Outcome-based commissioning in domiciliary care: overview of regional roundtables

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Summary

Following on from our 2012 publication Outcomes Matter: effective commissioning in domiciliary care, the LGiU worked with Mears, a leading provider of home care and support services, to hold a series of roundtable events between November 2012 and February 2013. The six roundtables, which were held in locations across England, aimed to discuss the challenges and opportunities associated with outcome based commissioning in adult social care. This extended briefing provides a summary of these discussions.

It covers the following subjects.

- Background to the discussions: an overview of the findings of the LGiU’s research report Outcomes Matter: effective commissioning in domiciliary care.

- Current commissioning practice: broad outline of current trends and practice based on the discussions at the events.

- The provider’s perspective: comment from Mears, a leading social care provider on the experience of being commissioned by local authorities.

- Key issues: analysis of the main themes and issues addressed in each of the roundtable events.

- Comment.

The current context of declining budgetary allowances, an ageing population and growing complexity of social care needs makes this topic particularly timely.
This extended briefing covers the main content of six events, and is relevant to policy officers and commissioners who work in adult social care, as well as councillors who have portfolio responsibility in this field.

**Briefing in full**

**Background**

Six round-tables discussions took place between November 2012 and February 2013, in Birmingham, Nottingham, Gateshead, Knowsley and twice in London; they were attended by officers and councillors from across the UK.

The sessions followed an LGiU/Mears report, published in October 2012, which reviewed outcome based commissioning in adult social care. The report sought to investigate current practices in commissioning for domiciliary care and identify barriers and potential opportunities to better outcome based commissioning.

In exploring this subject, LGiU undertook a programme of research including a survey of elected members and officers from over 110 councils. The results from 210 respondents made the following findings.

- Over 70 per cent considered outcome based commissioning to be a ‘very important’ priority for social care; however 36 per cent said that it was used only to a ‘limited degree’.
- Less than 10 per cent paid service providers according to the results they delivered, as opposed to an hourly rate.
- Three quarters of people regarded ‘a culture of running services on a time-task basis’ as an important barrier to outcome-based commissioning, but over 90 per cent still paid their service providers on a time/task basis.
- More than 75 per cent said their current systems and processes were not sufficient to manage adult social care provision in future.
- More than 90 per cent agreed that pressure on resources was leading them to reconsider their methods of social care provision.
Current commissioning practice

Commissioning describes the process of designing services and choosing delivery agents, rather than referring to a particular choice of agent. It is now an intrinsic part of the care system, involving a chain of people from service users through to care workers. The roundtables revealed a broad consensus that the key stages of commissioning include the following:

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

Traditionally, most commissioning processes in a social care context have tended to pay providers for particular tasks, often within a set period of time, rather than for the delivery agent’s achievement of specific results, or outcomes. Outcome based commissioning refers to the practice of contracting providers on the basis of the outcomes they achieve, rather than the activities they deliver. It is intended to shift the focus of service delivery away from the activity itself and onto the benefits it will achieve for service users.

Another core narrative forming practice in social care is personalisation. For many of the local authorities that attended the roundtables, part of embracing a more person-centred approach to homecare delivery has involved moving away from block contracting, often using some of the following steps.

- Making a strategic shift away from traditional 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.
- 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.
There have been significant benefits to these developments, which in many cases have given people more control over the results they want to achieve, challenged the ‘one-size-fits-all’ model of service delivery and placed the service user at the heart of the service.

However, roundtable discussions suggested that the move away from block contracts has also created challenges. With a larger volume of providers in many areas of the country, it has been difficult for some authorities to maintain successful relationships with them all.

The ‘framework contract’ has also allowed councils to drive down the hourly cost of care, by placing providers in direct competition with one another on their ability to reduce this cost. However, in many instances this has had a direct impact on care quality, in some cases resulting in zero hour contracts for care workers and the non-payment of travel time. For smaller providers, competing in this environment can also be problematic. Increased competition with a large number of providers can create greater uncertainty over volumes of work and mean providers are given shorter contracts and are expected to take on increased responsibility for risk.

While block contracts were, in many cases a serious obstacle to the personalisation of services, they did in theory allow for economies of scale, for the development of complex supply chains, and for close relationships between council and provider in a way that is more difficult to achieve in a framework agreement.

In some instances the process described above has made it more likely that providers will be contracted on a ‘time-task’ basis, rather than paid for the outcomes they achieve. The roundtable discussions highlighted this key tension, and the need for councils to find a way to make services responsive to service user need, while also addressing the financial and other challenges faced by the authority in commissioning these services.

The Provider Perspective

Mears, a leading provider working in the field of repairs and maintenance and social care, supported the programme and attended each of the roundtables to prompt discussion around the provider perspective in the commissioning process, and to highlight the reasons they feel outcome based commissioning is valuable for both councils and providers.

They made three broad points:
First, that outside some reablement contracts, social care is almost entirely commissioned on the basis of task and time, which ultimately gives the provider the wrong target: to contract a provider for a 15 minute visit specifies how long a care worker should be in the property, but tells you nothing about the quality of care received in that time.

Second, paying providers on the basis of time gives them an active monetary incentive to increase the length of care packages. This is unsustainable in the current adult social care context and results in poorer results for individuals as it creates a dependency culture rather than one which helps promote independence.

Third, they suggested that a shift to an outcome-based approach to these services would deliver better customer satisfaction as service users are able to work with providers and frontline staff to obtain the outcomes they want. Outcome based commissioning also gives providers a greater incentive to invest more in their workforce and deliver better quality care, which empowers their workers, results in fewer hospital visits and reduces the strain on the NHS budget.

Local authorities have great power to shape the context in which care is requested and delivered by service providers. Alan Long, Executive Director of Mears expressed how outcome based commissioning has influenced their incentives as a provider in other markets.

“We have seen outcome based commissioning used for several years in repairs and maintenance contracts. However, it wasn't always like that. Contracts used to be let, for example, on the basis of who could supply a single tap at the cheapest price. This incentivized providers to quote for the cheapest tap they could: not a long-sighted approach to property maintenance. Nowadays, repairs are contracted on a 'cost per property' basis. If the cost of maintenance and repair for a property costs the council an average of £500 every year, we are now paid to reduce this to £300 over a period of three years, for example.

As a provider, our incentive has therefore shifted from supplying the cheapest product to investing in quality; thereby reducing repeat visits from the repairman— which is where the real costs lies. This also generates better customer satisfaction, as people don’t have to face the inconvenience of having the repairman constantly come to their house. In these contracts, the council can also specify a certain level of customer satisfaction, and community engagement activity. In return, if we succeed in reducing the costs below the agreed level, we can share in the savings.

We don’t see this kind of thinking in adult social care however. Instead, we are paid for a specific product — such as a domiciliary care service or a reablement service. This means
that we are invariably paid for the time we spend with a service user, rather than the outcomes we achieve for them."

Social care is clearly a very different service to repairs and maintenance, but the example raises questions about the way in which we commission providers in this context. Do we give them the best incentives to deliver the services people want?

Many service providers still feel that they are given contracts based on the lowest cost of output per hour and not the results they can deliver. This can reduce the need for them to respond flexibly to individual demands and can actually work against service user interests. Providers are given an active incentive to increase, rather than manage an individual’s need for care, as they will receive more hours of work as the package grows.

Mears commented that they would like to see more responsibility for finding the solution passed to providers, so that the outcome is specified, rather than the activity (which should be agreed between the service user and provider). They noted that the transfer of risk to the provider can free up resources. For example, Mears have recently made an offer to local authorities, stating that they will pay upfront for the installation of telecare for recipients of their domiciliary care service, with no risk to the council. If the use of telecare is found to lead to long-term savings and better results for the service user then Mears are paid back their initial investment and a share of the savings. If however, no savings are found and set objectives are not achieved Mears do not recoup their initial investment.

From a provider perspective, whilst outcome based commissioning cannot solve all the problems currently faced by adult social care, a successful model should give more power to the service user, help to address issues of quality and care worker support and deliver more economically efficient services than a ‘time-task’ basis to commissioning.

The Discussion: Key Issues

The discussions in each roundtable took place over the course of an hour and a half, and covered a wide range of subjects. Some of the key issues were as follows.

Defining Outcomes

While many who attended the roundtables felt that assessment of outcomes represented an opportunity to engage service users in service design, there were concerns about the difficulty of defining them. Defining and differentiating outcomes for the individual and outcomes for the service is challenging; linking them together, establishing causal links and demonstrating cost savings where applicable even more so. While many councils worked with service users to establish the outcomes they wanted to achieve, in most
cases this was then translated back into a number of hours for the purpose of commissioning the provider.

Other delegates stressed the challenges that they had faced in ensuring that the outcomes identified in a care plan were the ones that the individuals concerned truly wanted (rather than the council’s interpretation of their needs) and also being confident that they could be achieved. Some attendees also highlighted that increasingly domiciliary care attends to the needs of very vulnerable people, whose trajectory is unlikely to be one of recovery. As a result, outcomes are more likely to relate to a ‘managed decline’ than a reablement process.

One delegate spoke about the innovative work of Oxfordshire County Council, which has used ‘three wishes’, as a new performance measure to assess the effectiveness of public services in helping people achieve the outcomes that they value. Under the scheme, all service users are asked what were the three most important goals that they want to achieve with their care worker. These three answers were useful in helping the council define more clearly what types of support plans they needed to design and which outcomes they needed to be monitoring.

**Monitoring and Evaluating Outcomes**

One of the biggest obstacles to paying providers on the basis of outcomes, rather than time or task, was agreed to be the difficulty in measuring achievement of outcomes. Monitoring and evaluating outcomes could be time consuming and resource intensive, as opposed to monitoring the length of a visit, which can be automated using electronic monitoring.

In evaluating success against a desired outcome, there are many factors that could influence the outcome attained and it is often difficult to discern which of these were attributable to the work of the service provider. Most importantly, delegates noted that monitoring outcomes becomes very difficult when high concentrations of service users transferred to direct payment plans.

Using some of the lessons of Helen Sanderson’s person centred planning approach, Wiltshire County Council has created a standardised framework of observable and attributable outcomes (as opposed to a self reported level of wellbeing for example), which they expected all their service providers to deliver. These outcomes were developed using a personalised assessment of the service user, and of which, the service user, provider and Wiltshire County Council all approved.
‘I can’ statements formed the basis for each outcome. For example, ‘I can cook a meal for myself’, ‘I can use the bath without outside help’ etc. Progress in achieving these outcomes had to be directly attributable to the work of the service provider. Some of these outcomes are contracted out on a payment by results basis and the provider receives a penalty for not delivering them.

The council monitors the service user’s progress using an online ‘Carefirst’ social care case management system, which everyone involved in the programme, has access to. Service users are constantly asked for feedback and everyone is able to use the online system to see the development trajectory against each outcome. Each programme lasts for a maximum of six months, after which the council reviews it. If the council approves, it is then offered to the service user – who can either accept or alternatively take the monetary value of the plan and transfer to a direct payment system. As providers are given the responsibility of developing the detail of care plans, social workers have more time to monitor the quality of services.

**Electronic Monitoring**

Some councils at the roundtable said that they favoured the use of electronic monitoring as it helped them to free up officer’s time. This enabled them to devote more time to engaging with service users and less time focusing on reducing the risks of missed appointments. Commissioners noted that use of electronic monitoring gave them precise information on how long a care worker had been attending to a service user. This served as a form of accountability for the provider and enabled the council to pay for exact allocations of time. One commissioner at the roundtable commented that:

“When we incorporated electronic monitoring into our system we found that between 10 per cent and 40 per cent of service providers didn’t deliver”

On the other hand, there were also some authorities at the roundtable who disagreed with the use of electronic monitoring. They expressed concern about commissioners ‘creating a whole new industry to monitor another’. Others highlighted the negative impact it had on the workforce, as providers looking to cut costs refused to pay their worker’s expenses for their journey time. Some suggested that electronic monitoring was useful within the time/task framework but not so much within the outcomes based commissioning context, as it did not provide evidence on the quality of the service. Indeed, one local authority commented:

“With the use of electronic monitoring it is relatively easy to observe how long the care worker’s visit lasted for, but that doesn’t tell us anything about how he or she feels”.”
Payments by Results

‘Payments by results’ entails funding a service provider specifically for the results they achieve, rather than the outputs they produce. It is intended to increase the incentive for service providers to achieve better outcomes for service users.

Payment by results is not yet common in domiciliary care services, although one participant commented that it had been used in Supporting People services, and that domiciliary care could learn from experience in this area. For example, in 2011, Derbyshire County Council introduced a Supporting People model where 80 per cent of costs were paid to providers in advance on a quarterly basis. The remaining 20 per cent were paid in arrears, and were dependent on the providers’ service users meeting a number of pre-agreed outcomes.

In most cases where payment by results had been used, a method was employed which paid the provider a proportion of the fee for delivering the contract, and a bonus or penalty depending on whether the outcomes were achieved or not. These bonuses are not necessarily financial; they can include, for example, a guaranteed flow of work or longer contracts.

In a social care context, payment by results has so far been predominantly used in reablement services, where the provider is, for example, given six weeks to help the service user achieve certain targets, and is specifically paid for reaching that goal. In some of these contracts the provider is paid a proportion of the savings generated should that individual be fully ‘reabled’ before the completion of the six-week time limit.

One delegate highlighted how it made it difficult for her to penalize providers for lack of agreed outcome. Another commissioner said that because of this, his council only set penalties for extreme circumstances, and then only when there is definite evidence of negligence by the provider. Some felt that payment by results can skew provider behaviour, and cloud the real aim of the service, which is to provide rounded quality care for an individual. Others commented that payment by results encouraged ‘cherry picking’ of less complex patients on the part of providers.

However, other delegates concluded that payment needed to be linked to outcomes for the individual, and if a robust mechanism can be found for turning outcomes into a ‘currency’, then it could give providers a better incentive to improve and invest in services.
Delegates frequently highlighted that lack of trust between commissioners and providers was a key obstacle in achieving better commissioning arrangements.

Some councils have taken great lengths to break down the distrust that can often exist between commissioners and service providers. Cheshire East Council, for example, offer free training and information services for all providers via provider forums in order to foster a closer relationship and enhance knowledge sharing between the many providers they have within their district. Training is delivered jointly to encourage better relationships between providers.

Home care providers can be part of the solution in tackling matters of distrust. Mears commented that an open book policy where financial information is shared openly with commissioners can be a good way of achieving a better understanding – this can be specified when the service is commissioned. Some council delegates noted that this can be resource intensive, as it requires significant investment from the council in training staff to understand financial information, or employing forensic accountants to explain it to them.

**Market Management**

The way commissioners structure and develop the market has a significant effect on the supply and demand of adult domiciliary care, as recognised by the Care and Support Bill, which places a duty on local authorities to promote diversity and quality in the market of care and support providers in the local area. To maximise choice for service users, many local authorities have become more proactive in increasing the number of providers within the market. However, several delegates noted that alone, this 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.

During the roundtable discussions one metropolitan borough council noted that they had developed the market for domiciliary care in their area so that they have almost ‘taken the council out of the picture altogether’. The delegate said that their approach to market management is akin to ‘Trip Advisor’, where people are free to pick their own service providers, and review their services online. Whilst the council acted as a legal arbiter, providers were free to set their own fees. Individuals were given personal budgets and the option to choose whichever service provider they liked. This had the benefit of empowering the service users and not forcing them to break any relationships that they
have formed with specific care workers. They highlighted that it had also helped some providers in their market become more efficient as they competed to gain clients.

However, other delegates expressed concern with this model. Choosing a care provider can be complex, and people are often in a vulnerable position at the time of their choice. It was noted that in some cases, brokerage services had simply re-created old care management systems under a new name, and service user ‘choice’ was nominal. Whilst many local authorities did their best to give service users as much information as possible about the providers in their area, these choices were often limited by a lack of understanding over what is available. In many examples, service users would simply accept the recommendations that were given to them by members of staff, or alternatively settle for their status quo. Equally, smaller care providers could find it difficult to survive in this model.

Several commissioners mentioned that they struggled with managing the huge breadth of relationships that existed with having a large number of providers. One delegate noted that when they had up to 280 providers, they had experienced difficulties coordinating them, resulting in multiple visits for service users from different agencies.

Increasing the number of providers can also reduce the ability of councils to benefit from economies of scale. Competition over an hourly rate has driven down costs in many instances, but has also been linked to the erosion of care worker’s rights, as service providers seek to reduce costs by paying the lowest hourly rate, and offering zero hour contracts and unpaid travel time.

Some councils at the roundtables had a closer relationship with a smaller number of providers. They noted that this allowed them to develop successful working partnerships with these organisations. However, in the event of a provider failing, the council could be exposed to greater risk. There was no consensus about the ‘ideal’ number of providers in a local market, but it was agreed that this may vary depending on local circumstances and the demographics and geography of an area.

**Relationship with other services**

The relationship between health, social care and housing has a significant bearing on the successful delivery of outcome based commissioning. Many delegates at the roundtables discussed the difficulties they had encountered in merging the different cultures within the three areas and establishing shared outcomes between them. One council noted that whilst they had previously worked very closely with the health and well being boards in their area, the transfer of commissioning responsibilities from Primary Care Trusts (PCTs)
to the newly formed Clinical Commissioning Groups (CCGs) had been very frustrating and meant that they had lost some of their previously established relationships.

Housing can also play a key role in determining an individual’s social care outcomes. In ‘care and repair’ contracts, care workers have been encouraged to identify potential trip hazards, and the need for repairs and maintenance to a property, as part of their care package. One delegate noted that housing related support, most notably in the form of the Supporting People programme, which helps people to remain in their own homes for longer, could offer some useful learning in relation to domiciliary care.

A number of delegates suggested the idea of having councils, health and well being boards and service providers engage in further collaborations to share knowledge on best practice. There were several suggestions of councils setting up cross-board forums and network support groups.

**Asset based approaches**

Our discussions touched on a shift towards an ‘asset-based approach’ to delivering services. This approach highlights the total collective resources available to a community, including the often overlooked skills, knowledge, and networks held by individuals which can be used to promote local community solutions.

Darlington Council has embraced this approach and is currently working on building a community based asset network. This involves mapping the assets they have within the community, including the voluntary sector, and how they could contribute to care for older people, for example. A key element of this approach is about shifting the council’s attitude to risk, moving towards a more risk tolerant culture that allows greater involvement in service delivery by civil society.

Coventry Council highlighted that they have made significant progress with their *Shared Lives* model of facilitating social care. *Shared Lives* is a scheme that recruits, assesses, trains and supports local carers to offer accommodation and support within their family home to people who are unable to live independently. The programme is managed by Coventry Council and monitored by the Care Quality Commission. It is intended to provide a more personalised experience for service users and increase the capacity of the community to support its more vulnerable members.
Much of the debate centred on the need for significant culture change if outcome-based commissioning is to be successful. Commissioners will need to change the way they contract services, providers will have to rethink the way they deliver it and ensure their front line staff are sufficiently trained to understand and achieve outcomes. Delegates at the roundtable, however, highlighted a resistance to cultural change as one of the biggest obstacles to achieving outcomes based commissioning in adult social care.

Several sources of resistance were identified in the discussions. Many councils, for example, were used to paying a provider an hourly rate to deliver a specific product or service, but were not yet comfortable with the idea of having a currency of costed outcomes. In many cases service users themselves were satisfied with the service they had been previously receiving, and their expectations of care had been shaped by traditional models of service delivery.

Some councils expressed an unwillingness to give providers a greater role in designing and delivering care plans, and letting go of the service specification to the extent that might be required under an outcome-based contract. Providers might also be unwilling to take on the potential risk to cashflow in such a contract.

Families of service users can also be resistant to change in many instances, particularly in a care plan where care is to be reduced over time. While there is an expectation in a reablement plan that an individual will ultimately graduate from care, in a domiciliary care relationship, the expectation is often that the level of care will necessarily increase over time, and relatives will often push for this from authorities.

In all these instances, clear communication and leadership is key to making sure a change process is well managed. Several councils noted that when introducing different models of delivery, they had initially engaged with new entrants to the care system, before attempting change with existing service users.

**Workforce**

Another challenge that was frequently highlighted was that of frontline care workers. Care workers are crucial to the delivery of high quality care, but the continuing pressure on care budgets, the emphasis on an hourly rate and changes to service provider contracts often meant that care workers received lower pay and had to undertake more tasks in shorter visits than has been the case in the past.
In a framework agreement, the only way to deliver savings is often to reduce the hourly rate, but this has an inevitable impact on service quality over time. Many councils also felt that there was a lack of investment in care workers, in terms of training and development, which could result in low morale and poor quality care. The treatment of frontline workers within the care industry was constantly noted as an issue of concern, it resulted in the industry having a high turnover and detracted people from choosing care work as a potential career route.

Councils had responded to this challenge in different ways. Some London authorities had required care providers in their borough to pay the London Living Wage. Others had paid careful attention to tenders for work, and rejected those they felt made unachievable promises in relation to the hourly rate. However, this continued to be seen as an issue in many parts of the country.

UNISON, who attended one of the roundtables have recently issued their ‘Ethical Care Charter’, which provides a list of standards for councils to consider when they commission services. Amongst the 12 standards there is a call for an end to 15 minute visits, for time to be given for the care worker to talk to their client, for better scheduling of visits and for the same worker to be allocated to the same client where possible.

The Wiltshire Model

Many attendees at the roundtable events discussed Wiltshire’s ‘Help to Live at Home Scheme’ as an innovative example of outcome based commissioning. There was a significant level of debate about Wiltshire’s work and the lessons that could be learnt from them. While not all authorities aspired to adopt this model, the questions raised by the work are helpful in framing further discussion about a move towards outcomes.

When Wiltshire 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 a provider, ultimately moving from 90 providers to four. These providers were guaranteed all the initial support plans assessed by the council in their 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, using Helen Sanderson’s person centred planning. 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.

There were certainly challenges to delivering this process, which took place over several years. During the roundtable discussion, a representative from Wiltshire mentioned that it could be initially difficult to move existing service users onto a new provider, while maintaining relationships with existing care workers. Service users who insisted on this, however, were given the option of taking a direct payment and retaining the service...
provider of their choice. Wiltshire also noted that they are fortunate in having a robust care market in neighbouring areas, reducing the risks associated with provider failure, and that not everyone would choose to pursue this model. However, it raised interesting questions at each discussion regarding ways of breaking the zero sum game of ‘time-task’ commissioning.

Comment

The six regional roundtables revealed a broad range of practice in commissioning domiciliary care services, and several areas of innovation. It is clear that there is no single answer to the issues currently experienced in adult social care. Nevertheless, there was in most instances a broad consensus on the following points.

• Outcome-based commissioning will not resolve all the challenges facing adult social care at present and there is no substitute for continued calls for additional resources in addressing the needs of an ever-growing older population. However, the concept of outcome-focused services is highly valued and while there is still scope for sharing best practice and innovation between local authorities, outcomes must form a part of these discussions.

• ‘Time-task’ models of commissioning in domiciliary care are still prevalent and commissioning on this basis can cause a challenge in times of shrinking resources. Firstly paying providers on a time basis gives them a poor incentive for investing in the maintenance and rehabilitation of service users and secondly, it pushes commissioners into a position where their only means of making savings is to reduce the hourly rate. Over time, this has a serious impact on care quality and on care workers.

• Defining and measuring outcomes is challenging, but possible. Examples such as Helen Sanderson’s person-centred assessment and Oxfordshire’s ‘three wishes’, show the importance of placing the service user at the heart of the assessment process. Personal outcomes should be mediated by the authority as little as possible. The New Economics Foundation has also done some significant work in this area.

• Relationships with providers are central to achieving better outcomes for individuals in receipt of care. ‘Market management’ can mean different things to different authorities, but breadth of offer, as well as number and type of providers should be considered. There was no consensus on the ‘ideal’ number of providers, but it is worth bearing in mind that relationships can break down if there are too many providers, but that the council exposes itself to more risk in the event of provider failure if it has a small number.
A key message from the discussions was that there is no one size fits all method of achieving outcome based commissioning, and there are several ways of taking the agenda forward. We have seen councils in different parts of the country take innovative steps to do so, but this is a challenge that we all must face together. LGiU and Mears are keen to work with member authorities and partners to develop a practical approach to outcome based commissioning and facilitate appropriate networks and support.

For more information about this research, please contact Lauren Lucas, Policy Manager, LGiU at lauren.lucas@lgiu.org.uk, or Abigail Lock, Head of External Communications, Mears at abigail.lock@mearsgroup.co.uk.

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk

**Associated briefings**

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- **User-driven commissioning – report by Disability Rights UK and Shaping Our Lives**