for customers so that they can maximise their opportunities and time spent with each customer; and paying staff at a minimum level with few training opportunities. Many agencies also operate zero-hour contracts as a way of only using staff when work is available for them.

In addition to these pressures has been the emergence of reablement services. Supporting older people's recovery over a six week period has reduced demand for domiciliary care. There is some growing evidence that for some older people their recovery period is longer than six weeks and it would be good to incentivise providers to identify those older people who need less or no further care over their first year in the care system. Sometimes domiciliary care is provided for people when it is not quite the right service to meet their needs e.g. people who are socially isolated need assistance to make links in their local communities rather than to continue to receive limited visits from a single care worker. The challenges that face the domiciliary care market might be met by a more outcome-based approach and both some councils and a growing number of providers of domiciliary care want to explore this approach. If a provider could be rewarded for meeting someone's need – especially if this included helping the person in a positive way so that they needed less long-term care – there

should be a “win-win” for all parties: council, provider and, most of all, the customer.

### 3.1 Wiltshire County Council

One council who have looked to operate this at a large scale has been Wiltshire Council, who started on a journey about six years ago and has had an established set of contracts with providers for the last three years which they call their “Helped-to-live-at-Home” service.

The approach in Wiltshire was based on the principle that the way in which care is delivered (especially for older people) can have a big impact on the person’s ability to retain or regain levels of independence<sup>12</sup>. The progress that Wiltshire has made in delivering this approach was reviewed by the author in February 2015 and with the permission of Wiltshire Council a summary of the lessons learnt are presented below.

Commissioners in Wiltshire determined to divide its domiciliary care contracts into 8 segments of the council area. Each segment was offered up for procurement based on a move to payment by results. The aim was to move gradually over the first year to the new arrangements once providers had established themselves in the area. Four providers won these eight contracts between them, though over the three year period one of the original providers dropped out and one was bought out by a larger company. There are still four main providers with contracts in Wiltshire to deliver outcomes-based domiciliary care. In the model, the outcomes are initially determined between the assessor and the customer. These outcomes are then put to the provider who agrees with the customer how they will be delivered through a support plan. The payment is then calculated through a combination of a pre-set fee level for each described outcome and the detail of the support plan. There is no specific reward as such for delivering an outcome. However, if a provider delivers an outcome earlier than was anticipated, they are still paid the full amount.

In order to develop this service, Wiltshire closed down their existing in-house reablement service. Staff were transferred across to the new providers. The whole aim of the service was to produce better outcomes for customers which included both short-term and long-term help. About half of the customers in Wiltshire needed no further care help from the domiciliary care providers within six weeks. A further cohort of customers needed no further care delivered within a six month period.

The design and specifying of outcomes for each person is in itself a complex task. In Wiltshire, these were set up by their assessment staff, called Customer Care Co-ordinators (who were not social-worker qualified),

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<sup>12</sup> Op Cit Wiltshire Council- Help to Live at Home Service – An Outcome-Based Approach to Social Care



working alongside customers. It is important that these staff are appropriately trained and are supported by the right paperwork and forms to assist them in undertaking outcomes-based assessments. It is no good doing outcome based commissioning if there is not good quality and clear outcome based assessments!

Some lessons from Wiltshire:

- If there are new providers allow them time to secure themselves in the care market before asking them to deliver a full service. All providers need time to secure staff and to have them trained and supported in the way required. (Experience from Wiltshire and other Councils suggest that this is a minimum period of 6 months). For a number of reasons this did not happen in Wiltshire and all providers experienced some difficulty in gaining capacity to deliver services. This meant that the focus was moved away from delivering outcomes and more on the straight forward task of getting the care worker to the right customer at the right time.
- There needs to be important communication not only with customers but with their families and the wider community so that they understand and appreciate the new approach and how it is different from the “traditional” approach. Equally key partners, particularly the NHS, community and voluntary organisations need to understand the implications for their services. All of whom of course should be involved in the design of the service (parts of this worked well in Wiltshire).
- There is a cost for all parties (commissioners, providers, assessors and maybe customers) in delivering the services in this way. These need to be considered when setting up the process. To this end, the process needs to be made as simple and as straightforward as is possible.
- Domiciliary Care is delivered to a range of people with very different needs:
  - For some people it can be short-term reablement based services where recovery and recuperation is the main aim and this is achievable.
  - Others may have long term conditions (often multiple conditions) where they need help to learn how to self-manage their condition to reduce their bad spells. However, they will always need some on-going care.
  - A further group may suffer from memory loss or be diagnosed with a dementia. This group need a different level of support to help them focus on living with their condition, with using the technology that is available to help their daily living, to remain safe and to look to reduce the negative impacts that the condition may have on their lives. The strong focus here is helping people to remain in their own homes for as long as is feasible and supporting the family carers to achieve this.

- Finally there is a cohort of older people for whom palliative care is the correct help. This is the process to enable a person to die with dignity in their own home. For each person the approach for them may be fairly unique given their circumstances, accommodation, family support etc. The support plan has to be flexible to recognise this and the understanding of the outcomes to be achieved quite sophisticated. One of the key features for getting outcome based commissioning right is to be able to test the interventions (the help) that deliver the best outcomes for each individual.
- Wiltshire collects a range of outcome-based data. This should be used to positively manage the contracts and to ensure that the services continue to focus on delivering outcomes for individuals and for populations of customers.
- Outcomes can't always be delivered by one provider. Sometimes it requires a range of providers to work collaboratively with individuals to meet their desired outcomes. This can be complex but incredibly rewarding when achieved. This particularly refers to both the NHS (who needs to be part of the thinking as the scheme develops) and for the community and voluntary sector who are again often uniquely placed to ensure that the model is delivered.

Wiltshire has taken a national lead in developing their approach and even after three years of practice they have yet to fully realise all of their ambitions for the services. Many councils have visited Wiltshire to learn lessons from them. They are determined to continue to learn lessons and to deliver the model.

Other Councils are now adopting and adapting the approach used by Wiltshire to fit their circumstances – over the last year both the Royal Borough of Windsor and Maidenhead and Hertfordshire County Council have gone out to tender for domiciliary care with a focus on delivering outcomes for older people. Both Councils state that they had learned much from Wiltshire's approach and then adapted it for their own circumstances.

### **3.2 Hertfordshire County Council**

Hertfordshire offered some thoughts as a contribution to this paper as they have just started to procure their services on the basis of outcomes to be delivered. They have called their service – “the local offer of support”. They have awarded a lead provider contract in each of their ten district council areas plus two additional rural contracts. These 12 contracts have been won by 5 providers. No provider controls more than a quarter of the county. The “lead model” allows the provider, who has been awarded a contract, to sub contract the care to an existing registered care provider in the county. The lead provider then manages that contract for quality and outcome (reducing some of the local authority costs for both brokerage and contract compliance).

In Hertfordshire, they have taken a different approach from Wiltshire as contracts for enablement, complex care, specialist dementia care and home from hospital care are to be let separately. The lead providers may also bid for these contracts - but must also be able to take some people when capacity is short. The expectation is that each lead provider will have around 80% of the domiciliary care hours at any one time. It is still possible to procure care through a one-off ("Spot") contract. Hertfordshire has designed an accreditation process to go along with the award of a spot contract that ensures that quality is maintained.

Hertfordshire require that all contracts are let on the basis of paying living wage as minimum, offering staff travel and training time, employers paying for uniforms, staff receiving full checks etc. To assist providers in planning for the coming weeks' rotas, the commissioners will send each lead provider a statement of the hours that they estimate are required for a forthcoming eight weeks period. This information is drawn from an analysis of the current position, waiting lists, hospital trends and other system flow. When an individual package is required, the council will specify someone's personal budget amount, an indicative hour's envelope, an OT assessment if required and the outcomes someone wants to achieve. The providers will have care coordinators who will then meet with people and their families and design a typical week with them.

Any changes of package (times, duration, frequency etc) are between the provider and the person/their family. They may increase this to the level of their personal budget or store hours up for a specific reason.

Hertfordshire (like Wiltshire) also want to incentivise providers to make community links and seek alternatives for people to statutory care. Where they do this (and reduce the need for domiciliary care), they will be paid at a rate of 50% of the hours saved for the equivalent of 12 months. Outcomes will be checked to ensure that they are being met at care reviews. These will happen every 6 months alternating between a visit and a phone call. The care customer receive will be monitored by two Quality Monitoring Officers who expect to interview 600 people per year across all agencies about their satisfaction with the service. Providers will be required to supply actual visit data each day. This will both enable the council to offer a quick check on what is happening but will eventually be open on-line (through a secure log-in) for customers and their families<sup>13</sup>.

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13 Information provided by DASS in Hertfordshire

### 3.3 Royal Borough of Windsor and Maidenhead

In Windsor and Maidenhead<sup>14</sup>, they are also at the early stages of an outcome-based approach. Their service will only commence after the in-house domiciliary care reablement has completed its work.

In order to prepare the business case for their approach, they had undertaken a desk-top “proof of concept”. This study involved using a team of experienced Care Managers, an Occupational Therapist and the head of the Short Term Support & Reablement Team to evaluate a group of users currently in the system to see what the likely impact of continuing with a reablement-based domiciliary care service post-reablement.

The team considered 31 service users and the results in summary were:

- 19 would be able to achieve improved outcomes with a lower cost package.
- 2 would be able to achieve improved outcomes with a higher cost package.
- In 10 cases no change was deemed possible, although it was believed that with more experience and innovation, at least some of these might have had a different result.
- Risk levels seldom had any considerable change.
- The initial data indicated an average reduction in package costs of between 15-18% (note that this number should not be considered the potential saving for an outcome-based approach as there are numerous other factors that must be considered).

The review also produced information relative to the risks and issues associated with implementation of the new model. It also affirmed evidence that has emerged from elsewhere that many older people should continue to recover over a longer period and the way in which services are delivered should support this. There are five fundamental principles underlying this model that make it significantly different from their previous approach in Windsor and Maidenhead (RBWM).

- Focusing the entire system on meeting individual outcomes and increasing independence of users.
- Aligning the objectives and incentives of all players in the system – RBWM, providers and users – around this focus.
- Encouraging innovation in the development of services and activities aimed at increasing independence.
- Changing the relationship between RBWM and Provider by giving the provider more flexibility in working with service users to meet the desired outcomes.

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<sup>14</sup> Information taken from Cabinet Report 27th February 2014 - Outcome Based Commissioning for Social Care Services and conversation with Assistant Director for Commissioning

- The overall customer journey reflects a lean approach to service delivery.

A significant part of the development of the thinking for Windsor and Maidenhead has been the way in which they have built this new service into their work with the NHS on health and care integration (through using a current Department of Health approach to pooling resources – the Better Care fund). Their ambition is for care workers to play an active part in being the eyes and ears for the NHS with older people. They will look to monitor how older people are coping with day to day living and alert health professionals when there are signs that a person is having difficulties. There are both health and social care resources being used to support this approach through the pooled budget.

In summary, we can see some interesting developments in the field of outcome-based commissioning of domiciliary care. While Wiltshire has now been up and running for over three years it is still early days. Early reviews suggest that the service found it difficult to explain the changes to their customers. However, customer satisfaction has increased in Wiltshire over the time period for which this approach has been taken. The model in Wiltshire does not yet produce very different results to those councils who have not focussed directly on outcomes for the delivery of domiciliary care in relation to numbers requiring help or reduced admissions to residential care (though these have fallen in Wiltshire as they have done elsewhere). The two more recent exercises in Hertfordshire and Windsor and Maidenhead offer emerging thinking and planning of arrangements which others are keen to emulate.

#### **4 Other approaches and lessons learnt from elsewhere**

One of the bigger issues that emerged for councils approaching outcomes based commissioning is how to link the payment for the services delivered to the outcomes achieved in the simplest possible way. One approach that is being developed is to pay for outcomes for populations rather than for individuals. In this model, a council can commission a service with a clear expectation that the service will deliver a set of specified outcomes for a wider population.

One example of this is an emerging view of how to commission a range of Intermediate Care Services (often jointly commissioned between NHS and Councils). These are services that assist older people who have been discharged from hospital or to offer help in a way which avoids a hospital admission. The common feature of these services is that there are often quite high volumes which need to be met but outcomes can vary so much if the services are not designed and set up in the right way. Getting this

wrong has a big impact on the costs in both the NHS and Social Care<sup>15</sup>. So having a set of measures that ensures speed of discharge from hospital for older people that is backed up with low admissions to residential care and limited long term needs for domiciliary care is a set of outcomes a service (or set of services) may be asked to deliver. Good intermediate care can deliver speedy discharge without an increase in unexpected longer term demand for social care services.

One example of this approach has been the way in which Coventry City Council had managed (in 2013) to move their reablement domiciliary care service from an in-house service to a commissioned service where they focus on the outcomes that the providers deliver (though there is no payment mechanism to go along with this so a provider is not financially rewarded for the outcomes they deliver).

Coventry approached existing providers who were already on their home-care framework contract and invited them to bid for more hours in order to deliver a reablement based service. The result was that they offered three contracts to existing providers in the city (on a district basis linked to GP clusters) to provide 450 hours of domiciliary care each week to older people requiring a reablement service – most notably for those being discharged from hospital.

The contract price came out at about £2.50 per hour more than their standard domiciliary care (at around £15.00). They allowed these three providers 3 months from the point of contract award to establish their new service before phasing down the former in-house service (so some double running costs). This 3 three month period did follow extensive provider engagement and consultation to ensure that the lead in time was deliverable and service requirements were properly understood. They did, however, save approximately £1.5 million in establishing the new contract. They measured on a weekly basis the performance of each provider and these were published and shared with the providers. This is an important tool to help with the contract monitoring. Performance between providers does vary e.g. two providers achieve nearly 60% of fully reabled customers within a 6 week period (not requiring further services) whilst the third provider performs less well. This is a matter for the contract monitoring performance meetings with that provider. So although there is no formal payment for the delivery of improved outcomes, it is clearly a critical part of the way in which the contract is overseen and by which providers are held to account. At the same time, they also monitor volumes going into the service to ensure that demands can be met most of the time (particularly from hospital discharge to avoid delays). Coventry is currently satisfied with both the quantity and the quality of the service offered.

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<sup>15</sup> Better Support at Lower Cost – Welsh SSIA – April 2011

Another example which should lead a council to change their approach to monitoring outcomes emerged from work in Kent County Council<sup>16</sup>, where it was discovered that older people were receiving very different outcomes following hospital discharge depending on their destination. There are usually a cohort of older people who, when discharged from hospital, require further intensive care and support to help them with their recovery. This recovery may take place in a community hospital or in a residential or nursing care home. It was discovered by examining the outcomes that if older people were placed in a care bed within a dedicated service – whose aim was to support their recovery – that around 80% of older people after a short period (about 6 weeks maximum) would be fit enough to return home. If an older person was placed in a care bed within a residential care home where there was no specific service to support their recovery, only 20% of older people were returned to their own homes.

So though a range of services were being commissioned, the outcomes from that commissioning were not initially known. Once a council can hold providers to account for their outcomes, then it is more likely that these will improve and lead to reduced longer term admissions to residential care, in this example.

So far, this paper has focussed on domiciliary care for older people but, as long ago as 2008, Herefordshire Council procured services from Midland Heart Housing Association for them to move a group of younger adults with learning disabilities from in-house residential care into supported living. The contract was set up in a way that the costs reduced once people were moved, but the provider had to manage this paying proper care and attention to the customer's needs. The agreed price (set for five years) meant that, in the first two years of the contract, the provider bore more of the costs which reduced as people moved into new accommodation (owned by the provider). The provider started to make a profit only after all of the customers moved. (The contract was for five years and the price was reviewed after that period). This was a very early approach to commissioning for outcomes within the learning disability services. Many councils have in recent years had formal programmes to supported younger adults with learning disabilities to move from residential care to community-based supported living accommodation.

Another example is in Darlington<sup>17</sup> where they have a managed programme to help them target a reduced number of adults in residential care as people move to community support settings. This is based on an emerging model of practice in social care – sometimes called the Progression Model. The basis of the approach is simple in that it focuses on reviews of people's needs which should always look to improve the outcomes for each customer in a way that encourages and helps them to live a more

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<sup>16</sup> A review undertaken by Newton (Europe)

<sup>17</sup> Learning Disability Services Efficiency Project – Local Government Association February 2015

independent life. The model works on the assumption that each learning disabled service user ought to have a support plan which is looking to deliver improved outcomes for them year by year. Whatever the level of disability experienced by the service user, their support plan should focus on the interventions and help that is required that would enable the person to live a more independent life than they are currently. This focus on outcomes for customers through the annual review process should lead to a clearer approach to outcome based commissioning – at either an individual or a customer level.

This approach has also been adopted in a slightly different way for the new contracts that Nottinghamshire County Council has recently awarded for its community based support services for younger adults (though most of the service supports people with learning disabilities). Here the contract price has been agreed with four main providers to offer the services across the county. All the providers have a guaranteed number of people to support. However, the contract requires that all providers focus on helping their customers move to greater independence. The value of the contract will reduce at 4% per annum for the next seven years. This reduction will be offset by providers as they help people to need less help as they achieve greater independence. Providers are rewarded either for delivering outcomes in a speedier manner or for finding less formal support to help individuals (or groups of individuals).

A number of emerging approaches have been described in this paper. The author has been exploring the approach with providers of domiciliary care to see if there is a better and more costs-effective ways of delivering their service. The aim would be for providers to agree with commissioner the key objectives for the service. These might be examples of objectives that could be set:

**Objective 1:** To build a set of services that respond quickly to older people in crisis and ensure that at least 50% need no further care after a six week period and a further set of people require little or no care after a year's assistance (discharge care support services).

Performance Indicators:

- Low delayed discharges from hospital.
- High rate of reablement offered that enables older people to need less or no care after the help that has been offered.

**Objective 2:** To ensure that older people in the service are helped in the most cost effective way with a stable and trained workforce that can help them live as independently as they are able. To this end the service will combine the effective use of contact hours with the use of equipment to help meet someone's needs.



Performance Indicator:

- Low average costs per head for domiciliary care packages.

**Objective 3:** To have a service which has a strong focus on helping older people to remain in their own homes?

Performance Indicators:

- Low admissions to residential care.
- That the transaction costs between the providers and the commissioners are kept to a minimum for both parties.
- If the NHS is involved in commissioning the service – lower admissions to acute hospital for this group and lower readmissions for those supported through discharge.

Providers can then be paid to meet the needs of a wider population. This can be costed at different rates according to the range of services being offered. For example, the following rates might apply<sup>18</sup>:

Re-ablement	£1,575 per episode
Lower Level Dom Care	£75.00 per customer week
Higher Level Dom Care	£150.00 per customer week
Intensive and Specialist Dom Care	£320.00 per week <sup>19</sup>

Providers would discuss and agree with each customer how and when services would be delivered including the use of assistive technology and other equipment. Providers might employ therapists to assist them in helping older people regain their independence. The figures identified above should suffice for the purposes of each customer having a personal budget. However, they might be paid to the provider as a single sum to deliver the above outcomes for every 100 people referred to them.

The total budget for that comes out at around £600,000<sup>20</sup>. The provider should then bear all of the risks – encouraged to provide re-ablement support to people and to help to support people in their own homes (providers might take the risk of meeting the costs of residential care when this has to happen). This can give certainty to the local authority and opportunities for providers to be innovative and meet needs in an appropriate way. The transaction costs are kept to a minimum and the provider is rewarded for effective use of their resources. This approach also fits well with the prime-provider model<sup>21</sup> that has emerged in

<sup>18</sup> All calculations were based on an approximate price of £15.00 per hour for the delivery of the set of care services required.

<sup>19</sup> These figures are for indicative purposes only and would need to be calculated locally in the context of how domiciliary care is used within the wider care system.

<sup>20</sup> As above – an indicative figure.

<sup>21</sup> See definitions on Page 2 of this paper

commissioning in recent years and is very popular with NHS Commissioners.

Overall, the model appears to work best when both those assessing for services and providers are focusing on helping people to gain more independence. This might seem very straightforward but it is rare to observe this in practice. Providers could be helped to account for the outcomes they provide, alongside the overall quality of the experience. One of the features of the model is the way that risk is managed. There are risks associated with helping people to be more independent in that this may mean people have less supervision and some things may go wrong for the person. If this approach does not work for a particular person, the provider might have to bear greater financial risks as well. Commissioners and providers have to be mindful as to how these risks will be overall handled between them and the customers.

In summary, an approach which some councils are now exploring is to describe a set of outcomes that a particular service might achieve for a proportion of people who are in receipt of a service. This might be a percentage of people who require no service or less service after receiving help; a percentage of people who remain in their own homes (rather than an admission to residential care); or a percentage of people who gain employment or have moved out of residential care. So a service that is commissioned might always be given a specific set of outcomes that have to be achieved. There may be a reward element for this when a set of targets are reached or it may just be that the contract monitoring expects a certain standard of outcomes to be achieved.

## **5 The pros and cons for the approach**

Commissioning for outcomes can have a very positive impact in focusing the efforts of providers on clear objectives which need to be achieved before they reap full rewards. However, they can only happen when all three parties are fully engaged and have a full understanding of the delivery of outcomes: the commissioners (including contract monitoring), the assessors and the providers. It is rare in the United Kingdom to find all of these three parts of the system working collaboratively in this way. It is therefore a big cultural change to deliver the approaches required both in relation to skills and aptitude. Most commissioners are preoccupied with getting the right volumes of service delivered safely at the right price. Most assessors are preoccupied with assessing eligible needs and ensuring those needs are met. Most providers are working to deliver quality services which sustain and maintain people with care needs. There is little focus in many places in delivering significant improvements for people so that they do not need the service that is being provided. These three dimensions of social care all have to change if outcome based approaches are going to succeed.

The table below draws up some of the advantages and some of the disadvantages in adopting an outcomes-based approach to commissioning:

For	Against
A clear approach which focuses on maximising the opportunities for independence for the customer.	Each person will require a unique set of interventions to maximise their potential which is hard to achieve at the scale that may be required.
A focus on reducing demand for and within social care services.	The additional bureaucracy of the system may add to the overall costs – both for the social care assessment and the contract monitoring.
A model which breaks the “traditional” approach which has at times led to institutionalisation and services that create dependency.	A totally new approach to delivering social care – requires a big cultural shift with significant leadership.
The approach is straight forward and links to what most people say that they want from the care system.	A system that needs to be understood by all stakeholders – including the public – particularly customers and their carers.
The overall approach is often much liked by staff who can much more clearly see rewards and job satisfaction for their work.	Requires significant training for staff to adapt the way they had previously worked. Appears to be operated best by new staff entering the care system.
The approach is personalised – it relies on a unique set of interventions being offered to each person which are likely to work for them to maximise their potential for independence.	Some approaches to personalisation are not compatible with outcome based approaches. If a person has a right to a personal budget following as assessment, it can be hard to reduce the budget – even if the person becomes more independent.
Part of the approach is not to rush in to assess someone when they are in a crisis, but to hold the person and help contains their crisis whilst looking to get the right longer term help.	There is pressure in the care systems to complete each assessment in a timely fashion and to get people into the right set of services as quickly as possible.
Has a flexibility within the approach which does get away from the time and task models that have not	Difficult to manage the timing of getting it right for customers within the logistics of managing

For	Against
served people well in the past.	demanding services e.g. domiciliary care or residential care.
Links strongly to the prevention and well-being agenda that is contained within the new legislation.	Difficult to get the right approach when there is such a strong emphasis in legislation in the assessment process giving people a right to a service.
Gives clearer responsibility to providers who usually know the customer best of all.	Relies heavily on providers to know the best interventions to help each individual – requires a more skilled workforce.
Puts the outcomes for the patient at the centre of the service – not the needs of the organisation.	Requires a significant change in the way that some key players (e.g. the NHS) respond to their customers e.g. at the time of hospital discharge.
Straight forward contract monitoring – are outcomes being delivered or not?	Sometimes hard to measure and then reward the outcomes achieved.
Will help deliver a new evidence base about which interventions are likely to be more successful and which are not.	Some places find it hard to collect the data to demonstrate that they are delivering improved outcomes.

One of the comments that are made about the approach so far in adult care is that maybe councils have focused too much on the procurement process and not enough on commissioning the right range of services which will deliver the best possible outcomes. Can they leave the latter decision to providers?

There are further challenges to the approach. One of these is that the model may not sit easily with the traditional approaches to Direct Payments, a government policy which councils are required to implement, where a service user is allocated a sum of money in order that they can manage how their needs are met. In Wiltshire, they look to allocate the monies available in line with their resource allocation system which will fund outcomes to be delivered. Again, there is a question as to whether it is the customer or the provider who benefits if outcomes are delivered in a shorter time than the budget allows – or does the council claw back the monies (as generally happens if a Direct Payment is not fully spent by a service user)?

Of course, there is less need to commission services when Direct Payments are used to fund personal assistants, friends or neighbours to deliver care.

There may be particular challenges to delivering outcomes for personal assistants – should they be rewarded if they assist a service user to meet their stated goals? There is always the difficulty of any provider being incentivised to do themselves out of a job. In Wiltshire, customers do have the choice not to receive the outcomes based service from the main providers and they can use a direct payment to procure a “standard” service from other local providers. However, the care and support plan is still written in the form of outcomes to be attained.

One of the further challenges that, in particular, arise from recent Government policy which ensures that those people who still have to fund all or part of their care costs are treated in the same way within the care system. In part, this relates to those assessing people for services under the new Care Act (2015), where there is no distinction in the assessment between those who will be self-funders and those who will receive funding from the state. It also relates to the practice from providers who have generally been slower to examine the approach of delivering outcomes into their business model.

Many providers have been reliant in their business plan on high occupancy levels (for residential care) and high volumes of care hours for domiciliary care that they have not been minded to focus on outcomes that might assist their customers to need less care. It could be argued this is a direct consequence of the traditional way in which councils have procured services from them.

There are some signs that in small pockets this is changing. This paper has already cited some providers who will be contracted for outcomes. It will be a real gain if the culture and practices in Councils that focus on “delivering outcomes that promote independence” could be followed by providers of care. They will need to be commissioned to achieve this. The providers who are willing to bid for outcome based contracts do see this as an opportunity where best practice can be rewarded within the contract. In some places, there are current discussions about incentivising providers to deliver outcomes for populations (particularly out of hospital care) where they can be rewarded for meeting the targets. This is still very early days, and most providers of care do not appear publically to have considered these changes, though there are some notable exceptions who may now lead the way into the next phase alongside council commissioners.

## **6 Key pointers for councils**

The basis of outcome based commissioning is to design the delivery of care in such a way that will assist a person in maximising their potential for independence and reduce the risks that dependency is being inadvertently created. This is an approach which ought to help with the challenge for councils to meet people’s needs within a financial context of diminishing resources.

In relation to the assessment process, the delivery of care and the focus on meeting the agreed outcomes costs, it is possible that the overall cost of the approach is higher than the traditional approaches for domiciliary care. On the other hand, the traditional models can encourage some providers to increase the amount of care they offer each person or to reduce the amount of time with each person to maximise productivity of workers. The way in which this approach can save money is through clarity of the amount of care a person needs, which over time may reduce or stop for a number of customers. This needs to be managed by both commissioners and providers. Some key pointers for councils to consider from the emerging evidence and practice experience:

- Get the right set of providers in place to deliver the new model and work with them in a collaborative way in order to get the best possible system in place. Be clear what the likely outcomes that any specific service is being asked to deliver.
- Get the right range of care staff skilled up to deliver the service with the right training and aptitude to deliver the outcomes based approach. This can take some time.
- Ensure that all assessment staff are skilled and understand how to assess people for outcomes (that will promote their independence) – this is not the usual way in which staff will have been trained. The IT systems and all of the forms will also need to support the process which should not be over bureaucratic. Staff will need to understand the evidence for particular interventions to assist people with different conditions or to rely on the providers to deliver this. No matter which approach is adopted, assessment staff and providers need to work closely together.
- Agree who will ensure that customers have all the equipment they need (including telecare) to assist them in maximising their opportunities for independence – this can either be set up by professional staff (e.g. occupational therapists, physiotherapists and those with specialist knowledge of how telecare can support different conditions) before the care is delivered or set up by the care agency as part of the contract.
- Be aware of the need to ensure that all stakeholders are engaged and understand the nature of the changes that may impact on them in the way in which the new service will be delivered. This is particularly important for carers and their families.
- Make the payment mechanism as simple as possible. Consider whether any rewards will be paid for good performance in delivering outcomes. Consider if payments should be made on each individual outcome achieved or for outcomes for sub-sets of the population e.g. hospital discharges. The payment mechanism must also be able to assist service users with their personal budgets (in line with the Care Act 2015).

- Recognise the range of interventions that are required to deliver different assistance for people with different needs to meet their set goals. Help the provider(s) to organise their services appropriately and to link with others when they cannot provide a specific service to meet a specific need – without creating a whole bureaucracy of assessment and approvals. There needs to be significant trust on the providers to have the skills and knowledge to deliver the right outcomes in the most appropriate way.
- Allow providers to recognise with their customers when outcomes have been delivered. It may not require a further assessment to demonstrate that they are right, particularly when there is agreement that no further service is required.
- Recognise that an outcome can be attained for most customers to assist them in become more independent, even if the first steps are hard and may seem small.
- Ensure that the performance management system that is put in place is clear and simple, and that it is reported and considered on a regular basis both to meet demand and outcomes.
- If a new provider is brought in to deliver an outcome based contract (to replace an existing provider) do not rely on staff transferring across (through TUPE). The new provider is likely to have to recruit their own workforce.
- There does have to be work undertaken with NHS and other colleagues to ensure that they understand and can contribute to the approach. For many older people it is ensuring that they are getting the right help for their health needs that make a significant difference to the outcomes that are possible for them. This particularly involves NHS resources to be allocated to therapists and community nurses (the latter has been reducing in recent years). Important service such as memory clinics (that have an outcome focus for people to better manage their memory loss), incontinence services (that have a focus on helping people to regain continence); falls services (that focus on reducing further falls through a proper check of hazards, medication, promote fitness etc).

## 7 Concluding Comments

This paper started with a recognition of a change taking place in the thinking of many local authorities who have placed a new emphasis on interventions that either prevent or reduce someone's need for care. This approach is also stimulating more thoughts from commissioners (and some providers) about outcome based commissioning.

Those councils that are moving to outcomes based commissioning have found it tough initially to make the transition from their previous approach. However, there is a compelling logic that if social care could be delivered in a more effective way which rewarded providers who delivered improved

outcomes, then everyone would benefit. To some degree, the approach is counter cultural and certainly challenges some of the existing legislation which focuses on assessing and meeting needs in a static way. Wiltshire Council has showed the way by changing its approach and, despite several logistical problems, it is starting to make progress. For the approach to really deliver, it does require a combination of commissioners, assessors for service, providers of service and the NHS to all work collaboratively together in a new way. There is also much to do to educate the public to ensure that they understand and can work with the approach.

This author believes that the approach is very positive and should be pursued despite the challenges. It has enormous potential to deliver better outcomes for customers at lower cost. It does however require a cultural and workforce transformation that has only been achieved in part across the United Kingdom. The hope is that this paper can be used to help more who want to go on that journey.

**Professor John Bolton**  
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