



OUTCOMES MATTER: EFFECTIVE COMMISSIONING IN DOMICILIARY CARE

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“As we set out earlier this year, we want to put an end to undignified care by the minute. We want care that is judged by the outcomes that matter to people receiving the care.

“We know that some councils and care providers are leading the way, but there is still a long way to go. We will continue to work with care providers and people who use the services to bring an end to providing care that undermines people’s dignity and choice.

“I am determined that collectively we develop commissioning skills so that providers are rewarded for improving health and well-being, promoting independence and increasing mobility.”

*Norman Lamb MP,
Minister of State at the Department of Health*

“I welcome the research work undertaken by the LGiU and Mears to raise the profile of outcome based commissioning across social care and support services. In a time of increasing pressure on social care budgets, outcome based commissioning focuses attention on what is important and what can most benefit individuals and communities.

“In the London Borough of Sutton we are actively working to move away from traditional time and task commissioning to focus on outcomes and empower commissioners, organisations and individuals working in the social care sector to collaborate in more creative and innovative ways to transform people’s experience of care and support for the future.”

Cllr Colin Steers, Lead Member for Adult Social Services and Health, London Borough of Sutton

“We are pleased that the LGiU is focusing on the important issue of outcome based commissioning. In Essex our approach to contracting follows a number of commercial principles, which include; moving away from block contracting, allowing the market to regularly compete for business, linking quality and price and focusing on outcome based payments.

“The recently awarded reablement contract is one example of a shift away from an output focus, this enables the provider to innovate and develop new solutions to meet resident’s needs in a more efficient and effective way, delivering outcomes.”

Cllr John Aldridge, Cabinet Member for Adult Social Care, Essex County Council

"Wigan Council has been moving completely away from the old "time and task" approach to providing home care. The value to our residents who experience a more human, personal service, and get better outcomes is fed back to us as we regularly consult with our service users on the quality of the service they receive. Better outcomes for residents also means better value for money. This outcomes-focused approach helps to create the right relationship between the provider and the service user so that they can offer a more flexible service, able to respond at times when a bit more help is needed, and reduce appropriately at other times.

“In turn, this reduces the need for detailed specification changes and micro management and so improves back office efficiencies. The services for the future will, we believe, prove to be more cost effective and efficient if they are helping individual service users to make the best use of all the assets they have as people, and fit services round them rather than follow rigid service models of the past."

Cllr Keith Cunliffe, Co-Chair of the Health and Wellbeing Board, Wigan Council

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Forewords



AS A NATION we are living longer, which should be a cause for celebration, but when I speak with people facing old age they worry about what the future holds. Our current system of care has moved in a direction which demands that care workers clock in and clock out. Unfortunately this approach is on the whole, driving service delivery. With demographic pressures and immense financial constraints facing local authorities, there is a risk that we will see a race to the bottom with care providers competing for who can deliver care packages at the lowest per minute cost.

There is a general consensus that commissioning for outcomes is a positive move, but as a provider who sees care contracts on a daily basis, we continue to have our hands tied by task and time contracts whilst true commissioning for outcomes remains somewhat elusive and out of the ordinary. We believe that while this continues, older and disabled people will have their dignity and independence eroded and the longer term cost of social care will continue to rise for the sake of short-term unit cost savings today. Having spoken to many local authorities we understand that they feel the same, but they are struggling with the joint challenges facing social care and the need to make immediate savings.

It may seem strange for a care provider to be highlighting these practices. Many providers are happy with the status quo, but Mears believes that providers should work together with commissioners and other providers to improve services; and should be paid on the basis of the results they deliver. A task and time system de-incentivises prevention because if an individual's care needs escalate there will be more work. Instead of judging our care providers on their ability to get care workers in and out of a person's property in 15 minutes should we not be paying them on whether they have reduced hospital admissions, prevented falls and enabled independence?

So, if personalisation and commissioning for outcomes are almost universally agreed as good things what is stopping us from getting from the theory to the practice? Mears have worked with LGiU to explore current practices and the barriers to change. This report shows that commissioning for outcomes is possible and by rethinking current commissioning practices we can do more with less.

But we know that real change can only be achieved through working in partnership; private providers, the third sector, service users, local government and our health services. Mears welcomes the opportunity to work with commissioners who want to drive up the quality of care, integrate services, provide better value for money and ultimately ensure that older people live their life with dignity, choice and control.

Alan Long
Executive Director,
Mears Group



PUBLIC SERVICES face real challenges in the near future. Resources are shrinking at the very time that long term trends such as an ageing population and an increasing complexity of need are driving up demand.

Nowhere is this more true than social care.

A commissioning process, irrespective of your choice of delivery agent, is part of the solution to this problem – a way of offering efficient, targeted and personalised services.

This process only works, however, if commissioning processes are flexible and responsive to the needs of the individual. Outcomes are central to this. Defining them, measuring them and contracting around them is the best way to drive innovation, efficiency and results from in-house teams and external partners alike.

However, although this is widely recognised, cuts to social care budgets have in reality forced councils to ration home care services in ever-smaller chunks of time. In our survey, over a third of respondents paid their providers in slots of 15 minutes or less. Only 7% reported paying providers according to the outcomes they achieved for the individual.

Councils clearly recognise this as a challenge, with 75% saying they see a ‘time-task’ approach as their biggest obstacle to commissioning services that promote outcomes.

In this report, we argue that working with providers of all sectors to incentivise the delivery of outcomes is a priority. If we continue to pay providers according to the time spent with a service user, we incentivise failure and give unscrupulous providers the opportunity to deliver poor outcomes for the individual, in order to increase their care package.

This is a big ask for local authorities, and requires upfront investment, but there are already examples of forward thinking councils delivering services in innovative ways to meet this challenge. We’re delighted to be working with Mears on this report and hope the case studies will help to share best practice and support authorities to develop their thinking around outcome-based commissioning in care delivered in the home.

Jonathan Carr-West

Policy Director

LGiU



Executive summary

The concept of outcome-based commissioning has been a feature of the adult social care landscape for some time, as a method of delivering personalised services based on need. A recent LGiU survey has shown that over 70% of local government respondents regard outcome-based commissioning as ‘very important’ to the future of adult social care.

But what do we mean by commissioning? The renewed interest in in-house provision shown by some local authorities could be held to imply a move away from standard commissioning models. We would argue however that ‘commissioning’ describes the strategic process of designing services and choosing delivery agents, rather than proscribing a particular form of provision. As such, it remains intrinsic to the system, irrespective of the choice of service provider. Most definitions describe a cyclical process, where possible involving carers, care workers and service users through consultation and coproduction, and including the following steps:

- assessing the needs of a population
- setting service priorities and goals
- securing services from providers to meet those needs
- monitoring and evaluating outcomes.

Appropriately, different communities will require different models of service provision, but whether the service provider is ultimately a private sector organisation, a charity, a social enterprise, in-house service or a

dynamic mixture of all, the commissioning process will remain the basis for decision making about the design of a service.

Despite a general consensus about the value of this process, progress on the outcome-based commissioning agenda has been patchy, and fraught with difficulty. The use of service outcomes is now well recognised, but the process of paying providers on the basis of the outcomes they achieve is less common. The current pressures of the financial situation have also proved challenging, as local public organisations attempt to share budgets on cross-cutting outcomes, while simultaneously finding unprecedented levels of savings.

This report sets out to investigate current practice in commissioning for outcomes in domiciliary care in England. With rising demand for adult social care services, at a time of declining resources, the goal of promoting independent living and high quality outcomes for the individual has never been more important. Care and support in the home is at the centre of the debate. With this in mind, we undertook a programme of research to identify the challenges, opportunities and examples of innovative practice that shape council commissioning of domiciliary care.

Our initial survey of local government officers and elected members working in social care made some interesting findings:

- while most respondents reported the regular use of outcome-based commissioning, a sizeable minority of 35.9% said that it was only used ‘to a limited degree’ in their

authority. More than 70% saw commissioning for outcomes as a 'very important' priority for social care in future.

- 75.9% of respondents disagreed with the statement 'our current systems and processes will be sufficient to manage our adult social care provision in future', reflecting the present resourcing challenge facing social care. More than 90% agreed that pressure on resources was making them reconsider the way in which they provide social care.
- 74.4% of respondents regarded 'a culture of running services on a time-task basis' as an important barrier to outcome-based commissioning in future. However, over 90% still pay providers according to the time they spend with a service user, rather than outcomes.

The results of the survey throw up a number of important questions for local authorities.

- What further steps can we take to break down a 'time-task' culture in commissioning domiciliary care?
- How can we most effectively incentivise providers to deliver high quality outcomes for the individual, to promote independence and reduce the need for care where possible?
- How can we ensure outcomes are shared between health, housing, social care and other relevant services to minimise waste and avoid duplication?
- How can we establish and measure outcomes that are meaningful to both provider and service users?

- How can we ensure service users are fully engaged in shaping their own care and determining the outcomes they want to achieve?
- How can we ensure care staff are supported and empowered to deliver high quality services?

Our call for examples of innovative practice in this area highlighted a range of illuminating case studies, detailed in Chapter 5. Wiltshire County Council's 'Help to Live at Home' scheme rewards and penalises providers on the basis of their performance against outcomes. Wirral's Rapid Access Contract has broken down organisational boundaries to minimise discharge times for hospital patients around shared outcomes.

Trafford's Quality Checkers show how successfully service users can be involved in improving service performance, while Essex County Council demonstrates a useful model of market management and use of payment by results in reablement.

These examples draw attention to some of the challenges and opportunities in developing a successful approach to outcome-based commissioning.

On this basis we have developed a five-point checklist for raising our game in commissioning.

1) Are you contracting for outcomes?

Establishing outcomes as the basis for a commissioning strategy is important, but explicitly linking the payment of providers to the outcomes, rather than the outputs that they deliver, is a more powerful tool. When providers are paid on an hourly rate, they are offered no incentive to reduce dependency on services or respond flexibly to individual changes in circumstance. Giving them the right target will help to improve the efficiency of the service and result in better outcomes for the individual.

2) Have you considered the local drivers for need?

Service user need can be manufactured by badly designed services. If we are to deal with the current pressures on adult social care, and continue to meet the needs of our communities, domiciliary care services should be based on the premise of reducing or stabilising dependence on service provision wherever possible in line with service users' own expressed preferences.

3) How well aligned is your commissioning for housing, health and social care?

Housing, health and social care are the three pillars of independent living. Identifying shared outcomes between these three areas and commissioning together will offer more efficient and integrated services.

4) Do you empower providers?

The focus on a time-task method of commissioning, along with tight budgetary constraints and several high profile safeguarding scandals, have shifted the council's role into one of invigilator, often leading to a command and control approach to dealing with providers. Commissioning for

outcomes involves putting the onus on the provider to solve the problem, alongside the service user. Market management should be about increasing the range of care products available, rather than simply increasing the volume of providers in the market.

5) How engaged are elected members?

Councillors have a crucial role to play in connecting council processes to the outcomes they see through their case-work in the community. At present many people in receipt of care, and older people in particular, find it difficult to make their voice heard. Elected members can act as important advocates for people in the care system, while also holding influence over the internal processes for commissioning.

Responses to this set of challenges will necessarily depend on local circumstance: there is no one-size-fits-all model of service delivery that will provide the answers. By sharing practice we can move towards a better understanding of how outcome-based commissioning can help to deliver high-quality, cost-effective, personalised services for the individual in times of great financial pressure.



1 Context: resourcing pressures and implications for commissioning

The UK social care sector is facing a serious funding crisis. Rising demand for services, combined with shrinking resources, together present a worrying picture for the future of care for our oldest and most vulnerable residents. The sector is facing pressure on both sides of the equation, and calls for government to address the funding of social care are becoming increasingly vocal, particularly in the context of the recent White Paper. Nevertheless, while local government alone cannot answer the funding question, there is still scope for some aspects of commissioning to deliver better value and higher quality services.

Rising demand for services

Demand for social care is being driven by demographic change. The Office for National Statistics states that the population aged 65 and over will account for 23% of the total population in 2035, while the proportion of the population aged between 16 and 64 is due to fall from 65% to 59%. In future this demographic change will place additional pressure on council services, as the gap between demand and available resources widens.¹

These projections have profound implications for the delivery of social care. We know, for example, that life expectancy in the developed world is increasing at a rate of two years per decade. However, people now live with chronic illness for an average of eight years at the end of their lives.

As well as a general rise in demand, we are seeing a growing complexity in the needs social care services are addressing. There are approximately 1.5 million people in Britain currently living with learning disabilities, and that number is likely to grow by 14% between 2001 and 2021 according to research by Lancaster University.²

While the focus of attention in social care debate tends to rest with older people, it is important we do not forget the importance of other groups in receipt of services.

Resourcing challenges

The increased levels of demand and complexity are coupled with a reduction in resources. The government's commitment to eliminate the budget deficit within a single parliament has major implications for council budgets: the October 2010 Spending Review reduced central government's grant to local government by 28% over four years. Although this was offset to some extent by additional funding for health and social care, there are still major savings to be found from this service.

The 2011 Association of Directors of Adult Social Services (ADASS) budget survey has found that adult social care will provide a contribution to savings in 2012/13 of £890m. This represents 6.8% of the 2012-13 adult social care budget before savings. When combined with last year's figures, the cumulative reduction in adult social care budgets is £1.89bn. Over 85% (£688m) of planned reductions have been secured

¹ <http://www.statistics.gov.uk/hub/population/ageing/older-people>

² Emerson E, Hatton C (2009), *Estimating Future Numbers of Adults with Profound Multiple Learning Disabilities in England*, Lancaster: Centre for Disability Research, Lancaster University.

through service re-design and efficiency and £77m provided through increased charges. Only £113m – 12.7% – has been saved by reducing services.³

How big is the problem?

Despite the work of adult social care departments to preserve frontline services, the picture in the long term is less encouraging. In June this year, the Local Government Association (LGA) released a report that modelled the funding outlook for councils up to 2020. According to the LGA's calculations, the money to fund popular services such as leisure and libraries will shrink by 90% as adult social care and other statutory responsibilities soak up almost all council budgets by the end of the decade.

The report shows that by 2020 a £16.5bn funding shortfall will exist between the amount of money available to councils to provide services and the predicted cost of maintaining them at current levels. This gap is largely attributable to the rising cost of adult social care. Estimates suggest that spending on social care will exceed 45% of councils' total budgets by 2019/20.⁴

Some local authorities have drawn a starker picture. Barnet Council has recently attracted press coverage for its 'Graph of Doom', which shows that on current projections, within 20 years the council will be unable to provide any services except adult social care and children's services.

LGiU research, conducted as part of the Local Government APPG enquiry into adult social care funding, has gathered funding evidence directly from a wide range of local authorities on both the growth in demand and the decline in resources. This information suggests that while the picture

differs across the country, the current funding gap is at 4.4% per annum, equivalent to £634m in the next two years and rising thereafter.

Safeguarding

Concerns for the future of social care services are also being driven by a series of high profile human rights violations in care homes. Reports into institutions such as Ash Court and Winterbourne View have highlighted the vulnerability of people in care. These concerns are not limited to the care home sector: the Equality and Human Rights Commission (EHRC)'s Close to Home enquiry into home care reported that "our inquiry has uncovered serious, systemic threats to the basic human rights of older people who are getting home care services".

At the same time, the collapse of Southern Cross has demonstrated the potential impact of financial failure on the part of a large provider.

Implications for strategic commissioning

There is no easy solution to these challenges and increasing pressure on resources will have important implications for the way social care is to be delivered in future. While the social care White Paper 'Caring for our future: reforming care and support' initially deferred a decision on the Dilnot Commission's recommendations until the next spending review, it has since been rumoured that the government intends to push forward with the recommended £35,000 cap on care fees. Nevertheless, although a decision on this issue would deliver some level of consistency in the care system, the underlying funding question remains.

³ http://www.adass.org.uk/index.php?option=com_content&view=article&id=813&Itemid=470

⁴ http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3626323/PUBLICATION-TEMPLATE

However the central funding problems are to be addressed, there must be a shift in our understanding of how we address the needs of vulnerable people. The long-term gap between rising demand and availability of resource necessitates broader change in the way we provide care.

This cultural shift may include some of the following features:

- greater investment in preventative support
- more support for people to live independently at home for longer, and commissioning processes that support this;
- breaking down barriers to and supporting informal care
- better support, information and advice to ensure that people make good decisions about their care arrangements.

Local authorities have enormous power to shape the context within which care is requested and received. It clear that care in the home is an essential part of the solution. A recent report based on Department of Health accredited FACE assessment tools has identified savings of between £3m and £7.8m for councils with social services responsibilities across England if more is done to help elderly people remain in their own homes. This constitutes approximately 7.4% to 19.4% of their social care budget for older people.⁵ Besides the financial benefits, support in the home is an essential aspect of a high quality person-centred approach to care. Most older people express a

preference for living in their own homes for as long as possible.

Underpinning any new model is an effective commissioning strategy that brings together the public sector at a local level to deliver against shared outcomes for the community and for the individual. Commissioning is one of the most important tools councils and their partners at a local level have to shape the nature of demand and to determine the way in which care is delivered. Outcome-based commissioning can help to shape efficient targeted services, but it is also a tool for building a quality person-centred approach that meets the needs of the individual.

We should be clear that commissioning does not imply one form of service provision over another. The present funding gap, in conjunction with the shift to localism has generated interest in re-developing their in-house provision in some areas of the country. Commissioning and in-house provision are not alternative forms of service delivery, rather commissioning is the process by which a council assesses need and plans, designs and procures its services, whether they are to be delivered by the private sector, by charities, by social enterprise or by in-house teams.

With this in mind, this report will focus on outcome-based commissioning in domiciliary care. It will seek to identify current practice, identify challenges and opportunities and draw attention to innovative case studies. We have seen that councils are facing the twin pressures of declining resources and increasing demand for services. In this context, the need to ensure our commissioning processes are fit for purpose has never been greater.

⁵ http://www.thisishampshire.net/news/9814188.Big_social_care_savings_possible/



2 Where are we now with outcome-based commissioning?

Commissioning for outcomes has been an accepted part of the narrative in adult social care for some time. While there is still debate about the types of organisation authorities should commission, most would accept the core values of a commissioning approach in terms of process: identifying need in the community, designing service goals and outcomes, securing services that meet those needs and monitoring and evaluating outcomes.

Equally, few would challenge the value of outcomes as well as outputs. The need to shift thinking from how a service operates, to what it accomplishes is recognised and the concept of strategic commissioning has been taken further in children's and adults' services than in any other aspect of council service delivery. Nevertheless there are still challenges that must be faced before a truly outcome-focused approach is universally employed.

The development of outcome-based commissioning

One of the biggest factors in shaping the current context has been the evolution of the social care market, which is now one of the most developed in the public sector.

- In the 1980s, the government's commitment to a 'mixed economy of care' saw an expansion in the care market, which became more pronounced from the early 1990s onwards.
- The 1990 National Health Service and Community Care Act made it a

duty to assess people for care and support, and introduced an internal market into the supply of healthcare, making the state an 'enabler' rather than a supplier of health and social care provision.

- The 2007 Commissioning Framework for Health and Wellbeing represented another step in the journey towards commissioning for outcomes. It aimed to shift the focus on acute services towards prevention, and introduced the Joint Strategic Needs Assessment as the foundation of needs based commissioning.
- The 2012 Health and Social Care Act establishes a new outcomes framework for the NHS, public health and social care, giving local authorities responsibility for securing their identified outcomes.

In the context of the localism agenda some authorities have started to reconsider the option of in-house provision. Nevertheless, as the results of our survey will demonstrate in Chapter 4, the general trend is towards a greater diversity of service provision, incorporating a wide range of providers, from in-house provision, to charities, social enterprise and the private sector.

The commissioning cycle in which local need is considered, services designed, providers identified and outcomes monitored remains relevant irrespective of the type of provider involved. We will argue that the focus of debate should be on the quality of outcomes achieved for the

service user, rather than the form of provision used to deliver them.

More than 90% of respondents to an LGiU survey on commissioning regarded outcome-based commissioning as 'important' or 'very important' to the future of care. It is clear that the concept of employing outcomes as a basis for commissioning is here to stay. Outcomes, with an accompanying emphasis on personalisation and choice, are firmly set to form the focus of future commissioning in social care.

Outcome-based commissioning and personalisation

Discussion about outcome-based commissioning invariably goes hand-in-hand with debate about choice and personalisation. The growth of the disability movement, particularly from the 1970s onwards, challenged the traditional balance of power in social care and saw the development of the independent living movement.

The mid-1990s saw the introduction of direct payments and was followed by series of government publications that advocated 'self-directed' support for service users more widely. The coalition government has committed to a personal budget being available for everyone eligible for ongoing social care by 2013.

Outcome-based commissioning is very much a part of this agenda. Commissioning on the basis of individual outcomes, rather than outputs, shifts the emphasis away from systems and processes and onto the quality of the service and the impact on the individual. However, personal budgets and direct payments have had profound implications for the structure of commissioning. Under care management, services were usually bought in large block contracts for particular service user groups.

Service users were then matched to the service, rather than the service being tailored to their own individual requirements.

For many authorities, moving towards personal budgets has involved challenging this approach, using some of the following steps:

- making a strategic shift away from block contracts towards framework agreements; umbrella agreements that set out the terms (particularly relating to price, quality and quantity) under which individual contracts can be made throughout the period of the agreement
- moving service users onto personal budgets, and, where appropriate, onto direct payments
- taking an active approach to managing the market, aiming to increase the number of providers in order to maximise choice
- providing high quality advice and information for service users (in some cases including self funders) to enable them to make good choices about their care arrangements
- developing partnerships, particularly with health, to try to make the move between different services seamless for the service user
- seeking opportunities for co-production of services with service users where possible.

Personal budgets have been a success in many ways, giving people more control over the outcomes they want to achieve; a recent evaluation report by Lancaster University shows that of 14 measures of quality of daily life, between 57% and 76% of all respondents reported improvement in 10 as

a direct consequence of having a budget.⁶

Despite this, we are by no means at the end of our commissioning journey.

Personalisation, particularly in relation to personal budgets and direct payments, still faces several challenges that we will explore in the next chapter.

While important steps forward have been taken towards delivering personal outcomes for service users, there remains some way to go and parts of the reform have had far reaching implications that need to be considered in more depth.

There are still many important questions for outcome-based commissioning:

- How much choice do personal budgets actually offer?
- What does market management mean in the context of domiciliary care?
- Does maximising the number of providers in the market increase choice?
- How can we empower care staff?
- How far have we moved away from a time-task approach to service delivery?
- To what extent are providers incentivised to deliver outcomes for service users?
- How can we successfully articulate positive outcomes and measure their success?
- How can we support integration between the services that support better outcomes for individuals, for example housing, health and social care?

Many of these questions relate to the relationship between commissioner and provider.

In the next chapter we will explore some of these challenges in more detail and consider what issues must be addressed before outcome-based commissioning can become a reality.

⁶ <http://www.in-control.org.uk>



3 Challenges for outcome-based commissioning

The need for personalisation and for outcome-based commissioning has been the dominant narrative in social care delivery for the last decade at least. If we accept that it is not yet fully embedded, we must ask why we have not progressed further. What questions must be answered before outcome-based commissioning can be really put into practice?

How much choice do personal budgets offer?

Personalisation has been a very important aspect of adult social care reform over the last 10 years. Moving away from a 'one-size-fits-all' approach towards individually targeted service delivery represents a vital cultural shift for the sector. Nevertheless, there are still implications to be explored in relation to the financial impact of a personal budget approach, and the level of choice that they offer to service users.

First, the financial impact of person budgets is still to be fully explored. In 2010 the Department of Health's finance chief John Bolton announced that personal budgets were proving to be 'cost neutral' overall, whereas previous studies had shown an overall cost benefit.

In many ways this is a positive finding, but at a time when major savings are being sought, it raises questions about the scope for efficiencies. The move away from large block contracts makes economies of scale more difficult to achieve, as providers take on increased responsibility for risk, and face considerable uncertainty in relation to volumes of work, often over fairly short

contracts or framework agreements. If savings cannot be found in this way, other means must be sought. For many councils this has had a knock-on effect on other aspects of the service, either in terms of eligibility criteria, or in terms of the hourly rate an authority is willing to pay a provider.

Second, there are questions about the real impact of personal budgets. Many are still 'managed' budgets rather than direct payments, and there has been speculation about the real level of choice that is available to individuals. This will depend very much on the area in question and the training and support offered to frontline staff. In many cases, service users will simply take the services that are recommended by the authority or provider. If staff do not have a full understanding of the products available, the service user may simply receive the same service that they would have received in the past.

Even with a direct payment, service users may not always experience a greater level of choice and control. The use of personal budgets and direct payments in the context of young adults with learning disabilities is very different to their application in the context of elderly people. Successful direct payments require the service user to become a commissioner themselves, a challenging prospect for many individuals.

Having real choice in the use of a personal budget is dependent on users understanding the full range of options available to them, as well as the consequences of their choices. Unlike shopping for products in a supermarket, shopping for care can be an opaque and confusing process, and it is shaped as much by expectations as it is by

the availability of care products. The social care White Paper includes a duty for authorities to make information about local care provision more easily accessible online, but more information alone does not always make such choices easier. The way this information is presented determines its value to the individual, and many will still need brokerage and advice.

This is not to say the concept of personal budgets is necessarily flawed: clearly delivering an approach that empowers the individual and gives them control over their own lives is a desirable outcome. But we must think carefully about what we mean by choice, and how we make it meaningful for the service users.

Local authorities unconsciously shape service user choices through the services they provide and expectations that they build. We should be aware of this influence when we approach market management.

What does market management mean in the context of domiciliary care?

First, 'market-management' is often characterised by councils aiming to maximise the number and diversity of providers in the market place, with a view to increasing choice for the service-user. This can be an important aspect of market management, but on its own, increasing the number of providers does not necessarily broaden choice, particularly if they are offering similar packages of care. Choosing between 60 care providers all of whom offer the same services is no choice at all.

As we noted above, the ability of service users to make informed choices about their care is often limited by a lack of information, and a poor understanding of what is available. Market management needs to be focused on the breadth of service as well as the volume of providers.

Second, adult social care still has a significant level of savings to deliver, but as markets are becoming more diverse there are fewer opportunities to deliver savings through the economies of scale generated by large contracts. Savings must be found elsewhere.

How should we monitor providers?

Reducing waste in the system has been one way in which authorities have sought to reduce their costs. The introduction of framework agreements has provided some of this impetus, by asking providers to compete on the basis of cost and quality. In such agreements, providers are faced with a high level of uncertainty in terms of volume of work and their long-term position in the local area. In theory this drives cost down and quality up and providers jostle for poll position on the framework.

However, there are concerns about this approach. If the emphasis on cost is dominant, some providers are encouraged to submit 'suicide' bids in which they make unrealistic cost appraisals in order to maximise their opportunities for work. Without scrutiny from the local authority from the very start of the tender process, this can have a serious impact on service quality and in extreme circumstances cause the collapse of the provider. In Chapter 5 we will see how some authorities have worked to shift the emphasis away from cost and onto quality.

Another trend in cost reduction and waste minimisation is the renegotiation of hourly rates for care with providers and the introduction of electronic monitoring. Electronic systems are used to measure the precise amount of time the provider is in the home of the service user, allowing the council to pay the provider for exact allocations of time. This approach has allowed some councils to cut out journey times from payments to providers, and pay

them solely for the time they are delivering care. In a time of declining resources this approach has allowed some councils to deliver against their saving targets without any immediately apparent impact on services.

There are however, implications for service users in rationing time in ever smaller time slots. According to a survey conducted by the United Kingdom Homecare Association, three quarters of all trips to older people now have to be completed in less than half an hour, with one in 10 limited to no more than 15 minutes.⁷

Sian Davenport, Regional Operations Manager for Mears commented that:

“Many local authorities now use electronic monitoring of care workers such as CM 2000 or Ezi Tracker. These systems put the emphasis on clocking in and out rather than service delivery. As service providers we would like the flexibility to provide care services that an individual wants. So for example an individual may prefer three weekly visits of 35 minutes than a daily visit of 15 minutes. With care frequently purchased in 15 minute slots it is very difficult for a service provider to deliver a personalised service. Electronic monitoring can be a valuable tool for automating finance process and for health and safety monitoring, but it is increasingly being used as a mechanism to pay by the minute, leading to the system driving the service.”

The use of electronic monitoring in this way raises questions about the balance between cost and quality of service delivery.

How can we empower care staff?

The need for savings has also led commissioners to re-negotiate the hourly rate of care with their providers and to pay

for smaller and smaller chunks of time; however, there are limits to how cheaply care can be delivered by the hour. Care workers are among the lowest paid in society.

Research published by King’s College London in 2011 has even suggested that between 150,000 and 200,000 care workers over the age of 21 may be earning less than the statutory minimum wage. The figure is at least five times higher than government’s own estimate from the Office for National Statistics (ONS).

In their response to the *Caring for our future: reforming care and support* White Paper, public sector union UNISON identified several areas of concern in relation to current commissioning practice and cuts to finance in social care. Some of the issues they identified included the following:

- the pressures of cost has increased the so-called practice of “e-auctions race to the bottom” and “suicide bids”
- the low funding of contracts places a squeeze on workers’ pay and time limits to visits, creating pressure on both the care recipient and the care worker
- care workers feel they don’t have enough time or flexibility in their work, causing low morale
- the average hourly care worker rate in 2010 was £6 per hour, which is a drop of 4.8% since 2008 and, combined with rapid inflation increase, makes an average drop in wages of 7.3%
- poor pay and low reward increases churn. The majority of care workers

⁷ <http://www.telegraph.co.uk/health/elderhealth/9379877/Care-routinely-rationed-to-15-minute-slots-to-save-cash-study-shows.html>

move to another provider in the same sector for better pay. Often in health, which is seen as better paid and rewarded. The turnover rates of care workers in April 2010 was 21.4%.⁸

They also highlighted the reduction, or non-payment of travelling times between home care visits as an important workforce issue. It could be argued that the increasingly proscriptive approach to commissioning providers and the growing pressure on the hourly rate in response to savings targets is a central part of this issue.

These comments were reflected in the November 2011 Equalities and Human Rights Commission's *Close to Home: an inquiry into older people and human rights in homecare*. It found that 'some commissioning was driven by quality, and referred to human rights standards throughout the process, while other practices focused foremost on price. Cost pressures lead to shortened care visits and increase the risks to older people's human rights and to the quality and safety of their care'.⁹

"We need adequate time and flexibility to make sure that we meet the needs of our clients. Our support improves our clients confidence and encourages them to keep their independence... this wouldn't be possible if we had to stick to rigid 15 minute time slots."

Gloria Yearwood, Care worker for reablement service, Chiswick

As the funding gap in social care opens up, we will be forced either to deliver the same service to a dwindling number of people, or to seek more fundamental change to the way we deliver services. While the problem of the funding of social care cannot be

resolved without major decisions on the part of central government, some of the challenges do relate to the way in which we commission.

How far have we moved away from a time-task approach to service delivery?

Commissioning is built on a foundation of outcomes, but they are not usually carried through into contractual arrangements. In most cases, service providers are still commissioned to deliver particular tasks, often within a set period of time, rather than to achieve specific outcomes for the individual.

This is particularly evident in a domiciliary care setting. Even in a personalised service, providers in domiciliary care are usually paid to deliver specific tasks for an individual, within a specific allocation of time. In most cases these tasks are decided on the basis of the outcomes the service user needs to achieve, but ultimately the provider is paid according to whether or not the tasks are delivered, rather than whether or not the outcomes are achieved.

If the outcomes have not been achieved, not only is the provider still paid, but there is every likelihood that they will receive another care package to continue the additional support that is necessitated by their failure.

Translating outcomes into contractual arrangements with providers is an important challenge for care services. When providers are paid by the hour, it gives them a false incentive to maximise the number of hours they spend with a service user, rather than promoting their independence, and supporting their recovery where possible. This is a problem for two reasons.

⁸ <http://www.unison.org.uk/acrobat/A13845.pdf>

⁹ <http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-home-care-of-older-people/close-to-home-report/>

First, consultation with people approaching the care system invariably shows that they want to remain as independent as possible, for as long as possible: they do not want to be reliant on care when they do not need to be.

Second, when we give providers an incentive to maximise their number of hours with a service user, we are, in effect, paying them to fail. In many ways, the current system creates a false incentive for unscrupulous providers to increase the level of care an individual requires. Besides being counter-productive for the individual, this is also financially inefficient.

Service user needs change all the time, but paying a provider on a time-task basis makes it difficult for the support plan to adapt quickly, resulting in some people continuing to receive services they do not require. Payment by outcomes ensures that the type of support provided will adapt in whatever way will be most effective in attaining the outcome.

Given the pressures on social care budgets described in Chapter 1, the need to find more effective models of commissioning based on outcomes is now urgent. If we want providers to deliver against outcomes, we must build their incentives around outcomes.

This will not only benefit those in direct receipt of services from the council, but will in time open up similar approaches to self funders in the care system.

“It’s quite challenging for us as commissioners and for providers to focus on outcomes rather than inputs and processes – we’re increasingly trying to capture individual experience and what it’s like to receive care and support commissioned by the local authority”

LGiU survey respondent (assistant director for commissioning)

How do we establish and measure outcomes?

Deciding what outcomes you want to achieve is the first challenge for outcome-based commissioning. For many, this is an opportunity to use coproduction, the involvement of service users in shaping service design, as a way of setting the objectives of a service and determining what the outcomes should be.

Defining and differentiating outcomes for the individual and outcomes for the service is notoriously difficult. Linking them together, establishing causal links and demonstrating cost savings where applicable is more so. As we can see from the local authority comments from our research, this is regarded as an obstacle for many councils.

What do you see as the main barriers to effective outcome-based commissioning in the future?

“Outcomes are difficult to measure and resource intensive.”

“Lack of understanding of outcomes and how they can be measured to provide evidence of effective service delivery and value for money.”

“The inability to develop outcome based specifications that can be measured which can deliver the appropriate level of service.”

Respondents to the LGiU’s survey of local government social care departments

Nevertheless, innovative approaches to addressing this problem have been made. The New Economic Foundation proposed a ‘public benefit’ model of efficiency using Social Return on Investment (SROI)

principles.¹⁰ SROI measures the broader social and environmental impacts of a service, assessing the effectiveness of outcomes in terms of their benefit to users and the wider community. The model aims to build the 'triple bottom line' into public service contracts, incentivising providers to maximise their wider impacts where possible. SROI has been important in drawing the focus away from a narrow interpretation of cost, offering an advocacy tool that shifts the emphasis onto the social value of wider service outcomes as well as financial cost. However in the current economic climate, the emphasis is on cashable savings, which are more difficult to attribute. In a social care context, many individual outcomes are also hard to monetise.

A more recent model, focused specifically on adult social care, is the Adult Social Care Outcomes Toolkit (ASCOT), developed by the Personal Social Services Research Unit. It establishes 'social care related quality of life' over eight domains (accommodation, cleanliness and comfort, control over daily life etc.) and enables commissioners to measure the benefit of social care interventions on that quality of life. Service users can prioritise the factors according to their personal importance, and the achievement of outcomes can be considered as part of a cost-benefit analysis.¹¹

Some authorities may choose to use these models as a basis for developing their own outcome frameworks. Two of the most important principles when establishing

outcomes in a contract are that they must be attributable to the performance of the service provider, and they must be consistent for the sake of comparison. We will see both of these principles at work when we come to examine Wiltshire's Help to Stay at Home scheme in Chapter 5.

How can we support integration between the services that support better outcomes for individuals?

Health, social care and housing are mutually supportive in delivering personal outcomes for the individual. While Clinical Commissioning Groups and the shadow Health and Wellbeing Boards have the potential to shape the relationship between health and social care, there is still a long way to go in many areas of the country. The role of housing in social care is increasingly recognised, as demonstrated by the inclusion of provisions relating to diversity of housing provision in the social care White Paper. However, as our research in the next chapter shows, there are still broad differences between the culture of commissioning in social care and housing, raising questions about the future of integration between these services.

To explore these issues in more depth, we undertook a survey of local government, focusing on their domiciliary care arrangements. This was followed up with a series of qualitative interviews with leading councils to discuss their commissioning strategies. The next chapter outlines our main findings.

¹⁰ <http://www.neweconomics.org/projects/social-return-investment>

¹¹ <http://www.pssru.ac.uk/ascot/>



4 The local authority position

Commissioning in social care has progressed significantly in recent years, but there is still progress to be made in turning outcome-based commissioning into a reality. To test our assumptions and form a basis for further research, we undertook a survey of local government, focusing specifically on domiciliary care services.

We received 210 responses to our survey, of which roughly half were officers and half councillors.

Key findings include:

- while most respondents reported the regular use of outcome-based commissioning, a sizeable minority of 35.9% said that it was only used 'to a limited degree' in their authority. Seven out of 10 saw commissioning for outcomes as a 'very important' priority for social care in future;
- three-quarters of respondents disagreed with the statement 'our current systems and processes will be sufficient to manage our adult social care provision in future', reflecting the present resourcing challenge facing social care. Nine out of 10 agreed that pressure on resources was making them reconsider the way in which they provide social care
- three-quarters of respondents regarded 'a culture of running services on a time-task basis' as an important barrier to outcome-based commissioning in future. However,

more than 90% still pay providers according to the time they spend with a service user, rather than outcomes

- the types of organisations being commissioned as providers is expected to diversify. More authorities identified in-house provision as a method of delivery in future, while the number of councils commissioning social enterprise providers is expected to double.

Budget position

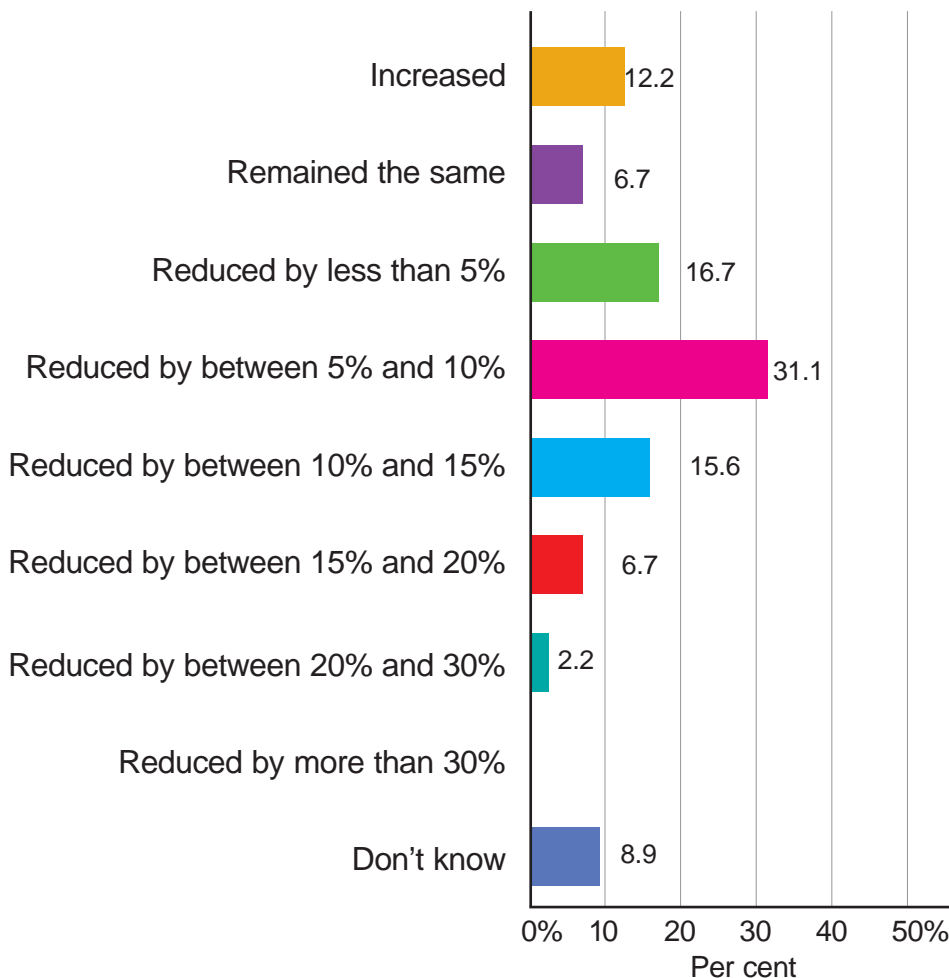
55% of social care respondents reported overall budget reductions of more than 5% in the last financial year, with the majority of these seeing reductions of between five and 10%. Just under 20% reported that their budgets had remained the same, or even increased (see *Chart 1*).

We asked respondents to identify where they had made their savings (see *Chart 2, overleaf*).

The most common choices were negotiation with providers, and back office restructures. However, there were a number of individual responses which included:

- re-tendering services
- charging for day care
- tightening eligibility criteria
- reducing other rates in the contract (other than the hourly rate)

Chart 1: How was your adult social care budget affected in the last financial year?



- increasing level and scope of charges and reducing level and scope of concessions
- increased use of reablement and extra care housing
- sharing services with health.

This confirms that while many authorities are finding innovative ways of delivering savings without affecting frontline services, the ultimate funding position is such that authorities are struggling to meet demand without raising eligibility criteria for services.

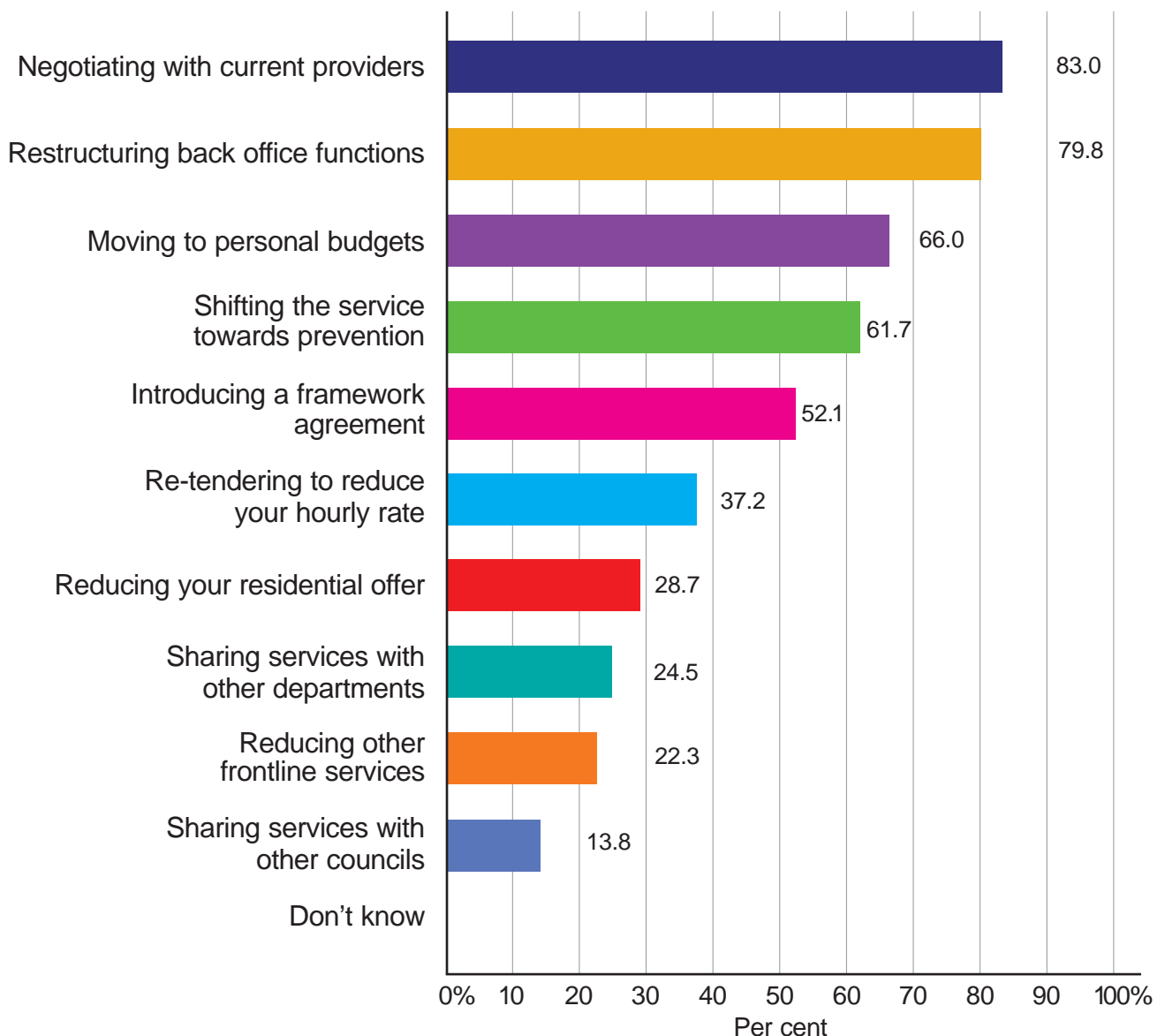
Providers

We asked respondents who they currently commissioned as domiciliary care providers, and who they planned to commission in future (see *Chart 3, overleaf*).

The majority of councils expected to retain a high level of private sector delivery, with over 90% of respondents reporting that they will continue to commission private sector bodies.

The most significant changes were the rise in prominence of social enterprise organisations (a massive increase from 35.1% to 74.2%), and the number of

Chart 2: Where appropriate, how have you made your savings in adult social care? Please tick all that apply.



authorities planning to take a proportion of their services in-house.

Whereas no one reported currently having in-house provision, 16.1% of respondents said they would provide some level of provision in this way in future.

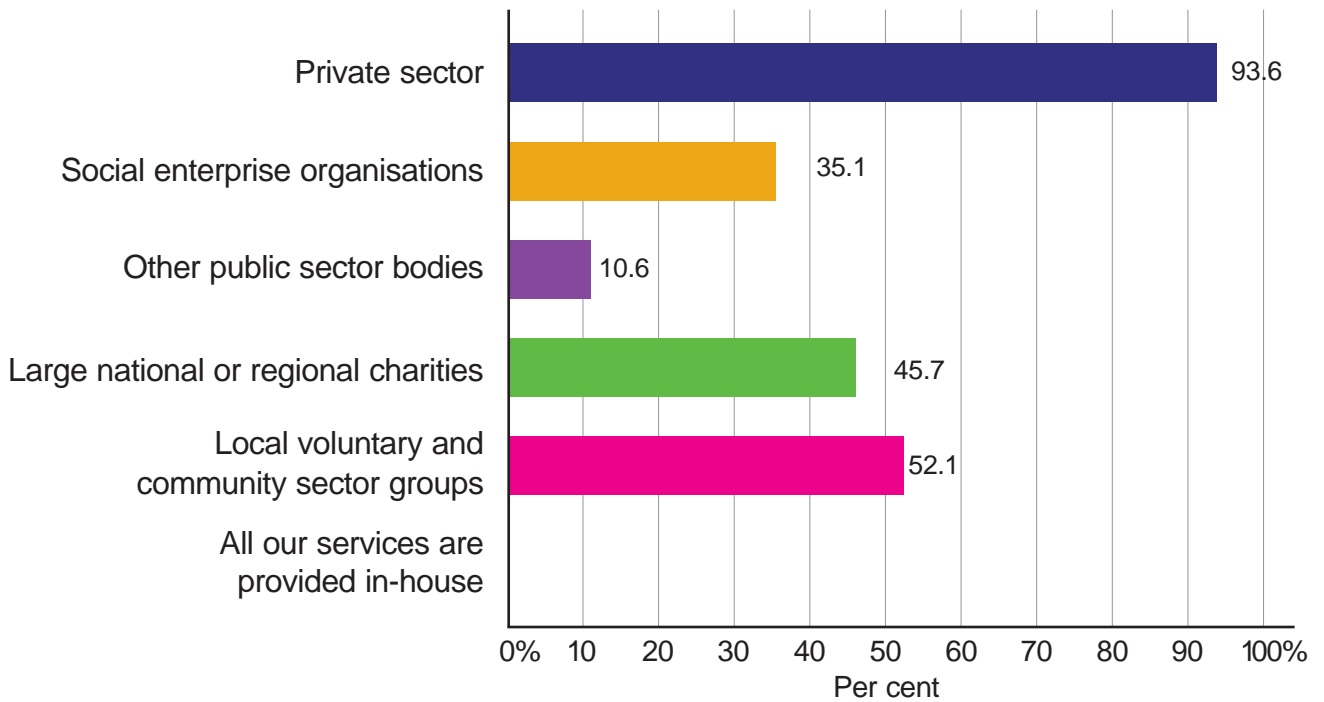
Nevertheless, it is also clear that most councils intend to retain at least some aspect of commissioning third parties, perhaps pointing to a greater diversity of providers (including some in-house options) going forward (see Chart 4).

The number of organisations that authorities were commissioning varied considerably. 60.5% of respondents had more than 10 providers delivering domiciliary care, with roughly two out of 10 having more than 30 providers in total (see Chart 5, overleaf).

Approaches to commissioning

Survey respondents reported a high level of engagement with providers prior to letting a contract. 81.4% of respondents said they engaged with providers in advance of all contracts. 67.5% said the same for service

**Chart 3: Who do you commission as adult domiciliary care providers?
Please tick all that apply.**



**Chart 4: Who do you expect your domiciliary care providers to be in future?
Please tick all that apply.**

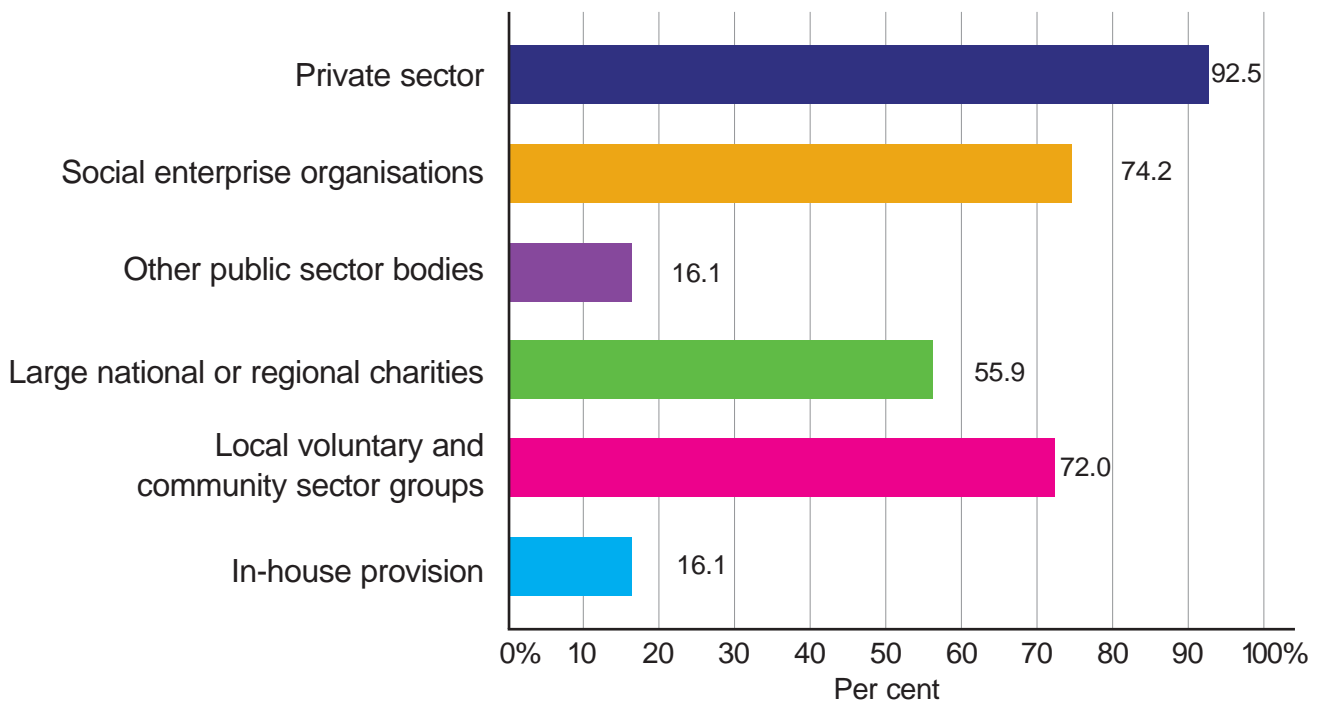


Chart 5: How many care providers do you have for domiciliary care?

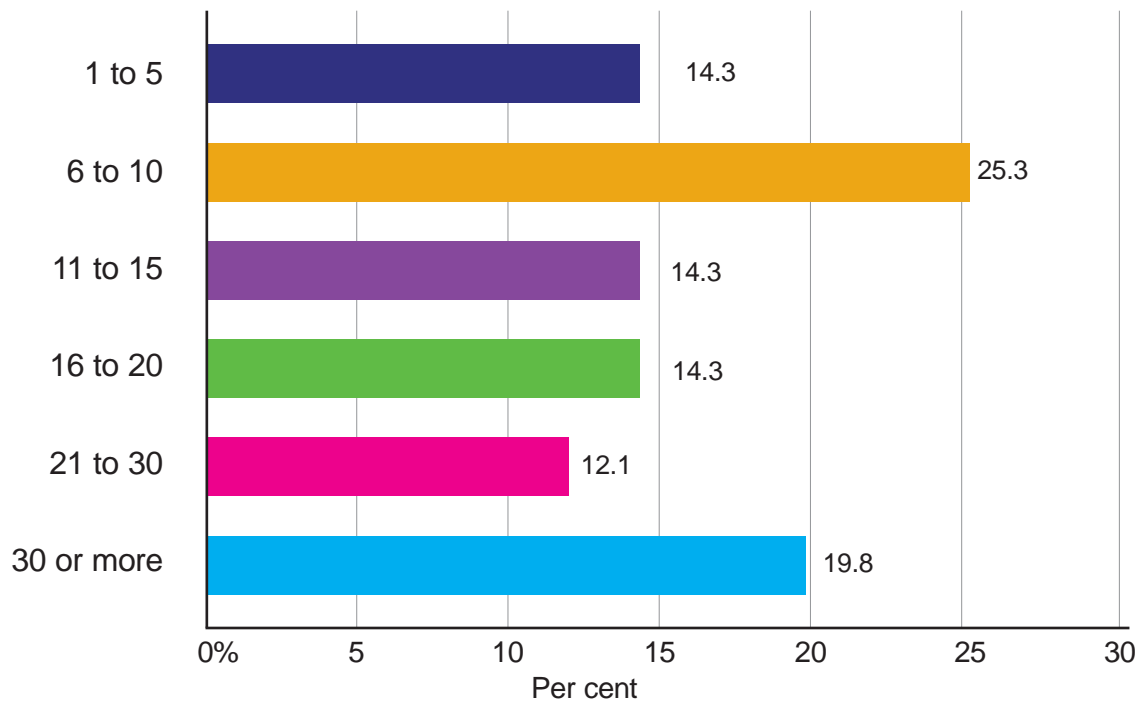


Chart 6: How important are the following considerations in tendering for a domiciliary care contract? Please choose the top 5 considerations (1 being the most important)

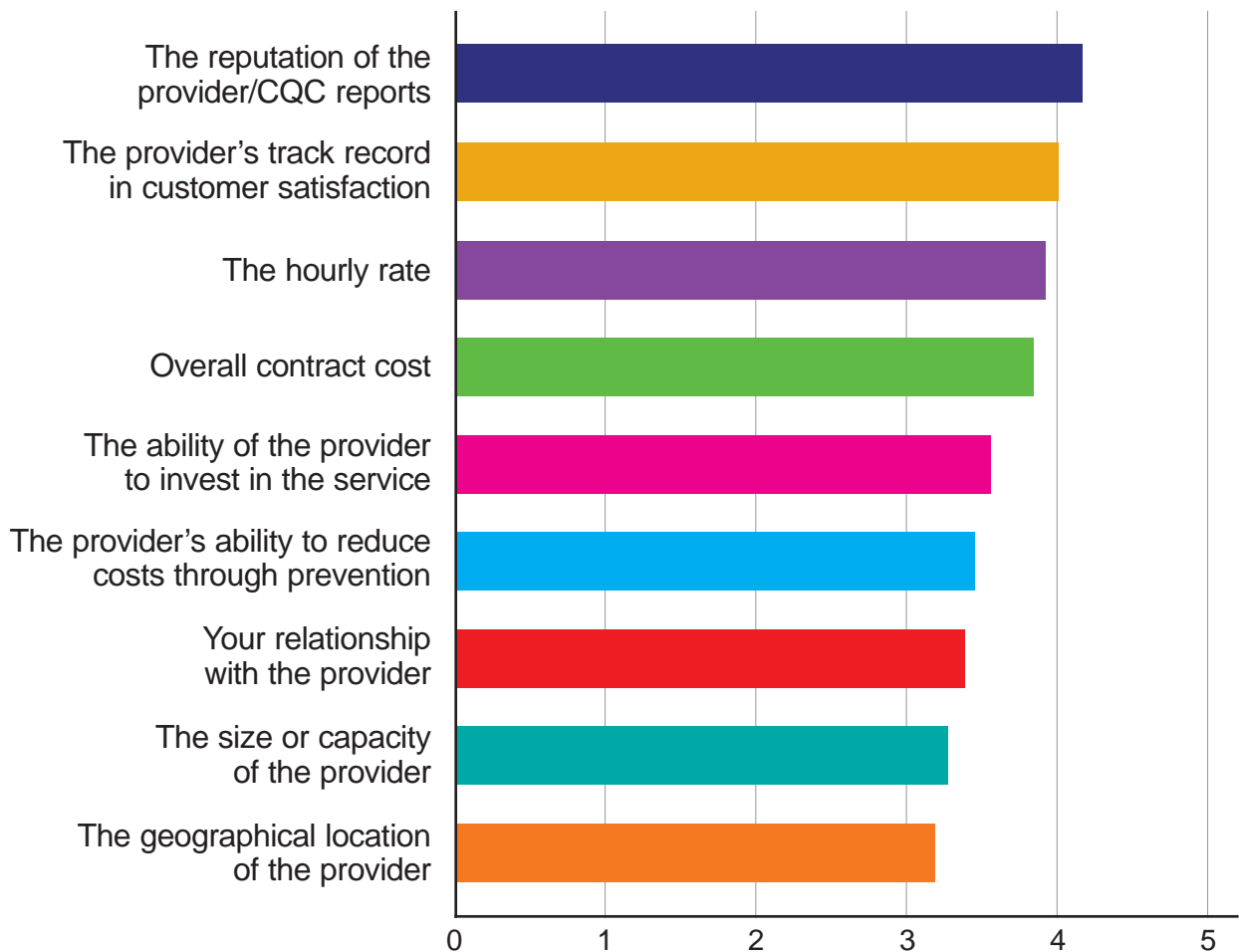
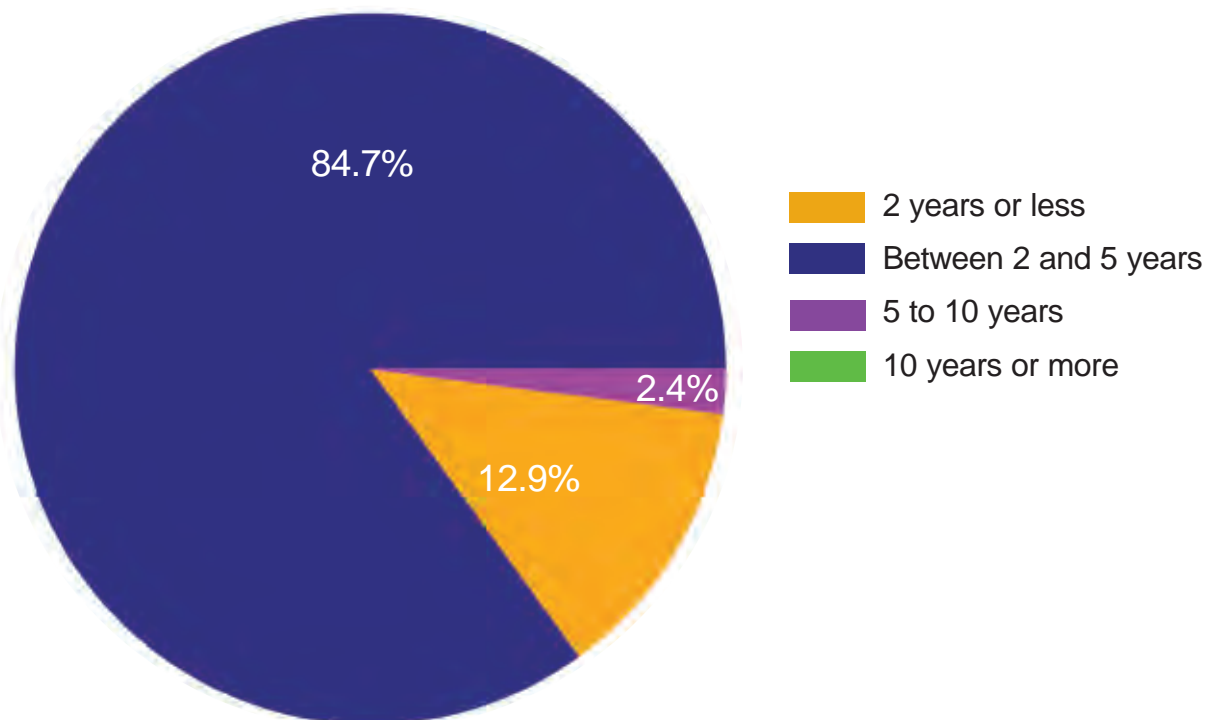


Chart 7: How long is a typical domiciliary care contract in your authority?



users. Nevertheless, a sizeable minority of 30% said that a 'lack of trust' between council and provider was proving an obstacle to better commissioning.

This assertion has also been publicly challenged by providers. In their evidence to the recent Local Government APPG enquiry into social care funding, social care provider Mears expressed concern about the level of local authority engagement with the sector.

"Providers can do much more to integrate services as we are doing at Mears. Local authorities should commission outcome based broad independent living contracts, which encourage providers with different skills to collaborate and integrate their services together. The problem we face is getting real dialogue with local authorities, at the right level, to encourage this type of thinking."

Alan Long, Executive Director of Mears

We asked respondents what their most important considerations were in choosing

providers. The most popular responses were 'the reputation of the provider/CQC', 'the provider's track record in customer satisfaction' and 'the hourly rate' (see *Chart 6*).

It was noted by several respondents that a move towards personal budgets and direct payments requires individuals to become commissioners themselves, and the role of the council has shifted to facilitating this process.

Domiciliary care contracts were typically quite short. 12.9% of respondents reported contracts that were less than two years long and the majority (84.7%) were between two and five years (see *Chart 7*). Many of these will be on framework agreements rather than block contracts as was formerly the case.

While this provides flexibility for councils, it can also cause instability for providers who may find it difficult to invest in services when there is so little certainty in terms of volume of work, and the renewal of the agreement going forward.

**Chart 8: How do you monitor your domiciliary care providers?
Please tick all that apply.**

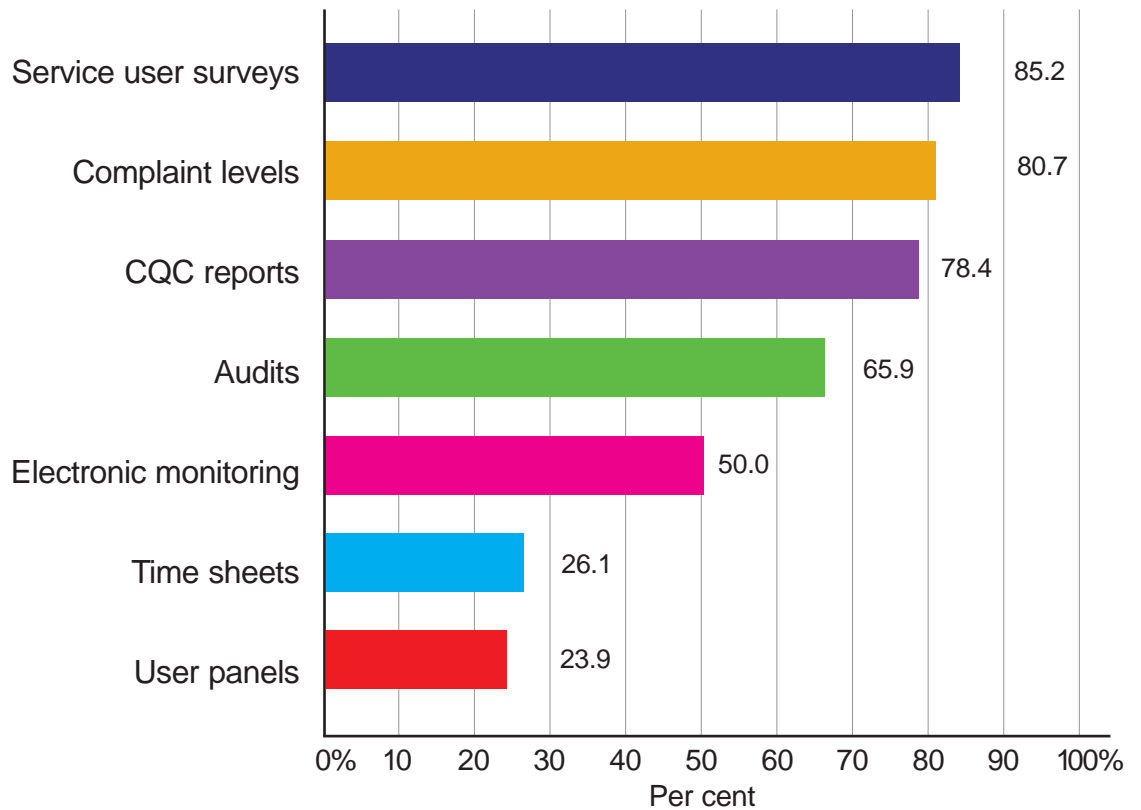


Chart 9: In your view, to what extent does your authority practice outcome-based commissioning in adult social care?

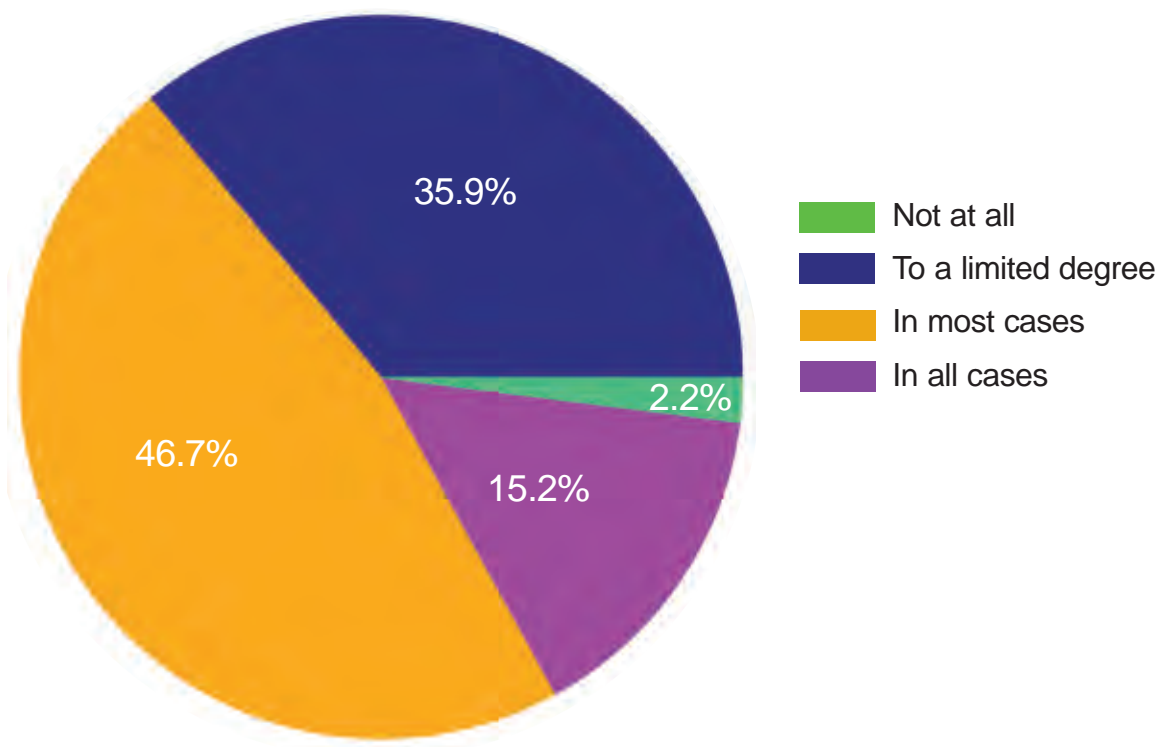
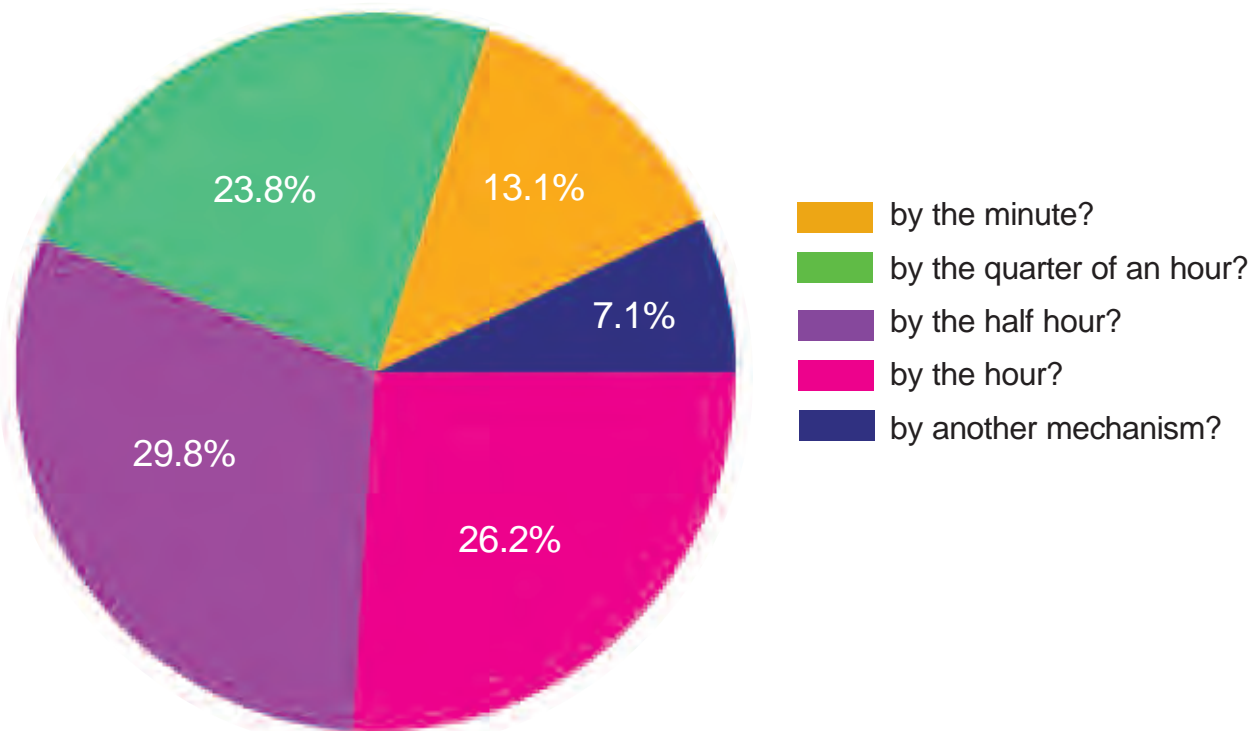


Chart10: Are your domiciliary care providers paid...



This may have a particularly adverse effect on small providers, but equally makes business planning and service investment more of a challenge for providers of all sizes.

“Commissioning defines shorter periods, and places greater risk onto the provider. Often this puts off new and smaller companies in being involved with local authority work at all. This is such a growth business, that local authorities are in danger of not finding enough providers of sufficient financial and staffing strength to give real local competition.”
County Councillor from East Midlands

Monitoring

A variety of approaches were taken to monitoring domiciliary care providers, the most important being service user satisfaction surveys and complaint levels. This indicates a level of service user involvement in monitoring processes. However user panels were much less widely employed, with less than a quarter of respondents reporting that they were used at all (see Chart 8).

Electronic monitoring was undertaken by half of respondents. This reflects the importance given to ensuring providers are meeting their obligations in terms of the time spent with a service user, and are paid for this time only.

Outcome based commissioning?

There was a mixed view on the level to which outcome-based commissioning is a current feature of the council-provider relationship. 15.2% stated that it was used in all cases. Roughly half said it was used in ‘most cases’. However, over a third said that it was only used ‘to a limited degree’ (see Chart 9).

The benefits of outcome-based commissioning were largely represented in terms of their impact on the individual and the ability to deliver personal outcomes. Six out of 10 saw it as an opportunity to reduce service costs. However, less than half regarded it as a way of increasing the capacity of the service and less than 10% regarded it as a way of transferring risk to the provider.

By contrast, more than 90% of respondents reported that they pay their providers on a time-based rate. A substantial minority pays them by the minute and the largest proportion by the half hour: only 7.1% were using other means of paying their providers (see *Chart 10*).

This is particularly interesting in the context of earlier views on commissioning. Can a service in which payment is made on the basis of time, not outcomes ultimately be described as ‘outcome-based commissioning’?

There was clearly a high level recognition of a need for review in the current system. Three quarters of respondents saw ‘a culture of running services on a time-task basis’ as a barrier to outcome-based commissioning in future.

Bearing in mind the predominance of the time-based rate as a method of paying providers, this finding raises questions as to why these models of commissioning persist. Possibly part of the problem lies in the complexity of measuring outcomes and in building them into a contract in a meaningful way.

Monitoring an outcome-based contract is also a more difficult challenge. Ensuring a provider is fulfilling a duty to attend a service user for a set period of time in a day is relatively straightforward to monitor. Ensuring they are delivering outcomes for the individual is less easy to assess. Payment by outcomes is also complicated by the rise of direct payments, in which the service user takes on the role of commissioner.

Working across boundaries

We asked respondents about the involvement of other local services in supporting the care agenda. While health was seen as being very active, there was

clearly scope for increased involvement of some of the other services (see *Chart 11*).

The interface with housing is of particular interest. The draft Care and Support Bill reflects this in its proposed duty for local authorities to work towards joining up adaptations and home repair services with care and support.

The NHS Future Forum reports that the NHS spends £600m each year treating people due to severe hazards in poor housing, mostly as a result of falls.¹²

Health, social care and housing needs are closely interrelated and a lack of coordination between the services can have a profound impact on service level and individual outcomes. If the interface is not working, a service user can be faced with a multitude of visits; someone to discuss domiciliary care, someone to discuss telecare and someone to discuss adaptations.

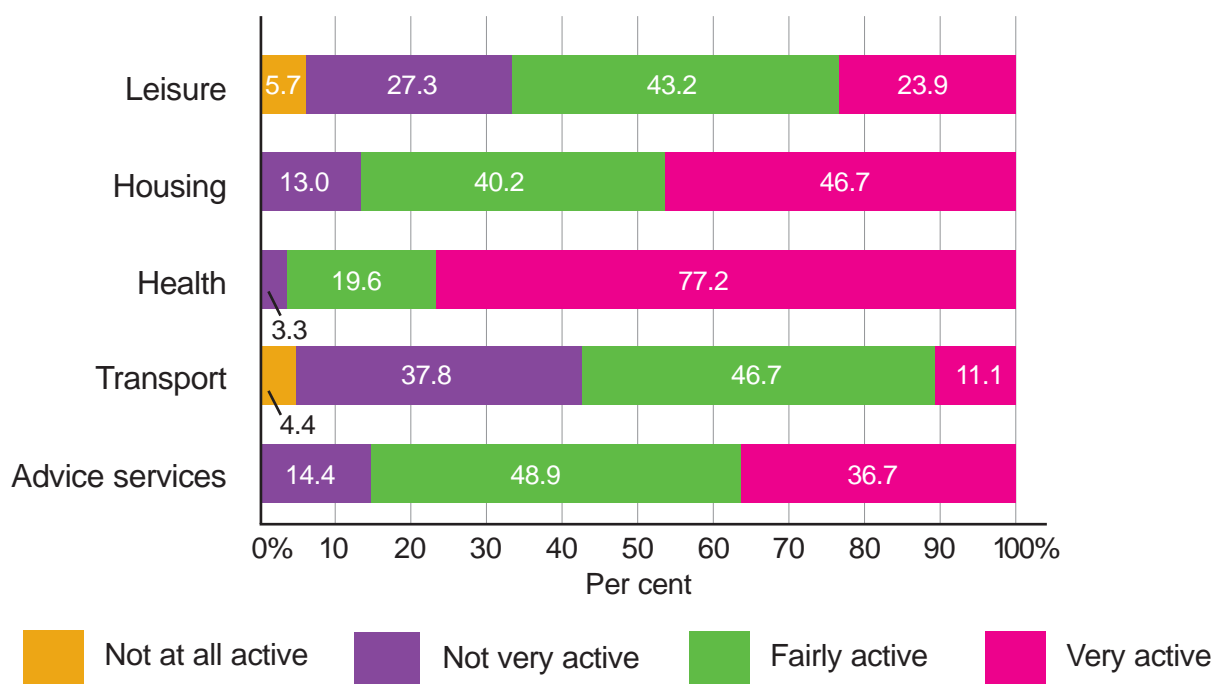
Roughly half of respondents to our survey said that housing was ‘very active’ in the social care agenda, suggesting there is still room for development in this area. To understand this issue better, we undertook an additional survey of housing departments, focusing on repairs and maintenance. We received 163 responses, of which 43.8% were officers and 56.2% councillors.

The survey demonstrated that while both social care and housing were engaging with third parties to deliver services on their behalf, there were considerable differences in their methods of managing this process. The two main contrasts relate to the distinction between a ‘contracting’ and a commissioning approach.

- **Number of providers/contractors**
In social care, 60.5% of respondents had more than 10 providers

12 NHS Future Forum, *Integration: a report from the NHS Future Forum, 2012*

Chart 11: To what extent would you say the following services are active partners in the adult social care agenda in your local area?



delivering domiciliary care, with roughly two out of 10 having more than 30 providers in total. The picture in repairs and maintenance was very different, with 70% of respondents having five or fewer organisations contracted to deliver these services.

● **Length of contract**

Domiciliary care contracts were typically much shorter than those in repairs and maintenance. 12.9% of respondents reported contracts that were less than two years long and the majority (84.7%) were between two and five years. In repairs and maintenance by contrast, nearly 40% of respondents said their typical contract was five years or longer.

Repairs and maintenance and social care are very different service areas, with very different models of service delivery. However, they are both ultimately services

which deliver outcomes for individuals, and are both essential in supporting people to live independently at home for longer and supporting them to achieve personal outcomes.

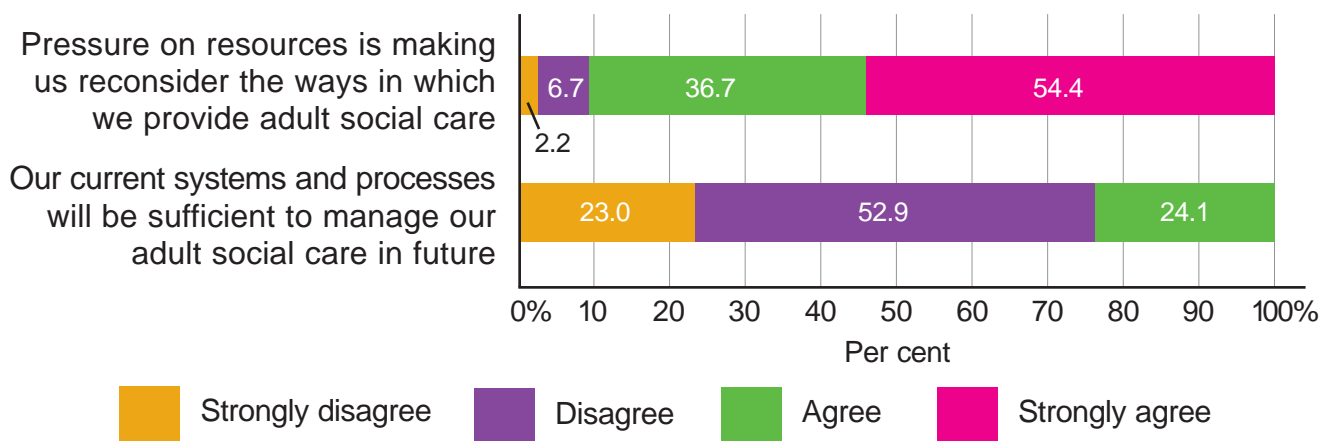
It is therefore worth considering whether social care commissioners and housing contract managers could learn more from one another's methods.

The future

The survey revealed a level of concern in the sector regarding the future of adult social care. Over three quarters of respondents disagreed with the statement 'our current systems and processes will be sufficient to manage our adult social care provision in future'.

More than 90% agreed that pressure on resources was making them reconsider the way in which they provide social care. Interestingly, by contrast, 78.8% of housing professionals said that they already had 'the

Chart 12: To what extent do you agree with the following statements?



right systems in place to manage repairs and maintenance effectively in the future’ (see Chart 12).

These responses acknowledge the growing gap between demand and resources in adult social care. They suggest that people working in the sector recognise a need for change as a result of some of the drivers outlined in Chapter 1.

Despite this, there was little consensus about the best way of changing the system to make it sustainable in the future.

Respondents regarded a whole range of tools as important in addressing the resourcing gap. Outcome-based commissioning was regarded as ‘very important’, as were reablement, partnerships with health and preventative services. Payment by results and electronic monitoring were only seen as fairly important by comparison (see Chart 13).

Barriers

Finally, we asked respondents what the main barriers to effective outcome-based commissioning were.

The most significant reason highlighted was ‘a culture of running services on a time-task basis’, with nearly 75% of respondents identifying this as a barrier.

However, a number of other issues were identified in the comments section including the following:

“Commissioning defines shorter periods, and greater risk onto the provider. Often this puts off new and smaller companies in being involved with local authority work at all.”

“Difficulty in measurement and resource intensive.”

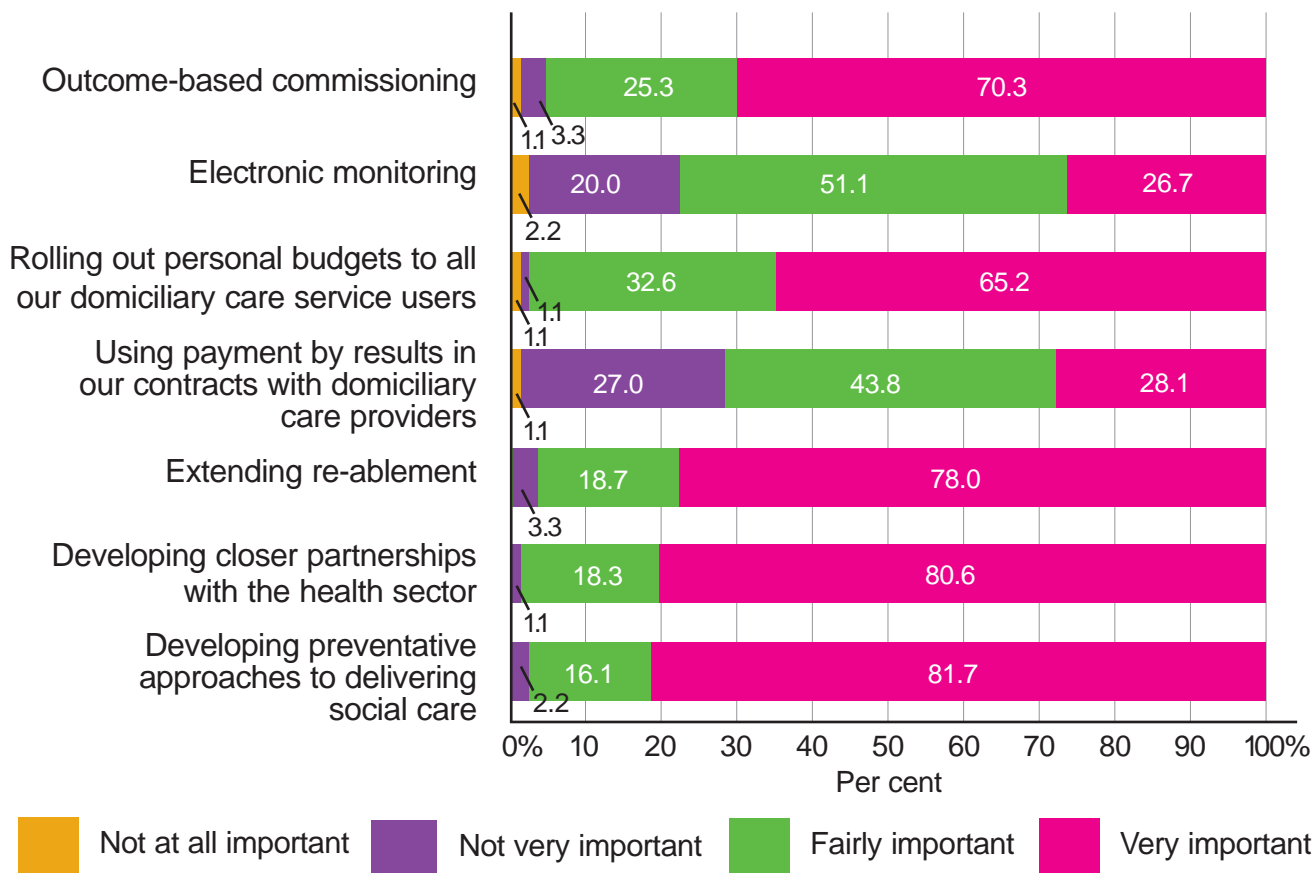
“Working with council lawyers.”

“The inability to develop outcome-based specifications which can deliver the appropriate level of service that can be measured.”

Elected members

The survey was targeted at elected members with the portfolio for adult social care, or those with scrutiny panel responsibilities for this area. Nevertheless, a significant proportion of councillors expressed a lack of understanding of the detail of social care commissioning; the type and number of providers in the market, the commissioning approach taken by their local authority and the way in which providers were engaged to deliver services on behalf of the council. Social care is a complex service area and perhaps this is understandable, but it does highlight a need

Chart 13: How important will the following be in adult social care commissioning over the next five years?



for training to ensure that elected members have the appropriate skills to both lead on, and scrutinise work in this area.

“I have no knowledge of the state of the market. As a back bench opposition member I have limited information as to the issues involved in what is a radical change in strategy.”

LGiU Survey Respondent (adult social care and health scrutiny panel member)

Implications

The results of the survey reinforce some of the concerns highlighted in earlier chapters in relation to commissioning challenges.

- There are concerns in local government about current systems of commissioning. The ‘time-task’ approach is seen as a serious

challenge for the future of outcome-based commissioning.

- True outcome based commissioning is by no means universal. The vast majority of councils still pay their providers on the basis of the time they spend with a service user (an output), rather than the outcomes they deliver for the individual.
- Market management for many authorities means increasing the number and diversity of providers in the market, rather than focusing on the range and diversity of services on offer.
- In many areas there is still a commissioning disconnect between repairs and maintenance services and care and support.

While councils are innovating to address these challenges and prevent an impact on the frontline, there is clearly concern that the current systems and processes they have will be inadequate to deal with demand for services in future.

This throws up a number of important questions for local authorities:

- What further steps can we take to break down a time-task culture in commissioning domiciliary care?
- How can we most effectively incentivise providers to promote independence and reduce care need?
- How can we ensure outcomes are shared between health, housing, social care and other relevant services to minimise waste and avoid duplication?

- How can we establish and measure outcomes that are meaningful to both provider and service users?
- How can we ensure service users are fully engaged in shaping their own care and determining the outcomes they want to achieve?
- How can we ensure care staff are supported and empowered to deliver high quality services?

With this in mind, we undertook interviews with local authorities about their commissioning approach, to help us build a picture of practice at a local level and to identify areas of innovation.

In the next chapter we will draw on some of the case studies to illuminate the ways in which some councils are working to answer these questions.



5 Commissioning approaches

In the previous chapter we examined LGiU survey results that highlight concerns in local government about the systems and processes associated with commissioning home care services. Councils are facing a serious set of issues in relation to capacity and resourcing in adult social care. Managing outcome-led commissioning processes against the backdrop of significant saving targets, rising demand and public sector reform is complex and challenging. While in the long term commissioning for outcomes is more efficient, and better at avoiding waste than commissioning on a time-task basis, it may require a level of up-front investment that is difficult to secure at the present time.

Nevertheless, many local authorities are working to find new ways of delivering these

services and improve the quality of service for the individual. We interviewed a number of councils to collect examples of innovative practice in delivering home care services across a range of themes:

- Incentivising providers to deliver against outcomes
- Breaking down a time-task culture
- Sharing outcomes across organisational boundaries
- Shifting the emphasis away from cost and onto quality
- Working with service users to design services and establish outcomes
- Supporting care users to make informed decisions

Incentivising providers to deliver against outcomes and breaking down the time-task culture

Wiltshire County Council: Help to Live at Home

When Wiltshire County Council reviewed their domiciliary care arrangements as part of their transformation programme they realised that the service needed to change. It was over-complicated, with over 100 different contracts with providers. Service users reported that they couldn't understand the system, and care package length was increasing to an extent that could not be explained by rising demand.

Consultation with service users showed that they wanted social care services to support their autonomy and to give them the skills and technology to live independently where possible. What they did not want, was increased reliance

on services, but the figures showed that this was what was happening. The council decided to address the challenge through their relationship with providers, by moving away from a time-task culture. With this in mind, they changed their commissioning strategy and established the Help to Live at Home scheme.

- They established eight geographical areas in the county, each with a separate contract for care with one provider. This provider was guaranteed all the initial support plans assessed by the council in this area, but they were also obliged to take everything they were given. Initial support would not be means tested and would aim to give the customer time to consider what care and support they might need in the long term where appropriate.
- Providers were asked to salary their care workers, rather than paying them an hourly rate. This was seen as an important step in driving up quality in the service.
- They established two rates of payment: standard and specialist. However, while these rates would be used to cost a package, the amount of time spent with a service user would not be the basis of payment.
- They established a framework of standardised outcomes against which the provider could be expected to deliver. These had to be observable (as opposed to a self reported level of wellbeing for example) and directly attributable to the work of the provider. 'I can' formed the basis for each outcome: 'I can cook a meal for myself', 'I can use the bath without outside help' etc. The outcomes fell into two broad categories: 'reablement' and 'maintenance' outcomes.
- The outcomes for a particular care plan are developed from a person-centred assessment of the service user, and must be accepted by the service user, the provider and the local authority before they are approved. A proportion of them are termed 'payable outcomes' and the provider receives a penalty for not delivering against them.
- Contract monitoring is managed using a new online system, developed specifically for this purpose. Everyone involved in the process has access to an online dashboard that shows progress against each outcome, along with other measures of performance including service user feedback.
- The initial support package is free and is reviewed by the council at its end. The provider is then asked to draw up and cost the next plan, which must be for a maximum of six months. The council approves it and offers it to the service user, at which point they can either accept the plan, or take the monetary value of the plan as a direct payment.

The London Borough of Sutton: payment by outcomes in the Substance Misuse Service

When Sutton re-commissioned their substance misuse service this year, they decided to review their commissioning approach: many of the services had been commissioned on service level agreements up to 10 years ago, and there was a need to ensure these arrangements were brought into line with the council's corporate commissioning strategy.

As a result of both national and local drivers, the council decided to use a payment by outcomes approach for the service to encourage the focus on delivering outcomes for all clients and to share financial risk with providers. An outcome was described as the benefit the person has gained from contact with the service, and a set of outcomes were agreed as part of the commissioning strategy. A market-testing day was held with potential providers to get agreement to what is deliverable and how the outcomes might be measured. It was agreed that 75% of the funding would be offered on the ability to deliver to set standards, while 25% would be retained and paid against the achievement of agreed outcomes. The council hopes to roll this approach out to other services once it has been trialled in substance misuse.

Payment by results in reablement – Essex County Council

Essex County Council is currently engaged in a long-term programme to shift their care and support provision away from a time task approach. They have articulated their new approach in a Market Position Statement, which sets out their vision for commissioning social care in the future. As we describe later on in this section, they have already moved towards a best value ranking framework which emphasises both cost and quality. Their next challenge is to work with providers to develop a performance-based system, which pays for outcomes, rather than activities, and which promotes independence for service users wherever possible.

With this in mind, they have embarked on further consultation with providers and re-tendered their reablement service. Formerly, providers were paid for six-week packages at a set price. Under the new model, they will be paid in two ways. They will still receive a set price for the package, but will also receive a bonus payment if, at the end of the reablement plan, the service user does not require any further support.

The council intends to move away from setting an arbitrary number of weeks for the package, which will be shorter or longer than six weeks depending on the needs of the individual service user. Ultimately they aim to move all their home care provision onto a performance-based model. For service users with learning disabilities, they are working specifically on developing whole life budgets with an emphasis on pathways to independence.

Wigan's home care transformation

Wigan Council has been moving completely away from the old "time and task" approach to providing home care.

It believes that there is both a human and a financial cost to providing services which simply fulfil routine tasks rather than responding to the real needs of the resident. Adopting an outcomes approach gives residents a more personal service, and with home care forming one of the biggest bills for a local authority, it also makes financial sense - there is a real cost to delivering services in ways that do not give customers the chance to improve, or to stop things that don't help their lives.

The council has transformed its services by creating a re-ablement team as part of a holistic local offer to people - anyone who first contacts its services is offered a package of support for an initial six weeks to help them recover their independence. This includes re-ablement home care, assistive technology and occupational therapy assessment.

The next step was to try to make this approach to supporting people's independence universal. Having decided to set the same challenge to all its commissioned home care providers, the council met regularly with them and actively developed organisational development and quality standards for all its home care services. It co-designed improvement standards for home care with the providers, asking them to self assess regularly and evidence improvement outcomes.

Wigan has also changed its assessment process to one which is entirely outcome focused, and established a team of brokers who are able to use the outcomes that customers have agreed they want, as the basis of helping someone plan their support. Along with this, an indicative allocation of money is calculated. So the request for home care is not, for example, based on specifying the number of visits, time of day and tasks to be done, but the outcomes the customer has agreed they want delivered for them personally and the indicative amount of money available to provide the service. Proposals from providers can then be reviewed and agreed based on the best offer that the social worker and customer feel will meet their need.

Wigan has now procured an on-line market place where providers will be able to advertise their services, prices and options.

Sharing outcomes across organisational boundaries

Wirral Rapid Access Contract

Wirral PCT wanted to reduce its hospital discharge times and develop more seamless referrals between health and social care. The referral system was complicated and was resulting in people remaining in hospital for longer than required. This had an impact on the patient's health and recovery time, and was costing the service money and creating a bottle-neck for bed allocation. To address this problem, the PCT formed a partnership with the local authority, and four social care providers to deliver a 'rapid access' contract that aimed to get people discharged within 24 hours.

Previously when a ward manager discharged a patient their case was referred to a broker, who tried to find a home care provider who could take on their case. Under the new arrangement, when an individual is deemed medically fit for discharge but does not have a package of home care in place, care plan and risk assessments are completed by a multi-disciplinary team at the hospital. Mears receives referrals from this team. Previously the referral could take up to seven days to put in place and the person would have to remain in a health and wellbeing bed until the assessment and package was in place. This cost an average of £250 per day.

Mears is one of four providers on the approved list who will accept a rapid access package. Within 24 hours the client will receive a home care package, this will continue for a maximum of 14 days when the care transfers to a domiciliary care provider. There is an agreement between the providers that no rapid access client will be kept on as a domiciliary care package by the same agency.

So far 280 clients have been allowed home from hospital on the rapid access contract, all within 24 hours.

Hertfordshire County Council and reablement

Hertfordshire County Council is committed to ensuring that individuals are able to maintain their independence whenever this is possible. To support this all individuals requiring ongoing support and services are finding that 80% can be supported through a reablement pathway with a view to optimising their independence and reducing their level of dependency on ongoing care packages.

This service has been commissioned from a single provider contract to ensure that they have equity to coverage and a targeted and dedicated enablement workforce. To date the success of this service has seen about 52% of those entering the service requiring no ongoing care package after six weeks of support and a further 21% requiring a reduced ongoing package.

Integrating home care and housing maintenance in Wigan

Traditionally if a care-services worker spots a trip hazard or other problem in a customer's home they report it to their supervisor. They in turn let their manager know. The manager should contact social services, which in turn, make a report to the landlord. The landlord will then put in a request to a contractor for an adaptation or repair.

Mears is working in Wigan to make services for older people more efficient. It has combined care-services with housing maintenance teams. This has meant that responses to problems are virtually immediate. Care workers are uniquely placed to identify potential problems or hazards that could cause an accident.

Older people who use the service have said they feel safer knowing trip hazards are repaired quickly and they like the fact that the repair worker visits are coincided with visits from the care worker that they know and trust so they feel reassured that the workman is genuine.

Shifting the emphasis away from cost and on to quality

Essex County Council: managing the domiciliary care market

Essex County Council no longer sets an hourly rate for domiciliary care. It assesses all providers on the basis of cost and quality (50/50 weighting) and then ranks them on a framework. Quality is assessed using a range of measures, from CQC assessments to service user feedback.

While the cost of running the service has increased slightly (as providers must be re-assessed every six months) the new system has generated savings overall. By letting the market set the hourly rate through competition between providers the council has found that the price has dropped without direct intervention on its part and has now stabilised. As a result of this stabilisation, there is far less change in the price element of the criteria, and the emphasis has shifted to quality. Providers are now competing primarily on this basis.

Bracknell Forest

Bracknell Forest Council has taken a different approach. It has set a single hourly rate for all its domiciliary care providers. The council feels that taking competition around pricing out of the equation has allowed providers to focus on quality over cost.

Staffordshire County Council's Green Paper on Care Quality

Staffordshire had retendered its domiciliary care services in response to the need to make savings, using block contracts across four geographical areas. However, it found that the strong emphasis on cost was affecting service quality and relationships with providers. The council invested £1.25m in the service and started to move providers onto a framework agreement.

In July this year it launched a Green Paper to set out its vision for a revolution in care quality as a basis for consultation. The recommendations in the paper include:

- Working with providers towards an accepted and transparent working wage for those working in the sector as well as further 'professionalising' working in the care sector to drive up care quality.
- Taking steps to reward excellent quality, via financial and other means; with a proactive 'zero tolerance' to poor quality.
- Introducing a raft of measures for more transparent information sharing with the wider community, for example, publishing the details of the minority of providers that aren't achieving the expected quality standards.
- Investing in more front-line quality monitoring and more targeted training and development for providers to drive up quality standards.

Staffordshire is also beginning to challenge geographical limitations in care provision, working closely with Derbyshire County Council to share providers across council boundaries.

Working with service users to design services and establish outcomes

Surrey County Council

Surrey County Council has produced a 'Framework For Working With The Voluntary, Community And Faith Sectors' that identifies the overarching approach to involving the VCFS sector, along with users and carers. It now has a common method of co-production that applies to all commissioning processes in adult social care. Its aim is that commissioning processes involve service users, carers, relevant partner organisations and the market in order to help shape, co-design and co-produce.

It has a protocol for each of its four stages of commissioning (analyse, plan, do, review) which sets out the roles of the users and carers, and those of providers.

It has several examples of how this has worked in practice, particularly in relation to people with a sensory impairment. A commitment to co-production throughout the development of the sensory impairment commissioning strategy, from people telling commissioners what was missing through to writing service specifications, has led to the provision of lip reading classes for people who are hard of hearing. Co-production continues through the Surrey Sensory Partnership, where the membership review services and monitor contracts.

Trafford Quality Checkers

Five years ago Trafford Council was experiencing problems with the variable quality of their social care providers. In response to this it initiated an improvement partnership that included providers and user groups. The partnership was launched with a home care conference to which all the partners were invited.

At the meeting a series of general principles were discussed and agreed, which providers were afterwards invited to sign up to. As the council wanted to place service users at the centre of the improvement programme, it began to train a team of citizen assessors to think about future proofing services. Working with the new citizen assessors, it held quarterly user-led audits of each provider. The user groups established an improvement plan for each provider, as well as an overall plan for the service as a whole.

The citizen assessors are now known as Trafford Quality Checkers. They are all trained to complete quality audits and are now taking on new responsibilities, such as reviewing the cost of care.

Supporting care workers to make informed choices Hertfordshire County Council's e-marketplace

Hertfordshire has established an e-marketplace described by the council as an 'Amazon for care'. The web portal, which will be launched this year and ultimately will allow council employees, members of the public, family carers and service users to buy home care or day services either directly or using their direct payments or personal budgets. It is being delivered in partnership with Serco, and is part of a wider review, which will help towards the council's wider efficiency requirements. Hertfordshire has also been working on a helpline, HertsHelp, which brings together more than 130 community groups and organisations in the county, and allows the public to access the services they need through one point of contact, preventing them having to try multiple routes and is particularly useful for GPs and other professionals who want to be able to direct their patients to a trusted source of support for a wide range of support services and voluntary organisations.

The innovation demonstrated by the case studies in this section show the extent to which commissioning practice has diversified at a local level and the ways in which local authorities, with their partners, are arriving at different solutions to address the unique problems that they face.

There are significant challenges in moving towards a commissioning approach that not only incentivises providers effectively, but shares outcomes across boundaries and helps service users to have real choice in the care they receive. Each of these examples demonstrate that change requires commitment and vision, with a view to how

the whole system of care will fit together. The most challenging examples have required a willingness to accept risk in exchange for the benefits of innovation.

While different local authorities will find solutions that suit their own individual circumstances, there are themes that emerge from this practice; questions that commissioners and elected members with responsibility for domiciliary care can ask themselves when they review these services. The next chapter deals with some of the lessons arising from the case studies, and draws out a series of recommendations.



6 Recommendations

We have seen that local authorities have concerns about the challenges ahead in social care, and are ambivalent about the success of outcome-based commissioning. We have also seen that a time-task culture is still regarded as an important challenge in delivering home care.

The case studies in the previous chapter highlight a number of examples of innovation in commissioning for outcomes. While the solutions to domiciliary care issues will differ from authority to authority, there are some broad lessons that could help to inform practice. These recommendations take the form of a checklist of five questions which commissioners, cabinet members for social care and councillors with overview and scrutiny responsibility for this area should consider in relation to their domiciliary care provision.

Checklist: five questions to help to raise the game of commissioning

1) Are you contracting for outcomes?

To incentivise providers to deliver outcomes, it is important that we distinguish between including service-level outcomes in the commissioning process and commissioning for outcomes for the individual.

The former involves identifying the service level outcomes you are aiming to achieve (potentially using coproduction methods), including them in commissioning strategies.

Commissioning for outcomes, however, means explicitly linking the payment of providers to the outcomes they deliver, rather than their activities.

Fewer than 10% of authorities reported paying their providers on this basis in our survey. When providers are paid on an hourly rate, they have very little incentive to reduce individual dependency on services. Giving them the right target to aim for will hold providers to account, reduce waste, help to improve the financial efficiency of the service and result in better outcomes for the individual.

This is by no means straightforward and requires significant planning and preparation. As we saw with Wiltshire's Help to Live at Home scheme, there are several questions that need to be addressed before outcomes can form a more central part of the way providers are engaged.

What outcomes will you use?

In Chapter 3 we outlined some of the work undertaken by the New Economics Foundation in relation to Social Return on Investment and the Personal Social Services Research Unit in relation to the ASCOT toolkit. Wiltshire establishes its outcomes for the individual based on a person centred assessment which is completed by the service user and consists of five questions.

When shaping the responses into the outcomes against which providers will be paid, the council uses what it has termed 'Payable Outcomes'. While Wiltshire has developed its own set of outcomes as part of its needs eligibility assessment, it used the ASCOT toolkit as a starting point.

“ASCOT gave us confidence to believe that we could define outcomes suitable for a system of payment by results with enough precision and objectivity for payment by results.”

James Cuthbert, head of performance improvement

Each ‘Payable Outcome’ must be attributable to the actions of the provider and comparable against other outcomes on the system. Not all the individual outcomes in the care plan will be payable outcomes. As in the ASCOT toolkit, the Wiltshire outcomes are of two kinds.

First there are improvement outcomes, where the provider is asked to help a customer gain or regain some skills or ability. Second there are maintenance outcomes where the provider is asked to deliver more conventional care, but to include the use of Telecare and other forms of assistive technology.

Either kind of outcome can be used in initial or ongoing support plans, depending what the customer needs and wants. Some ongoing plans can include a lot of reablement, while other initial plans are about maintenance only.

How will you monitor your outcomes?
Knowing whether or not outcomes have been achieved is more complex than knowing whether a provider has spent a given period of time with a user.

In Wiltshire, the council reviews each care plan retrospectively to determine whether or not the outcomes have been achieved. The provider speaks to the service user about their progress on a regular basis and, shortly before the planned end of each support plan, uploads this information onto the online ‘Carefirst’ social care case management system, to which both providers and authority have access. The progress report is checked by the council as part of its statutory review of the customer’s needs.

What will happen if a service user is to receive a direct payment?

Wiltshire puts every new entrant to the care system onto an “initial” support plan that normally includes some reablement, Telecare and assistive technology but may be as simple as temporary domiciliary care during a period of convalescence. ‘Initial support’ is not means-tested. It allows the customer time to recover and to consider what care and support they might need in the long term.

At the end of this time, if the customer needs more care, the provider is asked to produce a new ‘ongoing’ support plan with outcomes for the longer term and an estimate of weekly costs. This estimate is the customer’s personal budget. The value is not based on the Resource Allocation System but on the provider’s estimate of the cost of meeting their needs in a support plan. The service user can either accept, or take the cost of the package as a direct payment.

In this way the council has helped to preserve competition while the council contracts exclusively with four providers. This will differ from one authority to the next, but we should recognise that the council has significant buying power. If they begin to use a more outcome-based approach it is likely that this will have a broader impact on the market and the services providers will offer to self-funders and those on direct payments.

What impact will this have on providers?
Providers must be a part of any process which restructures their approach to the care market. In Wiltshire the council ceased to trade with a significant number of providers as they moved from a large volume of providers on a framework agreement to eight geographically based contracts. This approach would not be appropriate for every locality, but in the Wiltshire example it did offer the providers the certainty they needed to invest in the service, particularly in relation to training, recruitment, salaries and terms and conditions.

How will you engage care workers in the process?

Part of the Help to Live at Home contract asked providers to place care workers on a salary, rather than paying them on an hourly rate. This aims to dissuade providers from rationing care worker time with an individual; by making the provider's income depend on attaining outcomes, they must train, pay and organise their workforce in a way that reduces the risk of penalties for failure.

The council was able to do this through the certainty they could offer the provider in terms of volume of work and length of contract.

The Wiltshire model will not be suitable for all authorities. To implement this model they ceased trading with a large number of providers, and made a significant upfront investment in electronic systems designed to monitor outcomes, which may not be possible in every local area.

Nevertheless, it highlights a number of the questions we must answer if we plan to move towards a more outcome-focused commissioning model.

'Help to Live at Home' reconciles three competing aims of social care reform: personalisation, recovery and prevention.

Assessments are person-centred and focus on outcomes, especially outcomes that leave customers better able to live well with less care. We aim first to help people recover their independence and then to stop their need for care growing. In Help to Live at Home, reablement is not a special kind of service; it is the aim of all our services.

Help to Live at Home pays for results. Results are outcomes that improve or preserve independence. The council

applies financial penalties when customers' outcomes are not achieved and rewards care providers when customers recover faster than planned. Wiltshire Council believes that buying outcomes instead of hours is a commercial incentive to improve the pay and skills of the care workforce.'

Wiltshire County Council

2) Have you considered the local drivers for need?

We tend to think of the need for services, and the services we provide in a fairly rigid way, influenced by established commissioning models. On the one hand, need is an established fact about an individual's requirements. On the other, we must design services that meet those needs.

What we often neglect to consider is the way in which the two are contingent upon one another. Need can easily be manufactured by badly designed services, for example when reablement is neglected following a hospital discharge, 'creating' a long-term care requirement.

Need is also about the way in which individual expectations are managed. If a patient is told by a GP that they need residential care, their expectations about the services they should consider will be shaped by this recommendation.

Services should of course be commissioned on the basis of need, but we must also consider how the types of services we commission influence the pattern of need. If we are to deal with the current pressures on adult social care, and continue to meet the needs of our communities, domiciliary care services should be based on the premise of reducing or stabilising dependence on service provision wherever possible.

This is illustrated by Wirral's Rapid Access Contract, in which health and social care are working together with providers to develop a more seamless service for patients being discharged from hospital. As well as offering a higher quality service, it also releases hospital beds sooner and reduces demand for long-term care services as much as possible by employing a vigorous reablement approach and adapting the home to suit the needs of the service user.

3) How well aligned is commissioning in health, social care and housing?

Housing, health and social care are the three pillars of independent living: identifying shared outcomes between these three areas and commissioning jointly will offer more efficient and integrated services.

Health and Wellbeing Boards may forge better relationships and facilitate joint-commissioning, but do not hold commissioning power themselves. As our survey demonstrated, housing services and social care have very different cultures in relation to commissioning and contracting, with housing tending to establish longer contracts with a smaller number of providers.

There are benefits to be realised from better alignment between these two departments, and opportunities to coordinate their commissioning arrangements more effectively to offer more seamless interventions for service users.

This is recognised in the draft Care and Support Bill, which gives new duties to local authorities to ensure that adult social care and housing departments work together with the aim of joining up adaptations and repairs with care and support.

The solution to this commissioning problem does not need to be resolved by the council alone. Local authorities should put the onus on providers to work together to deliver

contracts that meet both housing and social care needs.

"Within several days of me talking with my occupational therapist, a member of Mears' Safe at Home staff called me to arrange for one of their team to visit me to assess what needed to be done and to supply and fit these rails. I didn't have to get anything – everything was done for me, with no fuss or mess. I am so grateful to the Safe at Home staff and to my occupational therapist. I will always want to remain living in my home with my family although sometimes my health problems make everyday tasks difficult. This service enables me to call for advice and help – this is so reassuring for myself and others in similar situations and has completely improved my quality of life."
Mark P, a service-user from Churchdown

4) Do you empower providers?

Market management is now an important aspect of a commissioner's role in social care. Because providers represent the care workers on the frontline of service delivery, they are often best placed to work with service users to find innovative ways of addressing their problems, and should be challenged to find the best ways to achieve outcomes for individuals.

The focus on a time-task method of commissioning, along with tight budgetary constraints has shifted the council's role into one of invigilator, leading to a command and control approach to dealing with providers. Energies have been primarily targeted at ensuring that providers do not cut corners in terms of activity and the time spent with a service user. Commissioning for outcomes involves a culture shift, which allows the provider to solve the problem, alongside the service user. Providers are paid on the basis of achieving outcomes, and they are responsible for finding the best way of delivering them. With or without payment by results, providers can be more successfully incentivised to deliver outcomes if the

authority is willing to let go of their close control of support planning and to be clear that their role is to be focused on assessment and quality assurance.

Market management does not simply mean maximising the number of providers in the market. It also means influencing the context in which these providers operate. Giving them the space to innovate is likely to expand the range of products available in the market more broadly, offering care users in both the funded and self-funded categories a better choice of quality services. Local authorities must always be aware of their safe-guarding responsibilities and ensure services are adequately monitored. But monitoring should focus on outcomes and quality rather than time based measures. Making providers responsible for attaining outcomes rather than outputs will improve service quality and help to shape the market to meet the needs of the future.

The other dimension to this issue relates to frontline workforce. In the current system care workers are often paid on an hourly rate to match the authority's commissioning approach and reduce cost. Besides the impact on the care workers, this can put pressure on them to deliver services in a way that does not meet the personal needs of the service user and can drive down quality. Councils have enormous commissioning power: if they have a clear view of what they would like to see in their providers, they can support this through their commissioning practice. Paying by outcomes rather than time-slots gives providers the incentive and ability to invest in the service and their frontline staff. Of course

there are implications to this approach. For providers to invest in the service they need stability, which is unlikely to be offered by short-term contracts on a framework agreement.

“The economic situation is currently impacting negatively on what was previously a very good partnership relationship based on trust with our providers.”

Third tier manager in unitary district council

5) How engaged are elected members?

Councillors have a crucial role to play in connecting council processes to the outcomes they see through their case-work in the community. At present many people in receipt of care, and older people in particular, can find it hard to make their voice heard. Elected members can act as important advocates for people in the care system, while also holding influence over the internal processes for commissioning.

Through proactive casework with excluded individuals, and their role in budget setting and scrutiny they can take on a vital role in closing the gap between processes and outcomes. However, it is essential that councillors have an appropriate level of understanding of these processes if they are to lead on, and more particularly, to scrutinise this area of work. Responses to our survey revealed a significant level of confusion among some councillors with scrutiny responsibilities. Offering the right training and support will be important in ensuring elected members can take a more prominent role in this agenda.

Conclusion

Councils recognise that a time-task culture in domiciliary care is still a barrier to true outcome based commissioning, but breaking down this culture is easier said than done. Reliance on a time-task approach has left many authorities nowhere to go in making savings but to cut down the hourly rate they pay to providers and use tools such as electronic monitoring to minimise payment outside contact time with service users.

While such tools have a value, there are limits to the extent to which savings can be made in this way without affecting the quality of the service and the conditions of workers in the care sector, and damaging the relationship with providers.

Councils should be asking for more from their providers. At present in many areas of the country they are required to spend time with service users in allocated slots of time, but have no direct incentive to deliver care in an innovative way that promotes better outcomes for that individual. While many people will find they need more care as they get older, we should always try to build a care system which incentivises independence and rehabilitation. Paying for outcomes shifts the freedom and responsibility for finding better solutions to the provider.

Of course this is not a simple choice to make, or more authorities would already have made it. Contracting for outcomes demands a shift in the way councils

commission and requires an investment of time and thought in re-designing commissioning processes. Providers must be able to invest in the service, and this is problematic in the context of short-term contracts and agreements. Care workers must be empowered to spend time with a service user and this is difficult when they are paid on an hourly rate rather than a salary.

However, these problems are not insurmountable. As the case studies in Chapter 5 demonstrate, councils across the country are finding their own local solutions, and developing innovative ways of shifting the emphasis of service delivery onto quality outcomes for the individual.

We hope the case studies in this report will help to promote discussion between authorities, and between partners at a local level about the ways in which they can make the best use of their commissioning power to produce the outcomes they want for individuals and communities. Models of commissioning will necessarily vary in different areas of the country, but the questions that need to be answered will be the same.

By working together to find better solutions to the commissioning problems we face we can build systems and relationships that deliver the personalised, outcome-focused services we need to address the challenges of the future.

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The LGiU is an award winning think-tank and local authority membership organisation. Our mission is to strengthen local democracy to put citizens in control of their own lives, communities and local services. We work with local councils and other public services providers, along with a wider network of public, private and third sector organisations. The LGiU convenes the Children's Services Network (CSN), which provides policy briefings, reports and events for children's services professionals.

www.lgiu.org.uk

Mears is the leading social housing repairs and maintenance provider in the UK and a major presence in the domiciliary care market – bringing the highest standards of care to people and their homes.

Partnering with clients, 13,000 Mears Group employees maintain, repair and upgrade people's homes, care for individuals and work in communities across the country – from inner city estates to remote rural villages. For more information, please contact Abigail Lock at Abigail.Lock@mearsgroup.co.uk

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