

SSIA / National Commissioning Board for Wales

Outcomes based commissioning in domiciliary care – a discussion paper

April 2016

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1 Introduction

This paper has been produced by the Institute of Public Care at Oxford Brookes University (IPC) for the Social Services Improvement Agency for Wales (SSIA) and the National Commissioning Board for Wales. It explores some of the opportunities and challenges presented by taking an outcomes-based approach to the commissioning of domiciliary care, and is intended to stimulate further discussion about how this vital range of services for people who need care and support in Wales can be further developed and improved. It is based on a short review of literature including previous work in this field by IPC in England, Wales and Scotland.

2 Context

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

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

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

3 Commissioning and outcomes

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

However, it is not always easy to be clear about what we are dealing with - this is a complex field with a range of different terms often used interchangeably. So, to be clear in this paper, the meaning of the following terms used in the report are²:

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

4 Why Outcomes – and what might they look like?

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

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

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

There has also been much consideration about the evidence for preventive actions and how a person can be helped in a way that may reduce or eliminate their need for longer term care and support. There has been much discussion and debate about the methods that commissioners might take to help manage longer-term demand for health and social care³. This is in part developed from a range of new approaches that have been given serious consideration in the last decade – the role of re-ablement in helping older people's recovery; the role of rehabilitation in helping people meet the challenges of physical impairments; the recovery model that is widely used as an approach to assist people with poor mental health and the promoting independence work-streams for adults with a learning disability.

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

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

- Short-term recovery (domiciliary care re-ablement) – this might be the continuation of a programme for someone who hasn't recovered within the current standard six-week re-ablement period that local authorities across Wales offer to people to support recovery from illness or injury.
- Longer term recovery – many older people will recover to some degree from particular conditions over a longer period (for example a study in Wiltshire⁴ showed that many older people's recovery takes place between six months and a year).
- To support health care specialists to deliver health care and support to a person e.g. medicine management or wound management.
- Helping a person through home-based practical support to live with or manage a long-term condition (or set of conditions) which may involve helping a person to do more tasks for themselves.
- Helping a person live with or manage having memory loss or dementia.
- Helping a person through end of life care.
- Supporting a carer who is helping any of the above.

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

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

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

specific outcomes are aimed for as a result of the care and support agreed. However, the table below⁵ describes for purpose of illustration, a range of potential outcomes that a service might aim to achieve, and a range of outcomes that an individual might aim to achieve.

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

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

	f. Continued involvement and support for family and spouse carers	
	g. Reduced anxiety about ill health by individual and their families	
	h. Ability to remain in own home for as long as possible	
f. Improvement in being able to undertake daily living function	i. Ongoing improvement, maintenance or minimised deterioration in ability to undertake daily living functions	f. Prevention of ill health
g. Improvement in undertaking the ability to self-care	j. Ongoing improvement, maintenance or minimised deterioration in ability to self-care	g. Ongoing improvement, maintenance or minimised deterioration in physical and mental health
h. Improvement in mobility function	k. Ongoing improvement, maintenance or minimised deterioration in mobility function	h. Prevention of hospital admissions and readmission
i. Improvement in confidence and independence in own home	l. Ongoing improvement, maintenance or minimised deterioration in confidence and independence in own home	i. Reduced stay in hospital
j. Improvement in health or the capacity to sustain health – both mental health and physical health	m. Ongoing improvement, maintenance or minimised deterioration in physical and mental health	j. Ability to return to a suitable home environment following hospital discharge
	n. Continued involvement and support for family and spouse carers	
	o. Reduced anxiety about ill health by individual and their families	
	p. Ability to remain in own home for as long as possible	

k. Improvement in being able to undertake daily living function	q. Ongoing improvement, maintenance or minimised deterioration in ability to undertake daily living functions	k. Prevention of ill health
l. Improvement in undertaking the ability to self-care	r. Ongoing improvement, maintenance or minimised deterioration in ability to self-care	l. Ongoing improvement, maintenance or minimised deterioration in physical and mental health
m. Improvement in mobility function	s. Ongoing improvement, maintenance or minimised deterioration in mobility function	m. Prevention of hospital admissions and readmission
n. Improvement in confidence and independence in own home	t. Ongoing improvement, maintenance or minimised deterioration in confidence and independence in own home	n. Reduced stay in hospital
o. Improvement in health or the capacity to sustain health – both mental health and physical health	u. Ongoing improvement, maintenance or minimised deterioration in physical and mental health	o. Ability to return to a suitable home environment following hospital discharge
	v. Continued involvement and support for family and spouse carers	
	w. Reduced anxiety about ill health by individual and their families	
	x. Ability to remain in own home for as long as possible	

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

Key Message

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

5 The role and nature of re-ablement

In some situations where outcome based commissioning has been introduced for domiciliary care⁶ the move has also led to the commissioners replacing a separate domiciliary care re-ablement service, as the new outcome-based domiciliary care service is able to ensure that all domiciliary care that is provided is based on the principles of re-ablement. This can apply to both for new packages of care and for longer-term existing customers, and there is no need for a separate re-ablement service.

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

This means that for all older people who have “completed a course of six weeks re-ablement” there is still a possibility that they may make a part or full recovery in any of the months following the specific help they received. Because someone still needs care after an episode of re-ablement based domiciliary care doesn’t mean that they will always need care for the long-term. This needs to be considered both by those commissioning care and for those who are providing care. One of the aims of outcome-based commissioning is to find a way of rewarding or at least encouraging providers to help people in a way that doesn’t mean that they will have to rely on care for the rest of their lives (though of course some people will need care to support them long term). The traditional approach to health and social care has always inadvertently encouraged providers to actually increase the amount of care a person needs.

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

The term re-ablement can sometimes be limited to be only seen as beneficial for those where there is a clear likelihood that the person will improve. Recent evidence⁷ has shown that a range of people with quite complex conditions can be assisted if the help is offered in “the right way”. People with depressive illnesses and other long term conditions for example can all be helped through a focussed period of help. In some areas those with the early stages of dementia can be assisted to better manage the condition and to prepare for the longer term impact. For example, anecdotally one of the providers in Wiltshire which runs a specific support service for those diagnosed with

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

⁷ The Torbay Case study in the Local Government Association’s Adult Social Care Efficiency Programme

dementia reports significantly improved outcomes for their customers (and low admission to residential care).

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

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

Key Message

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

6 The role and nature of providers in the care market

6.1 Fewer providers?

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

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

For those councils who have moved to fewer providers there are some risks as well as benefits. Even though existing staff working for providers who do not win contracts (which result in them losing or closing their business) may be protected by the rules

governing TUPE⁸ it is the experience elsewhere that staff can be reluctant to move to a new employer. This can give a new employer a problem with recruiting staff to set up the business in a new area in a speedy manner.

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

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

A further emerging model for commissioners to consider is for the council to contract with a single "Prime Provider" who then has the responsibility for managing the rest of the market. The council has a relationship with a single provider. That provider sub-contracts work to other local providers. The prime provider is held to account for the outcomes of the whole sector. This approach is being developed in Torbay in south-west England. The approach avoids the problems of closing down contracts with smaller providers but can still reduce the transaction costs for the council. This approach may work particularly well if a commissioner wanted to consider procuring services on behalf of a population of people with needs rather than for a group of individuals).

6.2 In-House Services and Local Authority Trading Companies

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

Some councils have in recent years moved their previously run in-house services into a Trading Arm (or social enterprise). There are a number of risks to this approach as it can give the council a longer term problem in being tied to budgets and services that it may not require in the longer-term or may require changes which were not specified in

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

the original agreements. With a strong emphasis on the value of social enterprises in the Social Services and Wellbeing (Wales) Act 2014, if a council does wish to pursue such a venture it is very important that the contract from the council specifies the outcomes (with specific measures) it will be holding the service to deliver.

Key Message

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

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

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

- To describe the important well-being outcomes that people who need care and support and carers who need support should expect in order to lead fulfilled lives.
- To set national direction for services to promote the well-being of people in Wales who need care and support, and carers who need support.
- To provide greater transparency on whether care and support services are improving well-being outcomes for people using consistent and comparable indicators.

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

1. People reporting that they live in the right home for them
2. People reporting they can do what matters to them
3. People reporting that they feel safe
4. People reporting that they feel a part of their community
5. People reporting they feel satisfied with their social networks
6. Children and young people reporting that they are happy with whom they live with
7. People reporting they have received the right information or advice when they needed it
8. People reporting they have received care and support through their language of choice
9. People reporting they were treated with dignity and respect
10. Young adults reporting they received advice, help and support to prepare them for adulthood
11. People with a care and support plan reporting that they have been given written information of their named worker in social services

12. People reporting they felt involved in any decisions made about their care and support
13. People who are satisfied with care and support that they received
14. Parents reporting that they felt involved in any decisions made about their child's care and support
15. Carers reporting they feel supported to continue in their caring role
16. Carers reporting they felt involved in designing the care and support plan for the person that they care for
17. People reporting they chose to live in a residential care home

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

At its simplest all domiciliary care contracts should include a requirement to measure the reported outcomes and for each supplier of care to be held to account for the performance of their services within that authority. The continuation of any contract beyond its stated term should be dependent of the provider being able to demonstrate a good performance in each of the relevant measures. The provider should be expected to understand how their service can contribute to each of these outcomes.

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

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

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

Example Service Outcome Measurement Framework A service that can contribute to the initial reduction of the levels of care and/or support over a period of time		
Individual Outcome	Measures	Methodology
	attending to overall health outcomes	

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

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

Key message

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

8 Moving to a more effective outcomes approach for domiciliary care

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

8.1 Moving to outcome-based objectives

In order to move to outcomes-based commissioning those assessing for services need to define this in the form of desired outcomes. An assessment of need drafted in the form of outcomes that may be delivered is completed and providers are rewarded for

delivering the outcomes in a timely manner. The circumstances in which commissioners might consider more requirements from a provider of domiciliary care are:

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

These approaches require certain conditions to be in place:

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

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

Key Message

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

8.2 Rewarding the achievement of outcomes

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

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

The commonly adopted mechanism is to pay a set sum to the Provider for each outcome that is delivered. A schedule is worked out which guestimates the amount of time a provider might need to deliver a specific outcome. The calculation is usually based on the findings from the PSSRU study on re-ablement⁹ which estimated that each person receiving a re-ablement care package on average received just over 100 hours of care costing about £2,000 per package. This is an offer of intensive support over a six to eight-week period. Other estimates suggest that this figure is slightly too high and a better average cost is £1,575 per intervention (includes the costs of therapeutic support). Based on this estimated cost it is possible to suggest that this might be the starting point to consider how much a provider might be paid to meet a short-term objective. The Provider is rewarded if they deliver the outcome in a shorter period and meets the cost if the outcome is not delivered in the agreed period.

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

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

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

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

¹⁰ 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.

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

Key message

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

8.3 Outcome-based objectives for populations

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

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

The payment mechanism for a population based outcome model again will need to be established locally. The approach expects that all older people in the defined area who are deemed to be eligible for care are referred to the lead provider. The service would include all aspects of domiciliary care from short-term re-ablement to longer term support. The service provider would expect, for example, to deliver a minimum of 50% of people re-abled so they need no further support after eight- ten week; a further 10-15% helped within the first year; and to sustain low admissions to residential care by ensuring people get the help to live at home. The cost of the service would be based on

¹¹ 'Options for Integrated Commissioning' King's Fund 2015

achieving these outcomes. A simple calculation considered that the price would equate to around £600,000 per annum per 100 older people referred. This figure is based on provider being paid the equivalent of £15.00 per hour (this can be adjusted for local circumstances).

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

Key Message

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

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

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

- Link the move to outcome-based commissioning to a model of social care which focuses on prevention and promoting independence.
- Get the right set of providers in place to deliver the new model and work with them in a collaborative way in order to get the best possible system in place. Be clear (with these providers) what the likely outcomes that any specific service is being asked to deliver.
- Get the right range of care staff skilled up to deliver the service with the right training and aptitude to deliver the outcomes based approach. This can take some time.
- Ensure that all assessment staff are skilled and understand how to assess people for outcomes (that will promote their independence) – this is not the usual way in which staff will have been trained. The IT systems and all of the forms will also need to support the process which should not be over bureaucratic. Staff will need to understand the evidence for particular interventions to assist people with different conditions or to rely on the providers to deliver this – which ever approach is adopted assessment staff and providers need to work closely together.
- Agree who will ensure that customers have all the equipment they need (including telecare) to assist them in maximising their opportunities for independence – this can either be set up by professional staff (Occupational Therapists, Physios and those with specialist knowledge of how telecare can support different conditions) before the care is delivered or set up by the care agency as part of the contract.

- Be aware of the need to ensure that all stakeholders are engaged and understand the nature of the changes that may impact on them in the way in which the new service will be delivered. This is particularly important for carers and their families.
- Make the payment mechanism as simple as possible – consider whether any rewards will be paid for good performance in delivering outcomes. Consider if payments should be made on each individual outcome achieved or for outcomes for sub-sets of the population e.g. hospital discharges.
- Recognise the range of interventions that are required to deliver different assistance for people with different needs to meet their set goals. Help the provider(s) to organise their services appropriately and to link with others when they cannot provide a specific service to meet a specific need – without creating a whole bureaucracy of assessment and approvals. There needs to be significant trust on the providers to have the skills and knowledge to deliver the right outcomes in the most appropriate way.
- Allow providers to recognise with their customers when outcomes have been delivered. It may not require a further assessment to demonstrate that they are right particularly when there is agreement that no further service is required.
- Recognise that an outcome can be attained for most customers to assist them in become more independent – even if the first steps are hard and may seem small.
- Ensure that the performance management system that is put in place is clear and simple and is reported and considered on a regular basis both to meet demand and outcomes.
- If a new provider is brought into to deliver an outcome based contract (to replace an existing provider) do not rely on staff transferring across (through TUPE). The new provider is likely to have to recruit their own workforce. This will also take time.
- There does have to be work undertaken across the health, care and wellbeing system to ensure that all partners understand and can contribute to the approach. For many older people it is ensuring that they are getting the right help for their health needs that make a significant difference to the outcomes that are possible for them. This particularly involves NHS resources to be allocated to therapists and community nurses. Important service such as memory clinics (that have an outcome focus for people to better manage their memory loss), incontinence services (that have a focus on helping people to regain continence); falls services) that focus on reducing further falls through a proper check of hazards, medication, promote fitness etc.).

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

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

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

10.1 **Option One**

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

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

The lack of financial incentives in this model may mean that providers of care are not motivated to make the changes required. Under the current procurement approach adopted by many councils the incentives tend to favour providers who can deliver more care and they are not incentivised to deliver less. The way in which care is delivered will make a difference to whether a person is helped to regain independence or if they become more and more reliant on the care provided. The organisation requires a strong focus on performance management of the contracts in place. This in turn means that it is best introduced into a market where there are fewer providers who can be more closely monitored. This approach might be best used to look at the outcomes from Intermediate Care Services or Supported Living/Extra Care accommodation, though it can work for all domiciliary care providers.

10.2 **Option Two**

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

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

The approach seeks a change in both assessment procedures and the behaviours and attitudes of providers. There is a risk that the transaction costs in the system increase as all parties need to agree both the defined outcomes and the cost of delivering these. Again this may be best managed with fewer providers who have the scale and capacity

to manage the delivery of the system and put their investment into staff training and support. It requires sophistication from providers to ensure that they are offering the right type of care in the right way e.g. different care for people who are recovering from a medical intervention or those with a dementia.

10.3 Option Three

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

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

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