Smarter Commissioning Support –
Commissioning for Personalisation: Models of Practice
Research Report

Produced for Walsall Council

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January 2013
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Smarter Commissioning in the West Midlands

The Smarter Commissioning project offers hands on support to adult social care teams in the West Midlands. Support is targeted towards local commissioning priorities and aims to improve the quality and consistency of commissioning decisions.

Walsall Council has identified ‘Strategic Planning’ as a priority for support. Specifically, the council wishes to use the support that is available to research and help develop a strategic commissioning framework that will enable the procurement of services in ways that adhere to the principles of personalisation.

Local Context

Walsall Council wishes to ensure that there is an appropriate range of affordable, quality services from which people can select providers of their choice in order to achieve the outcomes that matter to them, regardless of how their care is funded.

The council is transforming the way it commissions health, care and support services and is introducing outcome-focused framework agreements for all services procured by the Joint Commissioning Unit. Domiciliary care services have recently been tendered under the banner of the Support for Living at Home Service (SLHS) and the council is currently planning a similar supplementary SLHS exercise and to use a framework approach for the Residential and Nursing Homes market. Providers who have been accredited onto the council’s framework are required to satisfy stringent quality criteria and if successful are then eligible for work procured by the council on behalf of its citizens.

People in need of care and support – both those in receipt of a personal budget and those who fund their own care - have a number of options in respect of how they access the services they require and the council intends that everyone can get the information and advice they need to support these choices.

Walsall Council wishes to identify how other local authorities are developing a more personalised system of care and support and hopes to develop operational guidance for its commissioners based on an analysis of emerging good practice.

Abstract

The care and support market is beginning to come to terms with the demands of a system founded on the principles of personalisation, self-directed support, choice and control. The concept of personal outcomes is increasingly understood and accepted as the right way to do business, with commissioners and providers now seeking to adapt their business models accordingly.

There is an increasing bank of knowledge based on lessons learned by early adopters of a personalised and outcomes-focused approach around which independent analysts and consultants have developed useful strategic guidance; this includes highlighting some of the key challenges to be overcome if an outcomes focused approach is to prove successful.

This report seeks to signpost a selection of resources that may prove useful to Walsall Council as it seeks to further develop its own practice.
**Social Care Policy: A Focus on Outcomes**

The vision for adult social care is built around the principles of personalisation, prevention and early intervention; delivery of the vision is being achieved through self-directed support, with choice and control being extended through personal budgets and access to a choice of personalised services.

The sector led partnership agreement Think Local Act Personal envisages a community-based system based on collaborative and constructive relationships between commissioners, providers and people who use care and support services. This requires that all parts of the system are aligned to the achievement of better outcomes for people who use services.

Research conducted by the Social Policy Research Unit (SPRU) identifies 3 factors facilitating an outcomes-focused approach:

- **National policy** – the national policy framework is consistent in its support for and promotion of outcomes-focused approaches and this transcends party political influences, allowing long-term approaches to be developed without the threat of disruption from political change;

- **Local vision, leadership and change management** – a clear corporate vision, strong political leadership and robust change management all serve to reinforce the focus on outcomes;

- **Wider partnerships** – based on good relationships with a wide range of external partners are also considered essential.

According to the Office of National Statistics report *Measuring Outcomes for Public Service Users*, people do not value services per se but rather the effect those services have on them, the outcomes of service use. In order to measure the ‘value’ of public services we would, therefore, wish to measure the outcomes they confer to service users.

Outcome measures can inform value for money decisions through analysis of effectiveness, one of the ‘three Es’ through which value for money can be improved:

- economy – the amount of inputs that can be purchased given a set amount of expenditure

- efficiency – the amount of output produced by a given amount of inputs

- effectiveness – the level of outcome achieved given the output

Without a measure of outcome the focus inevitably falls on economy and efficiency savings. For example, value for money was previously demonstrated via unit cost benchmarking. However, it is becoming increasingly important to measure outcomes to help improve value for money. The Department of Health have stated that effectiveness is key to their transformation agenda. They argue that different ways must be found to deliver the same outcomes in order to realise the greatest value from costs. This lies behind the strategy, for example, to shift from institutional residential settings towards supported living schemes where people remain in their own homes.

Outcome measures can also inform analysis of cost-effectiveness which is a form of economic analysis that compares the costs and outcomes of two or more courses of action, for example care homes and care in people’s own homes. Typically it is expressed as the ratio of cost:outcome. Cost-effectiveness analysis can help commissioners move to a balance of services which has the greatest outcome for the given budget.
A lack of information on the outcomes of services may encourage service commissioners to contract to lowest cost providers rather than to those who provide better value for money. The development of outcome tools can help fill information gaps and enable commissioners to monitor the outcomes different services and providers are delivering.

The Department of Health has developed three Outcomes Frameworks to help all parts of the health and care system to work together to support people to live better for longer:

The **NHS Outcomes Framework** sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for improvements in health outcomes.

The **Public Health Outcomes Framework** concentrates on increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities.

The **Adult Social Care Outcomes Framework** aims to support councils to rise to the challenge of delivering the White Paper priorities by providing a clear focus for local priority setting and improvement, and by strengthening the accountability of councils to local people.

Figure 1: The 3 Health & Social Care Outcomes Frameworks

The three outcomes frameworks set out high level areas for improvement, alongside supporting indicators, to help track progress without overshadowing locally agreed priorities. The DH publication ‘**Improving health and care: the role of the outcomes frameworks**’ sets out how the 3 outcomes frameworks work together to achieve the desired outcomes for the health and care system.

**Benefits of an outcomes based approach**

In his paper for the Care Service Improvement Partnership ‘**An Approach to outcome based commissioning and contracting**’ The Institute of Public Care’s Andrew Kerslake identifies five benefits of an outcomes based approach:

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**Benefits of an outcomes based approach**

In his paper for the Care Service Improvement Partnership ‘**An Approach to outcome based commissioning and contracting**’ The Institute of Public Care’s Andrew Kerslake identifies five benefits of an outcomes based approach:
• A focus on outcomes should mean a better service for the end user. At the moment it is possible to deliver the volumes of service required, in the manner agreed, at the right time, to high quality standards, but still not achieve the desired outcomes.

• It makes the commissioning partnership focus on exactly what they want the provider to achieve and why. This may be of particular help where services are to be jointly commissioned.

• For both commissioner and provider it encourages a knowledge driven approach to practice. Both sides need to know and understand the rationale behind each outcome and to identify methods of practice that can achieve demonstrable results.

• It can help to focus agencies on the purpose of the task, both at a general level and at that of individual workers. Overall outcomes can link into personal targets and appraisal systems, eg, what are you doing to achieve the outcomes the agency is required to meet?

• Achieving outcomes can be both collectively and individually motivating, particularly where the absence of clear achievements, goals and targets in the past has tended to produce an approach which spurns the concept of success.

**Commissioning Models**

A key role of commissioning within social care is to ensure the availability, quality and diversity of personalised supports that are capable of delivering positive outcomes for people with care and support needs.

This requires that Commissioners develop a range of ‘intelligence-led’ approaches for assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

In its discussion paper *The Brilliant Local Authority of the Future* Management Consultant KPMG describes the need for councils to adopt a strategic commissioning approach for the services which it finances, procures and delivers. It argues that some outcomes will be secured through changing public expectations and persuading others to take appropriate actions and envisages managing commissioning, procurement and contract management as a single integrated lifecycle, avoiding the separation of for example commissioning from procurement and recognising the latter as one means of implementing the former’s outcomes.

Most models of commissioning emphasise its cyclical nature, with strategic commissioning providing the context for procurement and contracting. The example shown in Figure 2 below is adapted from a model produced by the Institute of Public Care (IPC) and is widely used. The IPC model links the commissioning and purchasing/contracting cycles, and is relevant across public care and support services.
Figure 2: Commissioning Model for Care & Support (based on IPC model)

The model is based upon four key performance management elements - analyse, plan, do and review. The model requires that each of the four elements receive attention, and all are kept in balance. The commissioning cycle (the outer circle in the diagram) should drive purchasing and contracting activities (the inner circle), and these in turn inform the ongoing development of strategic commissioning.

Commissioning for Personalisation

The commissioning model described in Figure 2 provides a useful generic basis for guiding operational practice but perhaps lacks some of the more detailed practical considerations for commissioning in a personalised way. The Scottish Government has produced guidance aimed at strengthening commissioning within a personalised care and support system and has defined a personalised commissioning approach involving successful engagement in 10 key functions:

1. Involving Service Users and Carers
2. Strategic Planning
3. Financial Planning, Individual Budgets and Resource Distribution
4. Market Management and Partnership with Providers
5. Service Specifications
6. Procurement and Contracting
7. Managing Risk
8. Workforce Development
9. Regulation
10. Governance

The Putting People First partnership offers an alternative approach to personalised commissioning characterised by a number of key principles. This does not imply a generic, one-size-fits-all approach
It is for councils to determine the principles that best reflect their local context and priorities. Key principles for personalised commissioning might include:

1. Empowering citizens to direct their own support.
2. Enabling people to identify what is important to them and to obtain the supports they require within their available resources.
3. Building on people’s existing capacities and social networks.
4. Enabling meaningful participation for citizens in the commissioning process through active co-design, co-production and co-delivery, rather than post facto consultation.
5. Paying equal attention to enabling self-funders to better meet their needs as to people who rely partly or wholly on state funding.
6. Working with colleagues in children’s services to empower the families of children needing support and ensure better transitions from children’s to adults’ services.
7. Ensuring that there is choice in the deployment options available for people to determine the arrangements that best suit them.
8. Ensuring clarity and transparency in commissioning processes.
9. Not assuming that greater choice of existing services is the solution.
10. Working in partnership with provider organisations and the voluntary and community sector to ensure that flexible services are available.
11. Maintaining a diverse view of the market and supporting equity of opportunity for the voluntary and community sector and social enterprise.
12. Prioritising the stimulation and support of User-led organisations when developing the market.
13. Developing a diverse range of support planning and support brokerage options that utilise the resources of the whole community.
14. Working to personalise universal as well as specialist services, across all sectors to reduce barriers for citizens with support needs wishing to access them.
15. Ensuring that outcomes are at the centre of all developments designed to integrate commissioning and service delivery.

This framework envisages commissioning activity working across multiple levels, but with the overall aim to empower citizens with support needs to make use of, and further develop their capacity to self-direct their care, and where possible, to directly shape the supports they receive. Examples are provided of individual, operational and strategic commissioning activities. Whichever approach is favoured, the functions and principles described here are intended to operate within, rather than instead of, the ‘Analyse – Plan – Do – Review’ model described in Figure 2 above.
Strategic Commissioning: an intelligence-led approach

Strategic commissioning involves taking a long term view of the needs of the whole community. Commissioners should be planning at least 10-15 years ahead, assessing what mix of services and supports will best meet predicted needs and preferences, as well as delivering best value. A long term approach is essential for sound decision making about investments in assets and workforce planning and in facilitating the development of the market for care and support services.

In its publication *Key Activities in Commissioning Social Care* the Care Services Improvement Partnership describes three strategic commissioning improvement priorities:

1. Understanding Demand – strategic needs assessment
2. Understanding Supply
3. Moving from analysis to written strategy

These themes are reflected in the National Market Development Forum approach to market facilitation. The approach is embedded in the Care & Support White Paper with support being offered to councils through the *Developing Care Markets for Quality and Choice (DCMQC) programme*. The programme will help all councils to develop a Market Position Statement (MPS) to reflect the analysis of available data and from projections, including data from people about their needs, preferences and the extent to which the service is delivering intended outcomes. The MPS is an important step in articulating the changes needed within the local care and support market and
will provide a basis for improvement planning and co-production of new and diverse services aimed at meeting the future needs identified by the analysis.

Examples of published Market Position Statements are available from:

- Leeds City Council
- Devon County Council
- Bradford City Council

Whilst the DCMQC programme should help councils to accelerate the production of their MPS, it will be important for councils to develop a long-term approach to handling market intelligence to reflect the planning horizons being considered. The West Midlands market shaping programme, Mobilising Community Capital, developed the Market Intelligence Framework to guide the handling of market intelligence so that commissioning decisions would become better informed and increasingly evidence-based. The approach was developed in consultation with a range of parties, including providers, people who use services and people who commission them and is an iterative process to gather, analyse, use and review intelligence from a range of sources:

**Figure 4: Process for handling market intelligence**

**Gathering Market Intelligence**

The actions to ‘Gather’ market intelligence address four basic questions:

- **What intelligence do we need?** The purpose of gathering market intelligence is to enable an analysis of the market, in the form of a Market Position Statement (MPS). The National Market Development Forum, set up under the Think Local Act Personal Partnership, has provided guidance on the format of the MPS and this should be regarded as the basis for the requirements specification.

- **Where can we get it from?** There are many sources of market intelligence and it is neither possible nor desirable to gather all of them for analysis. The analysis should, though, contain a balance of intelligence drawn from four broad categories:
  - Community Intelligence – drawn from the institutional assets in the community: for example, service providers, community groups, voluntary organisations etc.
o System Intelligence – drawn from the transactions, behaviours and relationships between parties in the system: for example, the number of times information about a particular service or provider is requested by members of public, the findings from internal or external quality reviews, etc.

o Predictive Intelligence – drawn from statistical data and modelling systems which find trends and predict future needs: for example, census data, POPPI and PANSI demographic projections, etc.

o Personal Intelligence – drawn from listening, close observation and personal experience: for example, through forums, contract reviews, care assessments etc.

• **How do we collect it?** System and Predictive intelligence tends to be readily accessible and relatively easy to collect; Community and Personal intelligence tends to be ‘softer’, discoverable through personal networks, relationship, observations and feedback. It is potentially rich in qualitative intelligence, but more reliant on ‘human’ intervention and therefore less consistent in its handling.

• **Where do we store it?** Some intelligence will be held within a single location, but much more will be maintained externally. A ‘library’ or catalogue of market intelligence should be maintained so that it can be easily accessed and referenced.

**Analysing Market intelligence**

Once intelligence has been ‘gathered’ it can then be ‘analysed’. Analysis involves the retrieval of the intelligence and assessment of what it means; this should be published in a report (the Market Position Statement). The analysis should provide information about the local context and priorities, current and predicted future demand for care services, the range and quality of supply including any gaps in provision, known or planned changes in the market including commissioning intentions and an indication of the resources available within the market (for example, the allocation of public money to commission services of a particular type).

The MPS should be a concise, market-facing analysis – the NMDF recommends no more than 12 pages. Our review of numerous draft MPS has shown that this is a challenge for councils, not least because of the wealth of intelligence that is used to form a view of the market. Our recommended solution is to publish the detailed supporting evidence in a separate appendix to the MPS. This allows the audience to delve behind the analysis if required.

**Using Market Intelligence**

The analysis will only add value if it is used to inform the decisions and actions taken: for individuals and operational commissioners arranging care and support packages this might influence their choice of provider; for strategic commissioners it may determine where stimuli for new or changed provision is required or may lead to some services being de-commissioned and for service providers it might prompt the development of new or more diverse services. At the strategic level, the use of intelligence will involve prioritising the changes required, planning the work (publishing the results in a Market Intervention Plan) and then putting the plan into action.
Actions should reflect the personal and organisational outcomes that have been prioritised. For example, a priority outcome to help people to live independently in their own homes for as long as possible may drive a reduction in the number of residential care beds commissioned and an increase in the provision of day opportunities.

**Reviewing Market Intelligence**

The final stage in the value chain is concerned with reviewing the effectiveness of the changes made, the outcomes it has delivered, the continuing relevance of the outcomes prioritised (for example, political priorities may change the emphasis of local commissioning strategy) and the adequacy of the underpinning intelligence. The review should consider the following questions, leading to a further refresh of the intelligence and the next iteration of the cycle:

*Did we do what we said we would do?* This is to consider the extent to which the plan has been implemented.

*What impact did this have?* This should describe the changes arising – for example, 75 fewer residential care beds commissioned, 3 new Day Opportunities providers added to the Framework Contract, etc.

*What were the outcomes?* Differentiate between personal outcomes (i.e. aligned to the 3 Outcomes Frameworks described above) and organisational outcomes (which may be wider than social care outcomes and include outcomes for public finances, local economy, worklessness etc).

*Do we need to do things differently?* Consider whether the desired outcomes are being achieved. Additionally, local priorities may have changed, or unforeseen events may have had an impact on the market (for example, the failure of an important provider organisation, causing reduced choice / quality in the market).

*What new or updated intelligence do we need now?* Even if the plan is ‘on course’ to achieve its planned outcomes, some of the intelligence held may have become out of date or may need to be validated periodically, whilst the emergence of new providers and the withdrawal of others will need to be catalogued.

**Personalised approaches to procurement**

Using a community-based approach to commissioning means engaging a range of people and organisations in all aspects of commissioning and service development and such engagement requires careful planning and impartial facilitation.

The Scottish Government has produced a *Summary Paper on Service User and Carer Involvement* which sets out ways in which such involvement might be carried out throughout the procurement process.

*Values-Based* approaches use customer engagement to identify the values and aspirations of specific user groups to inform contract specifications. In an *article for ETHOS journal* (published by Serco, October 2011), consultant Ian Keys (co-founder and currently managing partner of Gradus Consulting, which specialises in supporting health, social care and local authority sectors in their delivery of commissioning) envisages that local investment decisions will increasingly be informed by the values held by recipients and providers, stating that “These (values) firstly need to be recognised and then a way forward negotiated to determine the service response. As health and social care
moves inexorably towards individual budgets, values-based commissioning will constitute a necessary underpinning of the process.”

The Royal College of Psychiatrists Joint Commissioning Panel for Mental Health (JCP-MH) defines VBC as type of Values-based Practice in which a commissioning process rests equally on three pillars of:

1. patient and carer perspective,
2. clinical expertise and
3. knowledge derived from scientific or other systematic approaches (evidence)

All three of these components are aligned with procurement, contracting and other commissioning practice to integrate values, professionalism and science with the mechanics of commissioning. VBC should allow patients and carers to engage with the commissioning process on an equal footing to everyone else so that commissioning policy becomes developed around involvement and consensus, allowing more people to exercise active citizenship.

Dr Liz England, a GP in Birmingham who is RCGP Clinical Commissioning Champion, has published a short paper entitled Values Based Commissioning in Mental Health in which she very simply sets out some of the principles of VBC:

Values are the convictions and beliefs, which shape the way we work and determine the principles, which inform our policies. Values or beliefs create attitudes, which then lead to specific behaviours.

A number of positive ‘values’ underpinning mental health services have been previously described in the literature and include a focus on recovery, inclusion, support for social networks, peer networks, best practice and co-ordination and cost effective care.

A VBC framework is one which reflects both values-based medicine and evidence based medicine … In Values Based practice, and hence commissioning, conflicting values are balanced by means of ‘good’ process, or negotiation, and not by a predetermined hierarchy of values or priority of perspectives.’

In Values-Based Commissioning of Health and Social Care (summarised in a presentation here), Professor Chris Heginbotham, Warwick University Medical School and Emeritus Professor of the University of Central Lancashire, argues that Health and social care commissioning is values-driven as well as evidence-driven and describes how values-based commissioning complements evidence based commissioning by providing skills and support processes for working with differences of values. The approach, he says, is effective because it is seen to be transparent, fair and balanced.

Professor Heginbotham describes a process for Values-Based Commissioning involving four basic steps:

- Starts by identifying and making explicit the often very diverse values of all those involved whether as commissioners, as providers or as users of services;
- Maps this diversity within an agreed framework that includes not only ethical values but also needs, wishes, aspirations, strengths and resources;
- Draws on the diversity of values thus identified as a resource for balanced decision making within the context defined by the relevant framework;
Engages with an on-going process of evidence-based review.

With a wide and diverse range of stakeholders and interests, it must be recognised that their values may be contradictory or contentious and that not everyone’s expectations can or will be satisfied. “The commissioning process provides the opportunity to debate the differences between values, whether clinical, social or organisational. Where values conflict, there is an opportunity to share the reasons for those differences, to achieve a resolution that is acceptable to all parties.”

VBC offers commissioning bodies a real opportunity to actively involve communities in commissioning decisions by moving the debate on from a focus on the flaws within the current system, to a question of how to effectively put people’s values into practice through local commissioning.

We have already described how commissioners are responsible for ensuring the quality and diversity of provision and this means encouraging a market that comprises a range of providers of all sizes. The Office of National Statistics report Measuring Outcomes for Public Service Users concludes that Commissioners could lessen some of the barriers faced by voluntary sector providers by placing more emphasis on outcomes.

Procurement processes must comply with EU and UK legislation and the principles of probity, transparency and fairness. The choice of procurement approach is important in attracting expressions of interest from an appropriate mix of providers.

The open procedure is a one-step process, with no restrictions on who can submit a tender: it is open to all. This runs the risk that organisations will waste substantial amounts of time completing full tenders and may therefore discourage smaller providers from bidding for public contracts.

Restricted procedure procurement is most commonly used when contracting the types of services provided by smaller providers and the VCS. The value of this two-stage process is that by running an initial selection (requiring the completion of a pre-qualification questionnaire, or PQQ) to create a shortlist of providers, unsuitable organisations who don't make the shortlist don’t waste time and effort completing a full tender.

The restricted procedure approach can be used to invite pre-qualified providers to submit a full tender to deliver the specified service, or to be entered onto a Framework Agreement. When statutory authorities have relevant contracts to let, they will inform this group of potential service providers, so they can bid. This means there is a ready supply of interested providers if contracts need to be let quickly. This is the method most commonly employed by central government departments and increasingly within adult social care.

The 'Competitive Dialogue' process allows potential providers to advise contracting authorities about the service they are wishing to contract - allowing providers to shape the packaging, period and value of the service. Some commissioners may approach organisations known to them directly to seek bids from them. Although common practice this method does question the openness and transparency of the process. In some instance where there are no real alternative providers a commissioner can appoint an organisation as the preferred supplier and any suitable work will be passed straight to them.

There is usually an opportunity for potential bidders to ask the commissioner questions about the specification or to seek clarity about any aspect of it. This can take place either though the
commissioner convening a briefing meeting of all of who have expressed interest in bidding or asking for questions to be submitted in writing. Responses to questions are usually circulated to all interested parties to ensure that all bidders receive the same information.

The Welsh Assembly has produced a series of guides covering SME Friendly Procurement:

Resource 1 is an introductory guide providing key information on how organisations can ensure that their procurement is SME friendly, and how opportunities for SMEs can be maximised.

Resource 2 is a comprehensive guide containing detailed information on legal and policy matters, as well as information for buyers on what and how to buy, and how to support SMEs.

Resource 3 provides a series of model materials and practical guidance on how to buy.

Whilst these resources have been written to reflect some locality-specific (i.e. Welsh) requirements they can be used and adapted for use by all public sector purchasers of works, and for the procurement of supplies and services.

Scottish Government resources covering the Procurement of Care and Support Services, an online Procurement Journey Toolkit and an approach to Procurement Capability Assessment all offer useful operational guidance for procuring care and support services in a personalised way. Councils such as Wakefield have assembled some 33 ‘good practice guides’ around a Code of Practice for Procurement, whilst Dorset County Council has produced the Dorset Procurement Toolkit, with guidance assembled around four thematic sections:

1. Business needs
2. Sourcing plan
3. Tendering
4. Supplier management

Whilst these guides may be individually useful Walsall Council will want to ensure that guidance is proportionate and relevant to the local context.

Outcomes-focused framework agreements

Outcome based commissioning places ‘improved outcomes for people who use care and support services’ at the heart of the commissioning cycle. This requires that procurement and contracting also focus on outcomes to ensure that individual arrangements with a particular provider will deliver the outcomes that have been negotiated between the commissioner or purchaser and those with whom they are contracting. This means shifting the basis on which services are purchased and resources allocated from units of service provision (hours, days or weeks of a given activity) to what is needed to ensure that the outcomes desired by service users are met.

In a personalised care and support system there is a need for greater flexibility within contracts between the council and its providers. Most councils are moving away from ‘Block’ contracts (where the council commits to purchase a specific quantity of a service that can be used by a number of people at a specific price) towards outcomes focused ‘Framework’ agreements. These contracts aim to assure quality and supply through pre-selection or validation of providers. They do not generally guarantee demand for or volume of service but typically require any provider included within the framework contract to provide services in more flexible and personalised ways regardless of whether their customers are self or state funded.
Guidance from the Institute of Public Care suggests a 5-step approach:

1. Agree the service area, potential providers and the contract parameters. This should be set out in an initial statement for discussion with providers.
2. The development of outcomes and their rationale. These are then shared, discussed and agreed with the potential providers.
3. The provider prepares a statement of how it intends to design its services in order to meet the outcomes. This is discussed and agreed with the commissioner.
4. Commissioner and provider discusses and agrees the indicators used to measure the outcome and the methods for their monitoring.
5. Provider identified and contract terms discussed and agreed.

Global audit, consultancy and advisory company Deloitte identifies five critical success factors for the use of contracting for outcomes:

- Establish the contract fundamentals – to include the definition, agreement, measurement and management of outcome-based contracts. The paper offers useful measurement and pricing models which reflect the sophistication inherent in outcomes-based contracts (see Appendix 1).
- Consider and mitigate the ‘unintended consequences’ – the skills required to manage more flexible outcomes-based contracts are broad, for example requiring that commissioners shape provider behaviour by influencing the market environment. There is a need to share knowledge and learning within and across the sector.
- Manage overlapping multiple contracts – providers may have multiple contracts with a single council, managed by different departments. Sometimes the work delivered under one contract will influence the outcomes of another contract and this risks cross-service duplication and inefficiency. Joint commissioning may provide part of the answer, but only within the context of a relationship management model that recognises interdependency between activities.
- Develop a new relationship with and between providers and lenders – recognising that there are new and emerging sources of funding for providers and ensuring that there is transparency in the funding arrangements that sustain providers. For some providers, constrained access to business finance may affect the delivery of contracted outcomes. Commissioners need to understand the funding context and financial risks facing providers.
- Implement appropriate payment and performance systems – outcomes-based agreements are likely to require complex performance systems reflecting activity-based pricing and multiple weightings, with an appropriate balance of return for inputs, outputs and outcomes. Involving providers in the design of the system and appropriate incentives will be a key requirement.

The Office of Government Commerce (OGC) provides guidance on the use of Framework Agreements aimed at ensuring that call-off arrangements operate within the procurement legislation:
Framework agreements typically define the basis on which the council will purchase specific services from a provider. However, in some cases the time, task and type of support is not predetermined but is subject to a personalised addendum describing the type and volume of services to be used. Social Care Consultancy Helen Sanderson Associates advocates the use of ‘One Page Profiles’ to provide a summary of person-centred information that people in the person's life can use to either get to know them quickly, or ensure that they are providing consistent support in the way that the person wants.

An Individual Service Fund enables someone to draw on existing and new council contracts in a person-centred way without assuming responsibility for managing the money. The council lodges money with a provider on an individual’s behalf, with the individual working together with the provider to decide the exact detail of any support to be provided. The provider is contracted to the council and is required to account for the money on an individual basis. Money (or hours of support) can be rolled over into future weeks or months or banked for particular purposes and the ISF can contain services bought from other providers.

Whilst the contract – and financial agreement – is between the provider and the council, service users are identified within the agreement and usually required to sign it, as it will typically require a commitment from them to meet certain obligations. Importantly, this also enables people to terminate the agreement if they are unhappy with it, without having to involve the council in lengthy contract failure procedures.

The Think Local Act Personal partnership provides examples of Individual Service Fund Agreements, such as that used in Leicester, and also provides a case study outlining implementation considerations in Nottinghamshire.

The Department of Health publication ‘Contracting for personalised outcomes: Learning from emerging practice’ offers further evidence of improved outcomes and value from six case studies from councils who have introduced outcomes-based framework contracts or/and Individual Service Funds for Domiciliary Care provision.

From a provider perspective, NCVO has identified the advantages and disadvantages of Framework agreements as follows:

**Advantages**

- All sides can finish one stage before beginning another.
• They provide a quick start for contracts, and offers can be presented more immediately.
• A smaller, controlled pool for provision

Disadvantages

• This smaller pool potentially reduces market capacity, new entrants, and new ideas. It can reduce the relationship between the market and the public body, and significantly reduce the relationship between non-provider VCS and the public body. With this distance, public bodies lose access to those additional resources in non-provider VCS, as well as their understanding of local needs, causes, and solutions.
• There can be substantial costs to get on to a framework or to establish a framework, and potentially no call offs.
• Information on their timeframes, advertising, and call-off periods are not always well communicated.
• Frameworks may be so fluid that entry to them is not a useful spending of provider’s time.
• When run as prime provider frameworks, costs are reproduced down the sub-contracting chain.
• There is a lack of research on their effectiveness and most appropriate usage.
• If organisations commit to certain cost structures on entry, these may become fixed and therefore unfair if costs change over a period of time.
• Frequently reported that staff who begin frameworks move on, and their original clarity of purpose is lost in staff transfer. This is in part because frameworks – as with other contracts – are often developed by single staff members, so there isn’t a shared clarity across commissioning teams.
• Commissioners reported that they don’t often work the way they’re intended, therefore more training and advice is needed to improve their usage.
• Experience of many organisations entering frameworks for personalised services is that they are price capped, therefore commissioners are creating artificial controls over the market, and reducing scope for innovation or quality improvements. See the NCVO MOPSU research for evidence of how price controls the quality of outcomes, causing providers of all sectors to deliver a limited quality of services.

These observations are indicative of a market that remains sceptical about framework agreements and the council’s ability to design and implement them in a way that is fair and inclusive.

We have identified other case studies of outcomes based contracts that offer valuable learning:

Case Study: North Yorkshire County Council’s framework for outcomes based homecare contracts.

The approach describes a series of activities across seven stages:

Initiation is concerned with the goals, objectives and management arrangements of the commissioning ‘project’;

Boundaries define the scope of the project (for example, the nature of the services being contracted and any expectations around pricing);

Preparation is concerned with defining the outcomes and success criteria for the project and considers the interests of various stakeholders;
Contracting involves engaging with current and potential providers, developing the tender process, selecting the provider(s) and agreeing the contract;

Measuring and Monitoring means identifying and agreeing the measures and monitoring processes required in order to test the achievement of outcomes;

Implementation is primarily concerned with tailoring services to achieve the personal outcomes of individual service users;

Finance and Funding considers issues such as contractual payments to reflect a balance between effort, outputs and outcomes, together with provision for any direct ‘top-up’ charges allowed within the contract for optional ‘added value’ services.

Case Study: Manchester City Council’s Service Specification For Residential & Nursing Care Provision for Mental Health

Manchester City Council wanted to encourage a cultural shift in residential and nursing care provision for people with mental health problems and set about designing a service specification and pricing framework based on recovery oriented practice. Outcomes are defined in terms of the Mental Health Recovery Star with monitoring and self-assessment of performance and quality aligned to the Star’s 10 domains.

The framework’s pricing approach seeks to differentiate according to the level of need and to incentivise quality through additional payments for higher quality standards.

Case Study: Birmingham City Council’s Framework approach

Any bed-based or home support care provider wishing to provide care must register their business on the Framework Agreement. Registering a business does not mean there will be a guarantee of work. Care providers must be CQC registered and have relevant insurance cover.

The Framework Agreement is split into the following sections:

- Service type (e.g. residential care, nursing care, home support, acquired brain injury)
- Geographical area (e.g. Yardley, Erdington, City Centre)
- Citizen/Need group (e.g. dementia, substance misuse, learning disability)

Care providers are contacted for potential work opportunities if they have stated at registration that they can meet needs and outcomes in the sections required.

A micro-tendering approach is used to select the care provider that can best meet the care needs and outcomes for the citizen. The council informs care providers of each individual citizen’s needs, outcomes and preferences, as these are identified through the assessment and support planning process.

Care providers are then asked to respond to the micro-tender with an ‘offer’ that includes their ability to meet the citizens’ care needs and preferences, a brief description of how they intend to support the citizen in achieving their outcomes and the cost for them to provide their services.

Offers are assessed against set criteria and allocated a score. 60% of the score is based on quality considerations and 40% on price.
The contract is awarded to the highest scoring provider. However, in the case of bed-based services, citizens are able to exercise the ‘citizen choice directive’ and select the service that they would prefer. If the provider the citizen selects has quoted a higher price that the highest scoring provider, then a Third Party Top-up may apply.

Supply chain management partner Matrix SCM Software (SProc.net) is used to manage the micro tendering and Care Provider Selection parts of the process.

A new contract management approach operates alongside the Framework Agreement process. Every care provider is allocated a named account manager from the commissioning team. The aim is to provide a relationship management approach that is open and constructive, where problems can be identified quickly and where best practice can be shared. A new quality and performance management approach is being developed where expectations, targets and methods of measurement for service delivery are agreed with each provider.

**Reviewing performance for quality and outcomes**

The Care and Support White Paper makes it “clear that that the quality of care and support is first and foremost the responsibility of providers” and requires them to “ensure that systems are in place which accurately provide assurance to themselves, service users and their families, and the public that the essential requirements are being met.” The White Paper offers no exceptions to this requirement.

This does not mean, however, that the Local Authority can assume the role of passive observer. A new duty “to promote diversity and quality in the provision of services” will demand a broader approach to quality that spans the whole of the care and support market rather than limiting itself to that portion of the market that is under contract to the Local Authority. This in turn will require that councils develop different strategies to influence and stimulate good quality provision rather than simply relying on contract management.

In this context, the performance review needs to perform two basic functions:

- To inform decisions about the level of reward and remuneration associated with the delivery of the performance outcomes specified in public service contracts;

- To provide assurance that the essential requirements are capable of being met by all providers within the market, as a means of informing the buying choices of people who use care and support services.

**The Reward & Remuneration function**

At the core of the contract is the payment mechanism – the basis on which providers will be rewarded for their efforts, the outputs arising from them and the outcomes they deliver. These may include indicators taken from the relevant Outcomes Frameworks described earlier, combined with other indicators that have either been proposed by or co-produced with providers. This raises questions of balance and proportionality to ensure that the contract truly incentivises quality.

The Deloitte discussion paper ‘**Hit the ground running: Five critical success factors in contracting for outcomes**’ describes three basic variants of measuring and pricing in contracting for outcomes (see Appendix 1). These progressively seek to recognise an increasingly complex range of impacts on performance, for example by discounting the effects of external factors on the basis that reward should be based as accurately as possible on added value. The paper assesses that whilst providers
accept that such a complex payment matrix is inevitable, they have little confidence in the ability of commissioners to design and implement effective, flexible payment structures.

There has been an increase in the number of financial incentive programmes offered alongside health and social care contracts. Payment by results (PbR) refers to a system in which public service commissioners pay providers according to how much work they do or the outcomes they achieve, rather than a fixed sum agreed at the start of a contract. It is intended to incentivise improved performance from providers and to ensure commissioners use resources more efficiently. Formal PbR pilots are being run in a number of locations (including in Birmingham, through a group of Providers led by Midland Heart) and the learning from these pilots is likely to influence the wider application of PbR across the sector.

Service users have a key part to play in PbR, as described in a case study produced by Sitra (Services) Ltd involving specialist floating support provider Connection.

Walsall council is trialling PbR through its quality incentive scheme, based on the NHS Commissioning for Quality & Innovation (CQUIN) payment framework. This should provide important learning for the council in terms of the proportionality and flexibility of the payment mechanism and its wider impact on contract performance. CQUIN schemes are increasingly popular, with PbR being regarded as the ‘default’ for all public sector contracts in the future.

The impact of contracting for outcomes on the business model of the provider market should not be underestimated and as we have seen, there is much that remains unproven. There is a strong argument for productive engagement with providers to explore these and other issues well in advance of the introduction of an outcomes based approach.

The Assurance function

Whilst contract monitoring and quality monitoring visits help assess the quality and performance of contracted providers, they do not currently involve those providers working directly for service users who fund their own care or are engaged through a direct payment arrangement. There remains the possibility for such providers to subject themselves to quality and performance monitoring on an entirely voluntary basis, although this would inevitably have financial implications for the council. In any event the council may wish to consider how it extends its quality and performance monitoring function to consider quality outwith any contractual arrangements.

Quality in Care and Support services needs to be seen in the context of the social care policy agenda and in particular the primacy with which policy regards ‘personal outcomes’. This is reflected in the Adult Social Care Outcomes Framework (ASCOF), which sets out the basis on which accountability for quality and outcomes is assessed. Launching the first ASCOF in March 2011, (then) Care Services Minister Paul Burstow said: “Our ambition is to make social care services more personalised, more preventative and more focused on delivering the best outcomes for the people who use them”.

User-based definitions are based on the idea that quality is an individual matter, and services that best satisfy their needs (i.e. perceived quality) are those with the highest quality. Whilst this is a rational approach, service providers may find it difficult to aggregate varying consumer preferences within their core offering and retain wide appeal. This can lead to the choice between a niche strategy or a market aggregation approach which tries to identify those attributes that meet the needs of the largest number of consumers.

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Nevertheless, the approach is consistent with current thinking on individual choice and control and reflects popular management thinking that “the customer’s definition of quality is the only one that matters”.

The White Paper offers a series of user-defined markers of quality:

**A high-quality service means that people should say:**

- I am supported to become as independent as possible.
- I am treated with compassion, dignity and respect.
- I am involved in decisions about my care.
- I am protected from avoidable harm, but also have my own freedom to take risks.
- I have a positive experience of care that meets my needs.
- I have a personalised service that lets me keep control over my own life.
- I feel that I am part of a community and participate actively in.
- The services I use represent excellent value for money.

There are though, a number of available views on Quality, for example as derived from:

- Regulatory inspection – by the Care Quality Commission (CQC);
- Contract monitoring / Quality monitoring – by Commissioners of care & support services;
- External accreditation – typically associated with the application of nationally and internationally recognised quality improvement techniques (BS5750 / ISO 9000, IiP, Quality Mark, EFQM Excellence Model etc.);
- Self assessment – usually as part of the organisation’s approach to quality improvement;
- Customer feedback – which may be gathered continuously or as part of a periodic ‘customer survey’.

The extent to which each of these offers any firm assurance of quality is limited: in most cases, monitoring provides a retrospective view and is influenced as much by documentation and record keeping as it is by the delivery of care and support.

This section explores the advantages and weaknesses of each type of assessment and provides examples of where they are being used to inform the view of quality.

**Regulatory inspection**

CQC inspects most hospitals, care homes and domiciliary care services at least once a year to check that they are meeting the required essential standards of care. Inspectors ask people about their experiences of receiving care, talk to care staff, check that the right systems and processes are in place and generally look for evidence that care isn’t meeting national standards.

A report of each inspection is published on the CQC website.

CQC inspections are useful because they assess quality on a consistent basis, enable benchmarking and highlight specific issues for future attention.

As with all inspections, they reflect a ‘moment in time’ and can become out of date quite quickly, whilst this may not be an issue where weaknesses are identified (since follow-up visits will usually be undertaken until failings are rectified), there is the potential for deterioration from a previously satisfactory position to occur between inspections.

**External accreditation**
External accreditation approaches are expected to follow the government’s policy on Voluntary Conformity Assessment and should be driven by market demand rather than by vested commercial interests.

Certain nationally and internationally recognised quality improvement techniques require that an organisation submits to an external accreditation (e.g. ISO9000; EFQM Excellence Award; Investors in People) and some other voluntary standards (e.g. PQASSO Quality Mark for third sector providers and the Quality Mark for Micro Providers developed by Community Catalysts Ltd) also involve third party accreditation. Where external accreditation is undertaken there is an implicit assurance of quality that should be considered by those seeking to purchase care and support services.

**Self assessment**

Self assessment forms the basis of Northumberland County Council’s annual provider quality assurance process. The assessment aims to help services reach agreed quality standards and demonstrate these achievements to commissioners. The quality standards reflect local priorities, expectations of the Care Quality Commission and individual person-centred outcomes.

Self-assessment is an important part of the quality assurance landscape because it reinforces the notion that the provider is primarily responsible for quality and encourages improvement planning that is independent of external influence.

**Customer feedback**

There are various ways of incorporating service user viewpoints within a quality assurance approach. We have already seen that most quality improvement techniques include a focus on the ‘customer’ and many organisations will use customer feedback as a basis of improvement, whether within a quality improvement approach or not.

Some of the more commonly used approaches include:

- **Customer Satisfaction Surveys** – periodic sampling of customer views across a range of issues. Typically result in the development of an action plan to address key issues or concerns;
- **Customer Feedback Forms** – comments sheets made available to all customers on an ongoing basis, or as part of a campaign. Comments will be aggregated periodically to provide an updated view of ‘hot topics’.
- **Service Ratings** – most often these will be independently maintained within comparison-style service catalogues (for example, see the [Warwickshire Directory](#)), with customers able to rate their experience of the service / provider across defined fields (see ‘information and other systems’ below).
- **Complaints and Compliments** – whilst individual comments and compliments may not necessarily be reflective of quality across the operation, there may be some common themes that emerge from periodic analysis.
- **Customer Forums** – either face to face or virtual engagement with self-selecting service users. Discussions can be targeted towards particular quality issues or can consider how service users would like services to develop in the future.

It is worth reflecting that commissioners of care and support services may become aware of customer feedback – for instance, when a complaint is made about a provider commissioned by the
council – or may choose to use one or more of these techniques to find out more about quality from a service user perspective and to inform future commissioning approaches.

A balance of assessments

In North Yorkshire, quality monitoring visits are based around a Quality Assurance Framework (QAF) co-produced between commissioners and providers of care and support services. The approach balances annual self-assessments with periodic quality assurance visits which are intended to complement rather than duplicate the work of CQC and the self-assessment.

Harrow Council also operates a QAF although this is used mainly to assure the quality of its own services rather than those of care and support service providers. Nevertheless, the approach is worthy of examination in the context of achieving a balance of assessments:

Figure 6: Harrow Council Quality Assurance Framework

Community-based assessment tools, such as the My Care My Home service developed by Shaw Healthcare Homes Ltd, also seek to report a balanced assessment of quality. The approach considers CQC and Customer ratings alongside the ‘My Care My Home’ rating, which awards an overall score out of 100 for the Service, with up to 50% of the score reflecting the quality of the interactions and relationships observed between the staff and the individuals being cared for.

The existence of various sources of assessment provides the opportunity to take a balanced view and to help inform purchasers of care and support about the quality and suitability of a provider.

So far we have focused on assessing the performance of providers: however, it is also important that the council’s commissioning performance is subject to review. Scotland’s Social Work Inspection Agency has produced guidance aimed at helping councils to assess their strategic commissioning performance against a performance improvement model that asks 6 key questions:

1. What key outcomes have we achieved?
2. What impact have we had on people who use services and other stakeholders?
3. How good is our delivery of key processes?
4. How good is our management?
5. How good is our leadership?
6. What is our capacity for improvement?
Supporting personal choice through improved information, advice and advocacy

The government’s vision for adult social care is that “Individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.”

According to the Care & Support White Paper “there is a lack of understanding about how care and support works, meaning that very few people plan ahead for their care needs. This is compounded by a lack of easily accessible good quality information and advice to help people consider their options and make informed decisions about how best to meet their needs.” A range of actions to enhance information nationally and locally is needed to help people to understand the options available to them and to plan and prepare for their care and support.

Some council information systems include useful guidance on ‘buying your own care services’, (for example, see Salford Council) and many councils have set up ‘Support with Confidence’ schemes in partnership with local Trading Standards and Provider organisations (such as in Surrey).

Most councils now provide community-based service catalogues that offer detailed information about the providers and services that are available within the local market (as with Birmingham City Council’s online Marketplace). The potential exists for these systems to include far more information about the quality of services provided; the service catalogues being run by Staffordshire County Council and Warwickshire County Council both offer the ability for service users to rate their experience of using services, with these ratings being publicly displayed as a way of aiding comparison.

Some community-led service catalogues identify where providers have attained or signed up to voluntary quality standards or quality charters (for example, see Care Forum Wales), whilst others offer a balanced view of quality based on the pooling of assessments from a number of sources (as with the My Care My Home website).

The care and support white paper commits to giving people access to clear information about the quality of individual care providers and describes the introduction of a new provider quality profile, to be displayed on the NHS and social care information website at www.nhs.uk.

The focus on quality profiles and ratings systems is likely to herald a raft of competing systems and this may become counterproductive – there is a strong argument for a co-ordinated ‘source of truth’, albeit accessible from multiple touch points. In his discussion paper Informing self-directed support, produced for the West Midlands Market Shaping programme Mobilising Community Capital, Newcastle University’s Professor Mike Martin describes the challenge facing local authorities as one of nurturing and co-ordinating many organisations from different sectors within an ‘information economy’ that combines three distinct functions: Publication, Brokerage and Distribution. As service catalogues develop and add content this will become an important part of the ‘stewardship’ role being adopted by the council.
Conclusion and Lessons Learned

“Moving from contracting to outcomes from outputs has the potential to transform mainstream commissioned social care services. However, the scale of the challenge must not be underestimated. Councils have to avoid being lulled by the language of outcomes into thinking that all that is required is to adopt the language and suddenly require providers to work to outcomes without appreciating the changes they have first to address.”

OUTCOMES WORKING AND STRATEGIC COMMISSIONING AND CONTRACTING, Colin Slasberg, June 2009

The case studies and practice models analysed here provide some consistent lessons:

• A focus on outcomes can help ‘level the playing field’ and open the market for providers of all sizes, by providing a consistent basis for measuring the value added by each organisation;
• Moving to framework agreements requires time to plan, brief, encourage and facilitate the changes needed and will require both providers and commissioners to change existing practices. Such change will not be achieved without putting in place appropriate support mechanisms based on close working relationships, productive engagement and co-production;
• Outcomes should be defined in terms of – and with the involvement of – the people who will use the services being procured. There is a need to build flexibility into delivery and monitoring arrangements so that performance can be assessed against the widest possible range of outcomes. Responsibility for quality is primarily that of the provider;
• Measurement and monitoring should embrace the activity, outputs and outcomes specified; it should be capable of informing decisions about reward and remuneration and of assuring the quality of provision across the care and support market;
• Models of pricing need to reflect the approach to measurement, with reward linked to outcomes. There is a need to establish an appropriate baseline and to reward added value above activity;
• Information systems offer the potential to support increased personal choice, but require a different approach to the publication, brokerage and distribution of information within a broad ‘information economy.

The research has identified a wealth of operational guidance covering all aspects of the commissioning and procurement process and some of the sources are referenced in Appendix 2 below. In developing its own operational guidance to commissioning and procurement teams, Walsall Council will want to select the guidance that it considers to be most relevant to the local context, taking into consideration its current and desired operating model and the skills and capabilities of its staff. The council should resist the temptation to produce or amass a comprehensive range of guides covering all aspects of the end-to-end commissioning process unless it believes that such guidance will add value to its operation.
**Appendix 1: Measurement Models and Payment Structures in Contracting for Outcomes**

<table>
<thead>
<tr>
<th>Measurement Models</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Zero baseline</td>
<td>Commissioners pay for every positive outcome, with no adjustment for provider efforts or the complexity of each case. Ignores the potential for ‘deadweight loss’, where outcomes improve as a result of external factors not related to provider added value.</td>
</tr>
<tr>
<td>Fixed baseline</td>
<td>Discounts deadweight loss by adjusting the baseline for a proportion of the outcomes sought. The ‘fixed’ baseline can be adjusted periodically in light of new factors.</td>
</tr>
<tr>
<td>Predicted baseline</td>
<td>Baseline trend is forecast at the commencement of the contract using predictive techniques. Payments reflect variation from the prediction.</td>
</tr>
<tr>
<td>Combined approach</td>
<td>A zero baseline can be combined with either a fixed or predicted baseline, to offer transparency in pricing whilst enabling some ‘smoothing’ for deadweight loss.</td>
</tr>
</tbody>
</table>

A range of payment options similarly exists:

- **Fixed payments** – as with zero baseline measurement approaches, providers are paid for every positive outcome regardless of external factors. Requires clearly defined outcomes to avoid the risk of rewarding short-term outcomes that are not sustained. May not accurately reflect the effort expended on individual cases.

- **Variable payments** – rise in line with an increase in the number of outcomes achieved, up to a defined ceiling. Risks rewarding providers who target their effort towards a large number of straightforward cases and reducing the transparency of provider effectiveness. Conversely, variable payments can encourage ‘cross-subsidy’ of effort by allowing the ‘savings’ from easy wins to be reinvested in the more challenging cases for no net increase in effort.

- **Fixed payment ranges** – a menu approach with complex payment ranges reflecting both the complexity of individual cases and the existence of external factors.

*Adapted from Hit the ground running: five critical success factors in contracting for outcomes, Deloitte Insights.*
Appendix 2: Links to relevant Operational Guidance

- **Procurement Journey Toolkit**
- **Procurement Capability Assessment**
- **Wakefield MDC Procurement Code of Practice & Best Practice Guides**
- **Dorset Procurement Toolkit**
- **Lancashire County Council Procurement Strategy**
- North Yorkshire County Council’s [framework for outcomes based homecare contracts](#)
- Manchester City Council’s [Service Specification For Residential & Nursing Care Provision for Mental Health](#)
- Northumberland County Council’s annual [provider quality assurance process](#)
- North Yorkshire [Quality Assurance Framework](#)
- [My Care My Home](#) Community-based assessment tool
- [Outcomes STAR and Commissioning](#)
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