Department of Health

Putting **People First**

Transforming Adult Social Care

Commissioning and Contracting for Outcomes

Care Services Efficiency Delivery: supporting sustainable transformation

Outcomes are not just an important mechanism for expressing the support objectives for an individual. They also provide a basis for providers to deliver more effective services and for commissioners to structure the most cost effective service portfolios. This paper provides CSED's latest thinking on outcomes and illustrates how to incorporate outcomes within commissioning and contracting strategies. It also describes how it aligns with the emerging work on the new National Indicator Set (NIS).

Overview

Defining outcomes and other terms

The NIS recognises that outcomes are derived from results, experience, and activity and that it is the relationship between these outcome dimensions and cost which determine value for money. The first part of the document expands on these and other terms in order to set the context of the rest of the document.

The DH, DCFS & DCLG Outcomes Frameworks

The paper then explores outcomes in the context of the emerging National Indicator Set and the various related policy frameworks. There is a particular emphasis on:

- Putting People First;
- the Department of Health's (DH) seven outcomes model;
- The Department for Children's, Schools and Families (DCSF) 'Every Child Matters' five outcomes model; and
- The Department of Communities and Local Government's (DCLG) adaption of the latter to Supporting People.

Relating Outcomes to Individuals

The third part of the paper puts outcomes into the context of support planning and resource allocation. It argues that outcomes are important with regard to resource allocation.

Relating Outcomes to Service Provision

Outcomes allow for greater flexibility in how a provider delivers services. If, as suggested, money is correlated with outcomes, it becomes possible to develop self-funding incentive mechanisms to encourage creative solutions to meet outcomes. However, whilst outcomes are key, it is also important that:

- for sustainability reasons, service users are satisfied with how they were achieved;
- for efficiency reasons, that performance in delivery is considered; and
- for value-for-money reasons, that the cost of delivery (and the underlying drivers of cost) are properly considered.

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Some Definitions

Outcomes

Within the context of this paper the term *outcomes* focuses on the measurement of the impact of the service on individuals (referred to as *outcomes for individuals* in the NIS information packs).

There is a related set of outcomes (called *outcomes for populations*) which, whilst not covered in detail here, will be influenced by prevalence factors derived from aggregated views of the results obtained via this model.

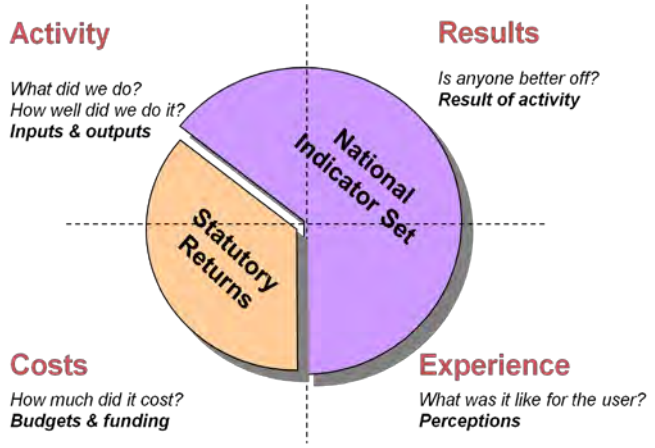
The NIS framework helpfully identifies three types of evidence necessary to demonstrate that an outcome has been achieved.

Outcomes = Activity + Results + Experience

It also implies a fourth dimension, collected via statutory returns, which is particularly important from an efficiency and effectiveness perspective:

Value for Money = Outcomes / Cost

The relationship between these aspects, the NIS and Statutory Returns is summarised by the following diagram:



Results

Within the context of social services, *results* measure the impact of a support plan. For reasons to be expanded on later, we believe it is essential to quantify results if value for money solutions are to be found for an increasing population of individuals in need of services within a financially constrained environment.

The framework at the back of this document is a *results* framework designed to capture such information. Whilst it looks superficially lengthy (in order to have universal applicability), it has been designed such that once the support planning process has been completed, it is only a subset of this framework which will be of interest for a specific individual. ***Results* are relative NOT absolute.**

Whilst also able to be completed by the individual and/or their personal assistants (within a self-directed support context) it has also been designed to be able to be completed by any third party observer – carer, advocate, broker, etc. and is therefore seen as an operational tool for routine usage.

In this model *results* are evidenced via measures, which we believe should largely be:

- objective, i.e. observable by anyone (including the service user themselves);
- independent of the service used to deliver them (although some outcomes may be more relevant to specific services); and
- universally applicable, to a lesser or greater extent, to all categories of service user.

Experience

Experience captures the voice of the service user. Based upon survey results (whether via paper, electronic form, or interview), experience is fundamentally different to results. It

- provides a different perspective (being based on feelings and individual experiences),
- can highlight issues (and opportunities) not observable via other inputs, and
- provides a measure of sustainability (good experiences leading to continued use).

As the example in the box highlights, an over dependence on *experience* as a measure of outcomes can be distorting. *Experience* feed-back is:

- usually relevant at a specific point in time (on the day versus over the duration);
- often disproportionally influenced by short term bad experiences (which stick);
- can relate to specific aspects of service delivery (such as person to person chemistry) rather than the whole;
- more likely to be provided by those having either very bad or very good services – often leaving the silent majority unheard;
- occasionally coloured by what the individual believes is the 'right' answer;
- sometimes filled in by someone else; and
- difficult to collect routinely (often time consuming and expensive to conduct).

For all of the above reasons, whilst *experience* is essential for the purposes of validation, temperature testing, service development and so on, we do not believe *experience* should be the sole measure of achievement of *outcomes*.

Activity

The activity quadrant covers three aspects:

- What did we do?
- How well did we do it? (which we refer to as *Performance*); and
- The relationship between *inputs* and *outputs*

What did we do?

This is usually measured in terms of *outputs*: e.g. how many hours of home care, how many weeks in some form of accommodation, how many service users having particular needs or of a given characteristic.

Outcomes versus Experience

Dorothy is 81. She has been receiving home care support for the last year and one of the tasks carried out by the carer has been the preparation of her meals.

On review, the assessment determines that, with some aids and investment in re-ablement Dorothy is capable of preparing her own meals. At this point Dorothy did not want to do this – she had become dependent and was more than happy for the carer to continue to do this for her.

Despite her resistance, she reluctantly agrees that preparing her own meals is an appropriate *result* to aim for in the support plan.

Imagine what her feed-back, in *experience* terms, would have been at the beginning of this process.

Four months later, Dorothy is able to prepare her own meals. She can get up when she wants, she can choose what she has, and has gained in confidence and self-esteem.

It is highly likely that Dorothy's feed-back at this time would be completely different – hence the need to differentiate between *results* and *experience*.

This is information usually captured by the statutory returns process. As will be expanded on later, we believe it is still just as important to collect activity wherever possible, especially since the signs are that, even under personalisation the majority of service users will still chose council commissioned services.

A service may be delivering exemplary *results*, it may be getting fantastic feedback, but, if it is only being delivered to a small proportion of the population in need it could hardly be regarded as a positive *outcome*.

Performance

In our definition, *performance* captures those elements of service delivery which are captured through operational mechanisms and which usually provide an indirect assurance of quality and compliance. Complaints, reliability, and the results of inspections such as those leading to council or provider star ratings, are included under this heading.

Many of the dimensions of performance address completeness of scope i.e. was everything expected of the service delivered. The scoring published via CRILL (*Capturing Regulatory Information at a Local Level*) or LAMA (*LocAl Market Analyser*) therefore also fall under the performance heading.

Inputs versus Outputs

This domain is directly associated with CSED's work since efficiency is usually defined as the ratio of outputs to inputs:

Efficiency = Outputs / Inputs

Whilst improvement has been the focus of much of the last decade, economic realities are pushing efficiency up the agenda.

Efficiency drives costs and it is necessary to have visibility of both *inputs* and *outputs* if positive ongoing improvements are to be made. From our related solutions on assessment and care management and internal versus external service comparisons we know there is still scope to release efficiencies (for example, client facing time with in-house home care teams is often only 50% of the total – with the rest lost through travel, waiting, high levels of sickness, etc.)

The Sandwell Community Caring Trust example in the adjacent box illustrates how one organisation manages to maintain its competitive position within the residential sector.

Sandwell Community Caring Trust

Sandwell Community Caring Trust was created in 1997 as part of a TUPE transfer out of Sandwell Metropolitan Borough Council.

It has maintained its competitiveness by:

- increasing turnover directly on caring from 60% to 82%;
- reducing administration from 17% to under 6%;
- reducing average staff sickness levels from 22 days per person per year to 0.6; and
- lowering staff turnover to below 4%

It is proud of the fact that staff packages have been maintained in line with those enjoyed by council retained staff.

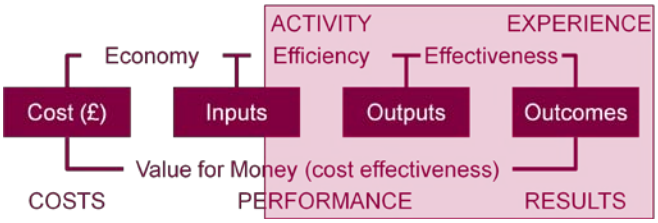
In 2006 the company came second in the Sunday Times list of the top 100 companies to work for.

Value for Money and Cost

Another way of representing the formula

Value for Money = Outcomes / Cost

is captured by this adaptation of an Audit Commission diagram:



There are a couple of additional points which come out of this diagram:

- *Economy* : getting more inputs for the same money is one way of improving overall value for money – but in our experience not a very good one; and
- How *Value for Money* is independent of *inputs* and *outputs*

Economy

Economy represents how much it costs for a given input. The reason we have reservations is that providers will usually see simple requests for a price reduction as an economic measure and they will feel constrained in what options they have available to them:

- a reduction in profits (which they will strongly resist even if currently considered excessive); or
- to change the inputs (e.g. by moving from relative high cost sources of labour to lower cost sources such as migrant workers). Clearly, if the provider has initiated such a change, for whatever reason, it is legitimate for a customer to negotiate that such savings are at least partially passed on.
- To reduce the quality. If such changes result purely from price pressures exerted by the customer, the old adage of 'you pay for what you get' can apply.

For these reasons, purely economic measures tend to be short lived.

Value for Money

Value for Money can be improved by looking at each of the parts of the diagram: via economy, via efficiency or via effectiveness. This is traditionally the approach taken. However, the greatest value is often released if the *inputs* and *outputs* are totally changed as a way of delivering the same (or better) *outcomes.*

In our view, this is the key to the transformation agenda. Different ways must be found to deliver the same outcomes. It is the basis of our re-ablement work, our care pathway planning approach, and our belief in the need to shift from institutional residential settings toward supported living schemes.

Capturing *costs*, usually via finance systems, is clearly key to demonstrating *value for money*.

Quality and Quality Assurance

The term *quality* on its own is taken to encompass the three dimensions of *results*, *experience*, and *activity* (incorporating *performance* and *efficiency*).

Quality assurance is taken to include the process of assuring the customer that the provider has adequate systems and procedures (in the widest sense) to deliver the required *quality*.

With the introduction of reliable measurable *quality* data we believe there is a huge opportunity to reduce unnecessary costs in inspection and, from a provider's perspective, reduce over-prescriptive requirements on how a service is delivered or the process executed.

We also introduce the term *root cause analysis* as a means of differentiating between primary quality assurance characteristics and those which should be examined in the event of something exceptional happening (usually when something goes wrong, but also quite useful when things go well).

Contract Management

The ongoing process of managing the contract. In particular we see this as covering the processes of collating and aggregating *outcomes, experience*, and *performance* for the purposes of reviewing services with providers on an appropriate routine basis. We believe the latter is essential for continuous improvement and early issue resolution purposes.

Commissioning

We use the term *commissioning* in its strategic sense within this paper. We see the key deliverable from this activity as a commissioning strategy, leading to specific, measureable, achievable, realistic, and timely (SMART) action.

Commissioning Strategy

A good commissioning strategy should include a clear pathway through the elements of:

- Needs (profile and demand) analysis;
- Market (capability, capacity, and contestability analysis);
- Supplier analysis (supplier positioning, supplier perspective);
- Resource analysis (infrastructure, labour, and financial);
- Service portfolio design (including business cases for any changes);
- Service specific acquisition strategy and associated high level contract design and negotiation planning;
- Contract (and performance management) regime;
- High level execution strategy (leading to action – with resource identification);
- Risk identification and management; and
- Communications and stakeholder engagement planning.

Contracting

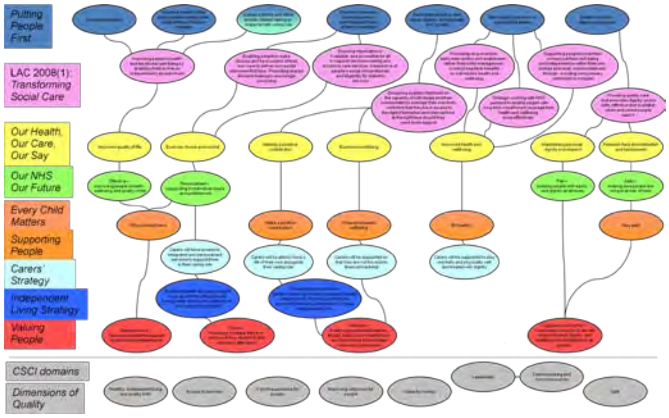
By *contracting* we refer to the processes of pre-tender supplier engagement (preparing providers to correctly respond to a tender), tendering, post-tender clarification, and agreement to a contract. Note that we deliberately add pre-tender engagement and post-tender clarification as necessary steps in arriving at a satisfactory contract – all too often we see little emphasis on these vital aspects.

Note that, in all cases, these definitions exclude detailed transactional processes.

DH and DCLG / Every Child Matters Outcomes Models

The NIS Perspective

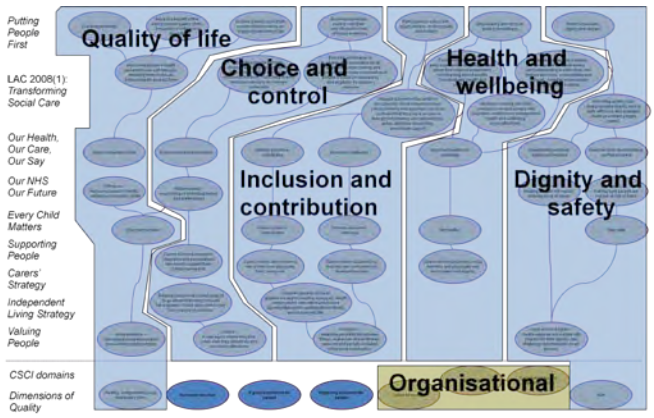
Work has been done by Simon Medcalf (DH Social Care Performance Strategy), to map the various outcomes to policy led strategic aspirations (full, more legible, version in the appendices):



The second diagram (below) groups the various elements into five themes for the purposes of collating the proposed National Indicators.

Note that there are elements of the CSCI domain which are classified outside of the framework since they relate to *Organisational* performance (and not *outcomes* as they relate to individuals).

Within the context of our model, we also believe that the CSCI domains of **Leadership** and **Commissioning and Use of Resources** fall outside of *outcomes for individuals*.



Top to Bottom Alignment

One of our objectives in designing the *results* framework at the back of the document is to create a model which can be aggregated up from an individual all the way up to the National Indicator Sets. This is consistent with the NIS work which also sees that locally meaningful metrics are of foremost importance (and that any National framework should support, not distort, this goal).

We illustrate how our results framework links to three of three of the national models (plus the NIS themes illustrated in the previous diagram).

Putting People First

Putting People First identifies the following outcomes:

- **Live independently**;
- Have the benefit of the best possible **quality of life**, irrespective of illness or disability;
- Sustain a family unit which avoids children taking on **inappropriate caring role**;
- Exercise **maximum control** over their own life and/or lives of family members;
- Participate as **active** and equal citizens, **economically and socially**;
- **Stay healthy** and recover quickly from illness; and
- Retain maximum **dignity and respect**

The DH Seven Outcomes for Adult Social Care

The publication and subsequent consultation on *Independence, Well-being and Choice* resulted in the establishment, in October 2005, of the 'DH' outcomes of:

- improved **health and emotional wellbeing**;
- improved **quality of life**;
- making a **positive contribution**;
- **choice and control**;
- **freedom from discrimination**;
- **economic wellbeing**; and
- **personal dignity**

Since then, these have been adopted widely. Importantly, they have become embedded within the inspection framework and councils are now obliged to demonstrate how they have met them.

The Every Child Matters (Five) Outcomes

The publication of the *Every Child Matters* launched a slightly different set of five outcomes for children and young people (updated in 2008):

- **Be healthy**;
- **Stay safe**;
- **Enjoy and achieve**;
- Make a **positive contribution**; and
- Achieve **economic well-being**

DCLG Supporting People Outcomes

DCLG elected to adapt the *Every Child Matters* set of outcomes to the needs of Supporting People (SP) and councils are obliged to assess their supporting people services in line with this.

Mapping *Results* to *Outcomes*

With work in some regions (e.g. East of England) trying to rationalise contracts and quality assurance regimes across these different services, it becomes desirable to be able to map *results* to each of these *outcomes* frameworks.

Mapping *Experience* to *Outcomes*

We have reviewed many of the existing *experience* based models (such as those developed by ADASS/Tribal and PSSRU) and believe that *experience* can also be mapped to the headings captured in the following table. We also think this is true of the 'Outcomes Star' approach.

Department of Health

Care Services Efficiency Delivery

Supporting sustainable transformation

Mapping Results to the Outcomes Frameworks

(the detailed measures are described later)

NIS Common Themes	Putting People First	Health, Care, Say	CSCI / DH	Result / Experience Domain	DCLG	Every Child Matters
Quality of Life	Live independently	Improved Quality of Life	●	Maximum Independence	◆	Enjoy and achieve
				Good accomodation / independent living	◆	
			■	Use of equipment and assistive technology	◆	
			●	Access to transport		
	Quality of Life			Living skills (practical support)*		
				Communication skills (hearing and being heard)*		
			●	Access to leisure, social activities, etc	◆	
				Contact with External Service/ Friends	◆	
			●	Life-long learning (chosen training, etc)	◆	
	Family / children caring		■	Sustain a family unit / avoid children inappropriately caring		
Choice and Control	Maximum Control	Increased Choice and Control	●	Choice and Control of Services	◆	
			●	Manage risk in personal life		
Inclusion and Contribution	Active & equal citizens	Making a Positive Contribution	●	Involvement in local activities	◆	Make a Positive Contribution
			■	Voluntary / unpaid work	◆	
				Caring for Others*		
			●	Involved in policy development and decision making	◆	
		Economic Well-being		Managing Money and Personal Administration*		Achieve Economic Well-being
			●	Access to income and resources (including access to benefits)	◆	
			●	Ability to meet costs (Reduce overall debt)	◆	
			■	Obtain paid work	◆	
Health and Well-being	Stay Healthy and recover quickly	Improved Health and Well-being	●	Physical health	◆	Be Healthy
			●	Mental Health	◆	
			■	Substance misuse	◆	
			●	Access to appropriate treatment and support		
				Appropriate medication*		
			●	Good Diet / Healthy Lifestyle		
			●	Opportunities for physical activity		
				Motivation and Confidence*		
Dignity and Safety	Retain maximum dignity and respect	Personal Dignity (& Respect)	●	Appropriate personal care		Stay safe
			●	Keeping clean and comfortable		
			●	Clean and orderly environment		
			■	Privacy in all settings / appropriate levels of confidentiality		
		Freedom from Discrimination & Harrassment	●	Safe from abuse and harassment	◆	
				Better manage self harm, avoid causing harm to others	◆	
			●	Security at home		
			●	Confidence in safety		
			●	Equality of access to services (reduced discrimination)		
				Maintain accomodation and avoid eviction	◆	
				Comply with statutory orders (offending behaviour)	◆	

KEYS ● CSCI, ■ DH, ◆ CLG * Additional results/experience domains added to cover other models

Results, Eligibility, Resource Allocation and Support Plans

The pressures to demonstrate value for money at an individual level

Councils have a legal and ethical duty to demonstrate value for money to both central government and their local community. In the past this has largely been achieved via some form of unit cost benchmarking. With a greater emphasis on choice and control, more focus on prevention, and with central government policy encouraging a greater use of direct payments and/or personal budgets, it is becoming increasingly difficult to use unit costs as a basis for demonstrating value for money.

Demographic pressures, economic climate (particularly for older people, many of whom are heavily dependent on interest income from their savings), and financial constraints mean that the current regime is also not sustainable.

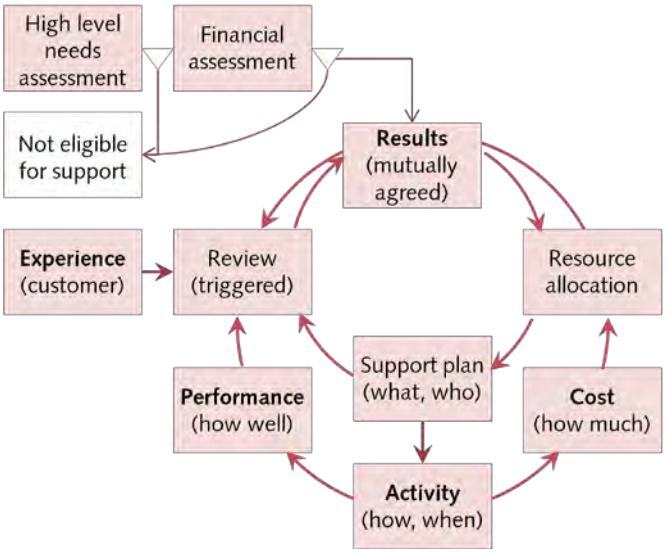
There is also a growing awareness of the disparity between younger adults receiving relatively generous care packages (regularly in excess of £50,000 per annum) compared with packages of residential care for older people which are routinely at less than half of this.

Measuring results

Quantifiable *measures* are used to arrive at *results*. When incorporated with *experience* and *activity*, they can be used to demonstrate value for money. Importantly, if the same set of *results* are used, regardless of service type and/or client group, then it also becomes possible to demonstrate this on a relative basis across different services.

Clearly, such *results measures* must be structured in a way to enable them to be captured as part of agreeing to a support plan, and subsequently monitored to measure progress and/or deviation.

Assessment and Support Planning



In recognition of the fact that assessment means different things to different people, we have split the process up.

In this model, the *high level needs assessment* process feeds into the eligibility decision. In our view this should be simple, universal and able to be completed, with reliability, by the individual on a self-assessment basis.

Likewise, for *financial assessment*. Whilst there clearly will be 'grey' situations which are more difficult to determine, in most cases it should be possible to approximate the extent to which an individual contributes to a service quite easily.

Agreement to results is a negotiation based on an assessment of an individual's potential abilities – not just their initial choices.

Because different *results* (see later) may be agreed for different individuals, even with the same underlying need, we believe it is mainly *results* which should be the basis for determining *resource allocation* (appropriately influenced by needs).

In this model, the *support plan* details ***the what*** and ***the who*** (if commissioned by the authority and not under self-directed support), ***the how*** and ***the when*** underpinning the achievement and/or maintenance of *agreed results*.

Results versus Needs

Edward is 68 and has just had heart surgery. He is currently unable to do many things for himself. Doctors have told him that, if he gives up smoking, he should be able to return to voluntary work and do most things for himself.

Richard is 83 and has the same underlying needs as Edward. However, smoking is one of the few pleasures he has left in life.

It should be obvious that the *results* for Richard (maintaining or improving his quality of life) will be completely different to Edward (where it would be expected that Edward would, with appropriate re-ablement, return to near normal life).

Equally, if there was a second Edward, who was not prepared to self-help and give up smoking it is appropriate to put in other forms of support (see the Outcomes Star).

The health and life insurance industries have long applied different premiums to individuals who make such choices. In the realities of a cash constrained environment we also believe councils will also have to make allocation decisions contingent on choice.

The cycle is completed by the *review* process. This may be triggered by a change (enabled by the *results* framework) or, as currently, by an elapse of time (typically every 12 months).

Activity, performance, experience and cost feed-back loops

The diagram has also been extended to illustrate how support plans lead to activity. Whilst it is hoped that relative changes to *results* alone will be sufficient to allocate resources, in practice it is activity which drives costs and this in turn will lead to appropriate levels of resource allocation.

(Note that in this model the support plan is primarily between provider and service user).

Likewise, it is *activity* which is captured by *performance* and *activity* which service users *experience*. All three of these:

- the *results* achieved;
- the *performance* in delivering the results; and
- the *experience* for the service user

should be factored into the *review* to inform any subsequent redefinition of *results*, re-allocation of resources and revision to support plan.

Resource Allocation and results

Whilst we recognise that individuals cannot be forced to do what they don't want to do, we also believe that, with appropriate coaching to climb the 'ladder of change' (see later example), any funds allocated to an individual should be accompanied by elements of commitment to *results* by that individual.

A possible model of operation using the principles outlined so far would be as follows (using our second Edward to illustrate):

1. Largely via self-assessment, it is very quickly determined that Edward is eligible for services.
2. Using something similar to the model illustrated at the back of the document, there is a process of agreeing to the initial results to be achieved. At this stage Edward is not prepared to fulfil his role within a re-ablement context. He does however, agree to be coached to identify what might be possible (and the Outcomes Star model may provide the basis for defining progress at this stage).
3. Based on historical data a nominal sum of money is allocated via the resource allocation process – this provides the 'budget' to deliver the first set of results.

4. In this case, the money is given to a provider with specialist counselling skills.
5. The counsellor sits with Edward and works out the details of what steps to take (captured in the support plan). Whilst guided by the allocated sum, there is a degree of freedom for the provider to flex this (provided that the overall commitment levels for all service users is not exceeded by an agreed tolerance, perhaps 10%).
6. The provider captures and reports on both activity and performance at client level.
7. At the end of an agreed period (probably in the order of quarterly), progress is assessed against the original *results* targets. User *experience* is also captured.
8. Importantly, the provider is encouraged to look for more cost effective ways of delivering results by being able to keep any savings from the overall allocated sums. However, because activity and cost is captured, learning is fed back through the resource allocation process to adjust what is needed to achieve a given result (it is therefore not an open ended cheque-book). (The provider may also carry a risk).
9. By the end of this process it is determined that Edward is now ready to be re-abled. A different (in this case larger) amount is now allocated to reflect the intensive effort required to re-able him. This is reflected in the new *results* expected from the intervention.
10. The whole cycle repeats. At the end of re-ablement, a new 'review' is carried out (typically after six weeks) and a new, longer term, set of results agreed.
11. This time it is determined that, with minimal support from a local voluntary organisation, Edward no longer needs much state support (reflected by the nature of the new results). The resource allocation is yet again adjusted to reflect this change.

There are several features of this approach which we believe to be attractive:

- Reviews are more frequent, but they are not as dependent on skilled resources;
- The resource allocation is continuously adjusted to reflect the desired results at a particular point in time; and
- It provides incentive mechanisms to improve both quality and cost.

The Outcome Star Model (Triangle)

The concept which underpins the Outcomes Star (developed by Triangle Consulting and the London Housing Federation) is that individuals in need require support to climb the 'Ladder of Change':

- **Self-Reliance** (don't need support [10] or independent most of the time [9]);
- **Learning** (with support able to overcome challenges [8] or know what help is required/heading in the right direction [7]);
- **Believing** (doing things differently / experimenting [6] or believe things could be different [5]);
- **Accepting Help** (starting to engage on a consistent basis but relying on others to lead [4] or not liking how things are and talking, but not yet changing [3]); and
- **Stuck** (possibility of change but not yet engaging [2] or not interested, in denial, unwilling to talk [1])

Whilst this is a useful conceptual model for understanding and overcoming potential resistance to change and demonstrably lends itself to scoring, in our definition this largely describes the process of achieving *outcomes* – not the *outcomes* themselves.

However, the reader is encouraged to look at both the Outcomes Star (Housing) and the related Mental Health Recovery Star

Results as a trigger for a detailed assessment

With the model described on the previous page the review process is much simpler and does not require the same levels of specialist input. This allows for this expertise to be redirected to the more value added areas of complex support planning and specialist service delivery.

However, it is collecting sufficient information to identify potential areas of concern. We believe there should be sufficient data collected via these *operational reviews* (most likely carried out by a carer or advocate) to trigger a full review when needed.

We believe this approach to be much more appropriate to the current, often mechanical, process of reviews on a fixed timescale basis.

Results and Self-Directed Support

Whilst the *activity* and *performance* dimensions may not be as available directly from a service user under self-directed support, the dimensions of *results*, *experience* and *cost* are.

If an individual is to receive cash, we see no reason why there shouldn't be agreement to the achievement of *results* at the onset and, on an ongoing basis, via the *operational review*. Furthermore, we see no reason why service users (or their representatives) should not be expected to 'self-review' and provide feed-back in the same structured way that a provider would (the results framework at the back of the document has been designed with this in mind).

Clearly, the role of the commissioner is then to validate such returns – almost certainly via some form of sample based *audit review*.

Social services are not currently funded on an entitlement basis. Economic realities dictate that it will be necessary to flex to resources to fit with the agreed results at a particular point in time. Expectations should be set to the effect that funding can reduce as well as increase.

Contracting with Providers

We are not going to attempt to cover the whole process of contracting with (and contract management of) providers here. What we focus on is our proposal on how *results* should be incorporated within the contractual framework and how this fits with *experience*, *activity* monitoring and *performance*, *cost* and *quality assurance*. This is an NIS compatible 'balanced scorecard' approach to contracting.

QA : Quality Assurance

Integration within the contractual framework

Traditional forms of contract

A traditionally worded contract will still be expressing the agreed scope in fairly traditional terms, usually going into some detail about exactly how a particular element of service should be delivered. There may be reference to the National high level *outcomes*, but the process of making a placement is likely still to be described in terms of specific activities at specific times. Payment will be contingent on a provider carrying out the specified requirements of the support plan at an individual level. We refer to this type of contract as 'prescriptive'.

Contractual Framework

With an outcomes based contract, there will be a much clearer differentiation between:

- the high level scope of services, obligations on the provide and how these services will be paid for (the contractual framework): and
- what happens when an individual is placed.

At the high level, because the majority of social care services are labour intensive, we still envisage providers being paid primarily on the basis of their *outputs* (e.g. in the case of homecare, the overall hours delivered to clients, in the case of care homes, weeks, etc). We see the linkage to outcomes via flexibility and incentive mechanisms. Therefore, they will still have to report their activity and break this down to client level (this provides the necessary feed-back to refine the resource allocation process). In order to identify opportunities for *efficiency*, we would also expect to see a 'right to audit' as a means of understanding the *inputs*.

The contract will also stipulate requirements with regard to reporting *results*, capturing *experience* and monitoring *activity* and *performance*. In this model, the primary role of quality assurance becomes one of ensuring that the information presented is sufficient and reliable enough to identify issues. The **how** is explicitly excluded from these requirements.

Functional versus prescriptive placements

As implied earlier, the main difference that we see under outcomes based contracting is at point of placement for a particular individual.

In the traditional environment the care plan is determined by the council and given to the provider to execute. This will typically stipulate, the how, what, when and where of meeting this plan. E.g. cook breakfast for Dorothy at her home every day at 8:00 and stay for half-an-hour to do so. Quite often the contract will put a significant procedural onus on the provider as well. More usually than not, the desired result will be lost in translation to activity. The provider will be refunded based on their adherence to this set of requirements (i.e. did they cook for Dorothy for half-an-hour – even if Dorothy didn't want it).

We refer to the above as a prescriptive placement (there is virtually no flexibility).

Under an outcomes model it is the *result* (and associated nominal budget) which gets passed either directly to the provider (the Thurrock model), or indirectly to the independent broker.

It is up to the broker/provider to agree with Dorothy on the best way of achieving the *result*. For example:

- via suitable adaptations to her home;
- by agreeing with a neighbour or relative to do the breakfast, possibly for a small sum, and maybe with respite provision when needed;
- by swapping the meal preparation for some form of practical support (Dorothy is quite happy to have a mid-day brunch but is really depressed about the state of her home);

If the cooking route is still taken, the timing (and importantly flexibility around timing) will be mutually agreed between carer/service user.

'Gainshare' and incentives

Recognising that, in order to assess progress against agreed results, 'reviews' happen much more routinely and can be included as part of the provider scope (as already commissioned by some councils), the provider (or broker) can be incentivised to look for the most cost effective way of achieving results by being offered a 'gainshare' scheme.

'Gainshare' operates by allowing the provider to keep a proportion of the money it has saved.

Remembering that results measurement is **relative** to what was agreed (i.e. not absolute), and that maintenance objectives can be captured as no change to a measure, then provided that, at an aggregate (versus client) level:

- the target *results* changes are achieved;
- reported *experience* is suitably positive; and
- *performance* (e.g. no complaints, no failures to deliver services, etc.) is satisfactory; and
- *costs* have been reduced.

then we see no reason why the provider should not retain a share (if not all) of the savings for a period of time.

The balancing process arises from the collection of activity statistics and how this feeds back into resource allocation. In this model, particularly for service users who have fluctuating requirements (e.g. mental health), the 'reviews' are conducted on a frequent operational (possibly quarterly) basis. The resources allocated will be adjusted to reflect the improving costs – using the principles of self-correcting feed-back loops.

Of course, this can lead to a requirement to increase resources. However, if the principle of feedback is collated across the spectrum of services in an efficient manner, there should be much greater ability to learn from the best.

The importance of gathering *experience*

We have argued that outcomes should not be based solely on *experience.* It is equally unbalanced to rely solely on *results*. *Experience* metrics can be designed to operate (as implied by the outcomes table) over the same domains and, to reiterate:

- They can validate what the provider is claiming;
- They can unearth issues in how the service is being delivered which cannot be picked up in any other way;
- They can be used to obtain positive feed-back (not often available in other ways); and
- They can be a useful source of input for improving services.

We note that many of the issues which are commonly identified by users in surveys (such as reliability, unacceptable practice, etc.) can also be identified via an appropriate performance monitoring regime (see below).

Performance

The sector currently relies heavily on inspection as a means of determining quality. As is common within the industrial sector, if there are appropriate operational performance regimes in place (in conjunction with *results* and *experience* collection), quality can be improved at the same time as significantly reducing the costs of inspection.

In our view, councils have an opportunity improve their ability to monitor and react to operational metrics and reduce inspection.

Performance encompasses such things as:

- The number of clients being serviced;
- Selectiveness – number of refusals to accept a placement (categorised by reason);
- Reliability – available either via timesheet processing or electronic monitoring;
- Complaints (at various levels of seriousness) and compliments;
- Staff turnover and sickness levels;
- Levels of staff training;

- Transaction efficiency – number of invoices (e.g. consolidated versus individual), correctness of invoices, etc.
- Willingness to make use of the internet and other electronic interfaces;
- Inspection results;
- Financial stability; etc.

All of these measures, and others, can be used to assess the health of a provider and whether or not they are providing a quality service.

These are also likely to be measures which a provider should be monitoring to ensure it is delivering an effective quality in any case and should not be a burden to be provided.

Aggregating Results to Feed into Outcomes

The framework at the back of the document has been designed to allow the results measures to be aggregated and then to be merged (with *experience* and *performance*) into the various outcomes frameworks.

As implied by the feed-back loop in the previous section, over time, we expect patterns to emerge concerning the relative costs to to achieve relative changes to *results* and *outcomes*.

Quality Assurance (QA)

We have suggested an opportunity to reduce the current costs of quality assurance. The present regime tends to favour larger providers who have the resources to demonstrate compliance more easily. It also acts as a barrier to entry for many smaller providers – particularly voluntary and not-for-profit organisations. Councils and providers have told us that quality in practice is much more dependent on the quality and values exhibited (often verbally) by the local team manager than it is on written policies and procedures.

We think there are three ways in which councils can reduce both their own costs and the costs within the market:

- Develop automated mechanisms for processing and analysing the *performance*, *experience* and aggregated *results* information they receive. Most councils request this information - few make effective use of it.
  In our view, reviewing such information alongside the provider can be much more insightful than many forms of inspection;
- Encourage a collaborative market-wide approach to familiarising practitioners with appropriate skills, policies and procedures. This sector is typified by high staff turnover and mobility. Under personal budgets, there are an increasing number of individuals providing care. Therefore, such investments need not be restricted to incumbent providers. Many councils already offer training, partially with this in mind; and
- Adopt a two tier approach to inspection. Primary inspection to focus on ensuring that the provider has the mechanisms and/or systems in place to routinely produce reliable *performance, results* and *experience* data. Secondary inspection to be carried out on an exception basis as a means of *root cause analysis*.

Outcomes & Commissioning Strategies

Outcomes provide the critical second dimension, in addition to *cost*, for determining *value for money*. Because *value for money* is independent of both *inputs* and *outcomes*, it becomes possible to objectively compare different service solutions.

CSED's work on re-ablement

The central hypothesis which led to our work on re-ablement was that a high investment in

re-ablement for a relatively short period of time more than offset the lower unit costs of traditional forms of care over the longer term.

It has taken us considerable time to prove this and we still struggle to compare the relative merits of different re-ablement schemes.

Had there been a consistent outcomes framework in place it would have been much easier to evidence the case.

Integrated Care and Support Pathways, Supported Housing, Crisis Response and Assistive Technology

CSED's work on integrated care and support pathways is predicated on the belief that the solutions and timing of intervention are sub-optimal for many forms of long term condition. We attempt to show that, with the right intervention at the right time, outcomes can be improved and costs reduced.

Under Supported Housing, including Assistive Technology, we have gathered evidence to demonstrate that such schemes can also achieve improved outcomes at lower cost. The same principle applies to Crisis Response.

Without an appropriate outcomes framework it is difficult to objectively evidence benefits.

Prevention and Putting People First

Putting People First puts an emphasis on Early Intervention and Prevention. Whilst intuitively felt to be the right thing to do, gathering evidence to demonstrate it is notoriously difficult. A suitable outcomes framework would help in this regard.

Outcomes and commissioning strategies

The previous examples demonstrate, from our own experience, the difficulty in building the evidence necessary to underpin a change in service portfolio. Councils have an obligation to demonstrate to their members and the public at large that changes in service can achieve the same or better outcomes at lower cost.

If costs are reduced in a particular service it is usually seen by the public as a cut – not a redistribution of funds to a more effective solution (e.g. day centre closures).

An objective outcomes framework provides the basis for demonstrating the relative merits, in cost effectiveness terms, of different solutions.

Achieving market accountability

Under the present transformation agenda, councils have a perfect opportunity to replace the current compliance regime – where councils have to manage the market – with a truly performance led competitive regime based on the achievement of a balanced set of outcomes. Under such a regime markets tend to manage themselves.

We would argue that the framework described in here is applicable to all service areas and all types of provider. Such a model also opens up the possibility of new kinds of provider emerging (e.g. true brokers and/or neutral vendors, and/or mixed solution providers).

Opportunity for market led creative solutions

At present councils tend to deal with providers in their respective silos (homecare, residential, day care, etc.). Talks are therefore often limited to efficiency (or even worse economy) type discussions. Councils rely on their own commissioning teams to come up with more cost effective service portfolios.

Experience from other sectors suggest that, under the right circumstances (e.g. a recognition that the current situation is unsustainable and that things have to change), it is possible to engage the more mature providers from across the sector and use their collective wisdom to come up with creative solutions. The language to use is outcomes.

CSED's Results Framework

Whilst the collection of activity, cost and performance data is relatively mature, structured mechanisms for collecting *experience* are only just emerging and there has been even less work on creating a universal *results* framework.

In order to fill this perceived gap we have compiled different elements obtained from a variety of sources to arrive at a suggested shape for such a tool.

Design Objectives

The framework was designed to meet the following objectives:

- Easy for anyone to complete and readily able to be validated by the service user or their advocate;
- Sufficiently comprehensive to provide a meaningful basis for measuring change;
- Independent of the nature of support and condition affecting the individual;
- Able to be completed quickly as part of the initial assessment / support planning process;
- On an exception basis, to be able to be updated on an ongoing basis in under 10 minutes;
- The metrics should be objective and able to be completed via observation (and therefore not be dependent on user survey input);
- Processing of the completed framework should be able to be done automatically (the framework should be machine readable); and
- It should be possible to correlate costs with outcomes.

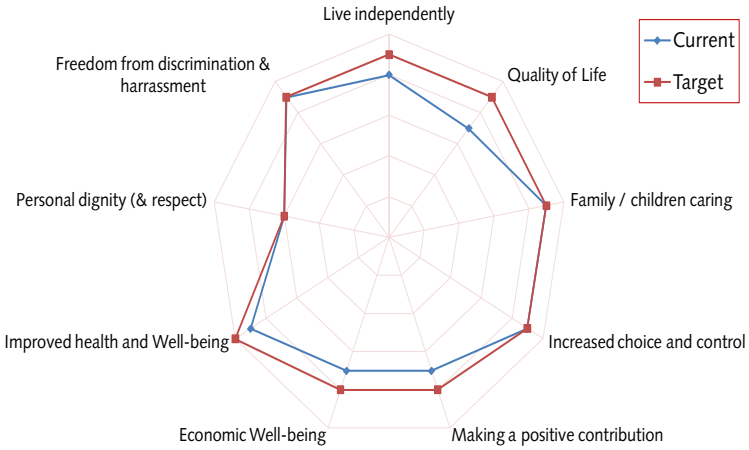
Filled in by the user or by someone else

Unlike many outcome frameworks which are dependent on the service user's perception and feelings, this framework has deliberately been designed to be able to be filled in by anyone.

It is based entirely on objective observable actions, characteristics and environment.

Presentation

As illustrated below, the framework lends itself to the popular radar diagram presentation format. The concept of using a relative change (current versus target) is illustrated.



Client Ref: Date:

The CSED Outcomes Framework

Independence

The extent to which you are (or the individual is) able to carry out the particular activity independently

0 Significantly dependent on others (can do less than 10% for themselves)
1 Somewhat dependent on others (can do some things themselves but requires full time support)
2 Partially dependent on others (can do more than 80% of the task themselves, possibly with prompting / instruction / supervision)
3 Independent with difficulty (can do the task or function, but with the assistance of equipment / technology / occasional help)
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Live Independently

Maximum Independence

To indicate the extent to which your (their) ability to get about is changing

	0	1	2	3	4
You/they gets about the house (excluding stairs)					
You/they go up and down stairs					
You/they routinely get up from a sitting position					
You/they routinely get up from a lying position					
You/they routinely walk short distances outside					
You/they routinely walk longer distances outside (1/2 mile or more)					

Good accomodation / independent living

This again is an outcome designed to encourage the move away from the more expensive forms of institutional care to those which encourage independence and reduce the cost of support (for either you/them as an individual or the state)

	0	1	2	3	4
You/they live in your/their own standard accomodation (with no major adaptations or onsite support)					
You/they live in your/their own accomodation, but within reach of support when needed					
You/they are making use of aids to daily living					
You/they live in your/their own specially adapted accomodation					
You/they are making use of short term care home accommodation					
You/they are making use of short stay emergency accommodation					
You/they are making use of assessment and intermediate / rehabilitation residential facilities					
You/they do not live in long stay residential facilities (without nursing support)					
You/they do not live in long stay care home facilities (with nursing support)					

Use of equipment and assistive technology

	N/A	0	1	2	3	4
You/they make use of appropriate daily living aids						
You/they make use of appropriate mobility equipment						
You/they make use of appropriate telecare equipment						
You/they make use of appropriate telehealth equipment						

Access to transport

	N/A	0	1	2	3	4
You/they travel to/from local facilities via public transport						
You/they travel to/from local facilities via your/their own transport						
You/they travel long distances on your/their own						

Quality of Life

Living skills (practical support)

Indicates the extent to which your (the individualls) ability to perform routine practical tasks has changed

	0	1	2	3	4
You/they prepare your/their own cold drinks					
You/they prepare your/their own cold meals					
You/they prepare your/their own hot drinks					
You/they prepare your/their own hot meals					
You/they undertake your/their own routine shopping					

Communication skills (hearing and being heard)

The extent to which you (or the individual) has changed your/their ability to listen/understand others and convey your/their thoughts (needs, desires, etc)

	0	1	2	3	4
You/they make your/their personal needs known					
You/they make your/their likes and dislikes known					
You/they hold appropriate social conversations					
You/they construct your/their own short sentances					
You/they communicate by objects of reference					
You/they communicate by photographs					
You/they communicate by symbols , line drawings					
You/they communicate by body language					
You/they understand the meaning of key words					
You/they understand the sentances					
You/they understand via sign language					
You/they communicate via writing					
You/they communicate via telephone					
You/they communicate computer or equivalent					

Access to leisure, social activities, etc

	N/A	0	1	2	3	4
You/they spend time involved in social activities						
You/they spend time on hobbies						
You/they spend time on other leisure activities						

Contact with External Service/ Friends

Used to indicate if there has been a change to the nature of your (the individuals) social environment

	0	2	4
You/they engage with others in a social context			
You/they have a regular circle of friends			
You/they have routine contact with services when needed			

Life-long learning (chosen training, etc)

	N/A	0	1	2	3	4
You/they are engaged in learning activities						
You/they are engaged in other forms of training/development						

☒ Previously ☒ Current ☐ Target

Environment

The extent to which you are (or the individual is) increasing your/their independence from more expensive forms of support

0 Never applies
1 Rarely applies
2 Sometimes applies, but inconsistently
3 Regularly applies
4 Nearly always applies

Family / Children Caring

Sustain a family unit / avoid children inappropriately caring

	N/A	0	1	2	3	4
You/they egularly meet up with members of your/their family	☐	☐	☐	☐	☐	☐
You/they demonstrate closeness to those with whom you/they have relationships	☐	☐	☐	☐	☐	☐
You/they have the environment in which to enjoy a normal healthy sex life (when appropriate)	☐	☐	☐	☐	☐	☐
You/they are not overly dependent on your/their children to the detriment of the child	☐	☐	☐	☐	☐	☐

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Choice and Control

Choice and Control of Services

Indicates the extent to which you (the individual) is independent of others in making decisions concerning aspects of normal life

	0	1	2	3	4
You/they choose when you/they receive support					
You/they choose which individuals provide support					

Manage risk in personal life

	N/A	0	1	2	3	4
You/they choose when to rest and sleep						
You/they choose what to eat						
You/they choose what to wear						
You/they choose how to spend time where you/they live						
You/they choose how to spend time out and about						
You/they choose who to live with						
You/they choose where to live						
You/they choose when/how to meet with family/friends						
You/they choose how to spend money						

Making a Positive Contribution

Involvement in local activities

	N/A	0	1	2	3	4
You/they get participate in local community events						

Voluntary / unpaid work

Indicates the extent to which your (the individuals) level of activity has changed over the period.

	0	1	2	3	4
You/they undertake community / voluntary work					
You/they are active in other forms of daytime and/or evening activity with others					

Caring for Others

To indicate the extent to which you (or the individual) has been able to improve your/their ability to look after dependents / relatives

	N/A	0	1	2	3	4
You/they look after their partner						
You/they look after one or more children						
You/they look after one or more parents						
You/they look after one or more relatives						

Involved in policy development and decision making

	N/A	0	1	2	3	4
You/they have access to influence the future direction of the services you/they receive						

Previously Current 0 Target

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3 Independent with difficulty (can do the task or function, but with the assistance of equipment / technology / occasional help)
4 Independent (can do the task and requires no assistance)

Characteristic

The extent to which you are (the individual is) observed to exhibit characteristics which indicate wellbeing

0 Rarely demonstrates (less than 10% of the time)
1 Sometimes demonstrates (familiar setting)
2 Sometimes demonstrates (any setting)
3 Typically demonstrates (familiar setting)
4 Typically demonstrates (any setting)

Economic Well-being

Managing Money and Personal Administration

Demonstrates how your(an individuals) ability to manage their own financial affairs has changed over the period

	N/A	0	1	2	3	4
You/they understand monetary values						
You/they manage your/their own small amounts of cash						
You/they manage your/their own valuable documents (passports, etc)						
You/they manage your/their own bank account						
You/they manage your/their own utilities bills, rent, etc						
You/they manage your/their own investments, shares, inheritances						
You/they manage your/their own support						
You/they set up new financial/personal affair related accounts (when required)						
You/they manage large amounts of cash yourself/themselves (when required)						

Access to income and resources (including access to benefits)

	N/A	0	1	2	3	4
You/they have been using all sources of benefits available to you/them						
You/they have full access to any funds you own and/or interest you are entitled to						

Ability to meet costs (Reduce overall debt)

	N/A	0	1	2	3	4
You/they remain financially solvent (and largely out of severe debt)						

Obtain paid work

	N/A	0	1	2	3	4
You/they are in paid employment						

Improved Health and Emotional Well-being

Physical health

	N/A	0	1	2	3	4
If you/they smoke, they are reducing the amount they smoke						
Your/their body weight is improving or being maintained (no untoward loss/increase)						
You/they are improving their mobility following an illness						

Mental Health

To provide an indication of any change in your/their emotional and/or mental well-being

	0	1	2	3	4
You/they regularly recalls recent past events					
You/they regularly recalls events which happened some time ago					
You/they are content and are not showing any symptoms of depression					
You/they Require no anti-depressant to maintain your/their wellbeing					
You/they are able to orient yourself/themselves					
You/they report concerns and seek help when appropriate					
You/they keep yourself/themselves and your/their clothing to appropriate standards of cleanliness					
You/they keep your/their surroundings to appropriate standards of hygiene and tidiness					
You/they show no signs of obsessive and/or compulsive behaviour					
You/they are able to concentrate					
You/they recognize friends and relatives					
You/they exhibit no suicidal (or other similar) tendencies					

Substance misuse

	N/A	0	1	2	3	4
You/they are not increasing the amount of alcohol you/they drink						
If you/they are on non-prescription drugs, you/they are reducing the amount you/they take						

☒ Previously ☒ Current o Target

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Improved Health and Emotional Well-being

Access to appropriate treatment and support

The objective of this set of outcomes is to encourage the appropriate use of friends, relatives and the community and release funds (your/their own or the states) for use for other things (or others in need in the case of state funds)

	0	1	2	3	4
You/they are able to meet all of your/their needs without having to have support from others					
You/they are supported by direct relatives					
You/they are supported by other friends and neighbours					
You/they are supported by volunteers from the local community					
You/they are making use of publically available advisory agencies (benefits, employment, etc)					
Your/their normal informal carer has periods of non-residential respite					
Your/their normal informal carer has periods of residential respite					

Appropriate medication

	N/A	0	1	2	3	4
You/they take no medication to help you/them get to sleep						
You/they are not increasing the amount of medication you/they take						

Good Diet / Healthy Lifestyle

To identify any improvements or changes in lifestyle which might indicate an improvement or degradation in health

	0	1	2	3	4
You/they eat a well balanced healthy diet on a regular basis					
You/they take appropriate quantities of water and other drinks					
You/they sleep a good nights sleep and shows no signs of sleep related tiredness					

Opportunities for physical activity

	N/A	0	1	2	3	4
You/they take some form of exercise on most days						
You/they get outside into the fresh air on a regular basis (weekly)						

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Improved Health and Emotional Well-being

Motivation and Confidence

To provide an indicator of whether confidence and morale are improving or getting worse. Also covers characteristics associated with safety and security

	0	1	2	3	4
You/they show no forms of hesitation when communicating about everyday things					
You/they speak up when appropriate					
You/they regularly smiles when communicating					
You/they make routine use of eye contact when communicating					
You/they are generally alert and show an interest when communicated with					
You/they are proactive in engaging with others					
You/they are willing to try new things					

☒ Previously ☒ Current o Target

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Personal Dignity (and Respect)

Appropriate personal care

Used to indicate how much you/they carry out (versus are able to do) the functions which maintain your/their own personal dignity.

	0	1	2	3	4
You/they are not making use of support from paid non-registered support organisations					
You/they are not making use of support from paid registered support organisations					
You/they are not being supported by community nurses					
You/they are not being supported by other health and allied professions					

Keeping clean and comfortable

	N/A	0	1	2	3	4
You/they wash your/their whole body						
You/they wash your/their face and hands						
You/they urinate cleanly						
You/they empty your/their bowels cleanly						
You/thay dress and undress themselves						
You/they maintain their own oral health						
You/they feed yourself/themselves (eat vs prepare)						
You/they drink for yourself/themselves						
You/they keep your/their own feet/toe nails in order						
You/they groom yourself/themselves						
You/they keep your/their finger nails in order						

Clean and orderly environment

	N/A	0	1	2	3	4
You/they carry out your/their own routine household cleaning						
You/they carry out your/their own essential household cleaning						
You/they undertake your/their own laundry						

Privacy in all settings / appropriate levels of confidentiality

	N/A	0	1	2	3	4
You/they have your/their own day-time space						
You/they do not have to share their sleeping space (unless they wish to)						
Your/their personal information is kept confidential						
Your/their communications are kept private						

Stay safe

Safe from abuse and harassment

	N/A	0	1	2	3	4
You/they are not being verbally abused by others						
You/they are not being physically abused by others						
You/they are not being discriminated against on the basis of race/religion/etc.						
You/they demonstrate socially acceptable behaviour						
You/they behave in a verbally appropriate and non-offensive way to others						
You/they behave in a physically appropriate way to others						

Better manage self harm, avoid causing harm to others

To indicate a change in behaviour which might be symptomatic of a breakdown or improvement in mental and/or learning capacity

	0	1	2	3	4
You/they treat property with respect					
You/they are not harmful to yourself/themselves					
You/they are not harmful to others					

Previously ☒ Current o Target

The CSED Outcomes Framework

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The extent to which you are (or the individual is) increasing your/their independence from more expensive forms of support

0 Never applies
1 Rarely applies
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4 Nearly always applies

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2 Sometimes applies, but inconsistently
3 Regularly applies
4 Nearly always applies

Stay safe

Security at home

Used to indicate if the environment is in place to ensure safety and security. The scoring relates to the number of times that the event was not handled appropriately (e.g. mitigated emergencies / total emergencies)

	0	1	2	3	4
You/they have the mechanisms to prevent others accessing your/their accomodation when required					
You/they have appropriate things in place to minimise the risk of minor injuries (falls, burns, etc)					
You/they have the means in place to deal with households accidents (fire, flooding, etc.) which could lead to major injury					
You/they have appropriate access to medication (and knowledge / means to ensure correct dosage)					
You/they live in an environment largely free from vandalism and other forms of criminal activity					
You/they have not yourself/themselves recently been a victim of criminal activity					
You/they have the means to maintain mobility without harm to yourself/themselves or others					

Confidence in safety

	N/A	0	1	2	3	4
You/they have the means to quickly get support in the event of an emergency						
You/they show no signs of panic or concern when left alone						

Freedom from Discrimination & Harrassment

Equality of access to services (reduced descrimination)

	N/A	0	1	2	3	4
You/they are not disadvantaged in accessing services within your/their place of residence						
You/they are not disadvantaged in accessing services within your/their locale						

Maintain accomodation and avoid eviction

	N/A	0	1	2	3	4
You/they maintain the inside of your/their accomodation						
You/they maintain your/their garden and/or grounds						

Comply with statutory orders (offending behaviour)

	N/A	0	1	2	3	4
You/they avoid getting into trouble with the law and other similar institutions (police, education, etc)						
You/they adhere to any restrictive orders placed upon you/them						

☒ Previously ☒ Current o Target

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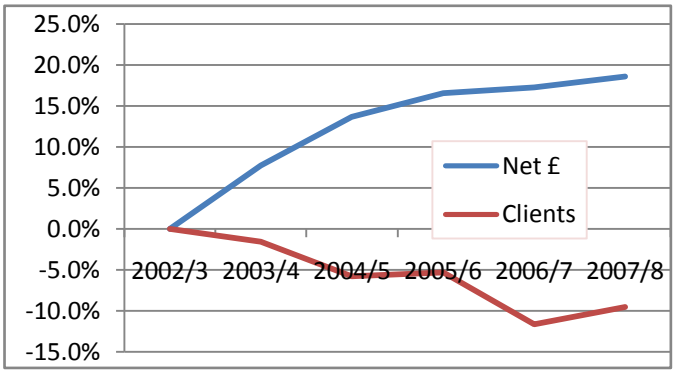
Concerns with this approach

As to be expected from a programme with the words 'Efficiency Delivery' in its title, this paper takes an efficiency perspective. The recent historical trend of spending more money (in real terms) on fewer people is clearly not going to work in a climate of reducing funds and increasing demographic demands.



Taking the efficiency perspective clearly has the potential to introduce tensions with some interpretations of the Putting People First agenda. In order to allow the reader to reach their own conclusions we share some of these concerns (and our response).

There are some elements which are incompatible with Putting People First with respect to being accountable for delivering what people want versus what their staff think people should be doing

We do not see this approach as incompatible with Putting People First. Given financial constraints and a council's obligation to demonstrate value for money, councils will still require to a make decisions, in conjunction with the service user, regarding results and the appropriate level of investment needed to achieve them (a responsibility of professionally trained staff). We expect to see much greater choice and control around the how, where, who by, and when within the detailed elements of the mutually agreed support plan.

How does this fit with early intervention and self-directed support and enabling an individual to achieve their aspirations (versus meeting basic needs)?

We see no reason why a model of this type can not be applied directly to early intervention services.

However, the main impact of early interventions should be to prevent individuals entering long term service and/or change the nature of their requirements by increasing their independence. It is the analysis of the profile of individuals entering the system which is likely to provide the most robust evidence for the effectiveness of prevention. A consistent and structured results framework provides a basis for providing such evidence.

With regard to self-directed support, we believe a framework of the type illustrated on the previous pages can also provide the essential basis for monitoring the cost effectiveness of funding received on this basis.

There are clearly many types of aspirations. Within the context of achieving their maximum potential, the framework allows this to be captured. Other forms of aspirations clearly need to be put into the context of available funds.

The paper rather discounts process / quality outcomes but these lie at the heart of personalisation (including feeling in control, dignity, flexibility, respect, etc)

This paper has tried to differentiate between *results*, *performance* and *experience* and argues the case for a balanced view on outcomes.

By definition any measure with the word 'feeling' in it has to be obtained via some form of user feed-back, the usual mechanism being the user survey or interview (or when not being delivered, via complaints).

There is a much stronger emphasis on *results* here because we believe it is primarily results which will drive the necessary transformation.

The examples given have a narrow "enablement" focus on improving "functioning" not wider aspects of people's lives

The examples were chosen to emphasis some key points. The detailed framework attempts to address all dimensions of the *outcomes* frameworks.

We emphasise that this is a contribution to the debate, not the final solution.

The relationship between needs and outcomes [now results] is complex. We assess needs not outcomes, people present with needs not outcomes. Needs should be seen as barriers to achieving outcomes.

This model effectively builds on the last of these sentences.

There is a difference between determining eligibility for funding (wholly objective) and ongoing monitoring of results (much more dependent on the individuals priorities and wishes)

The model has been designed to both set agreed targets and monitor progress in achieving them on an equally objective basis.

We see the detailed support planning process as the main means for capturing individuals wishes at the onset and subsequent *experience* surveys or interviews as the primary means for obtaining feed-back after the support plan is put in place.

The *results* framework captures whether agreed objectives have been met, the *experience* dimension (and planning processes) capture the individuals priorities and wishes, and the performance framework (complaints, etc.) whether there are any other breaches in quality.

The tool itself, while very comprehensive is perhaps just too sophisticated (and long).

The tool was deliberately designed to be comprehensive in order to ensure that all potential results could be captured in a consistent way.

In operation it was always envisaged that it would operate on an exception basis. i.e. once agreed only a subset would apply to any one individual.

The framework is not dependent on the service user's perceptions and feelings. The framework is a very de-humanised and mechanistic tool

The paper is suggesting the need for an objective basis for capturing the effectiveness of state funding interventions.

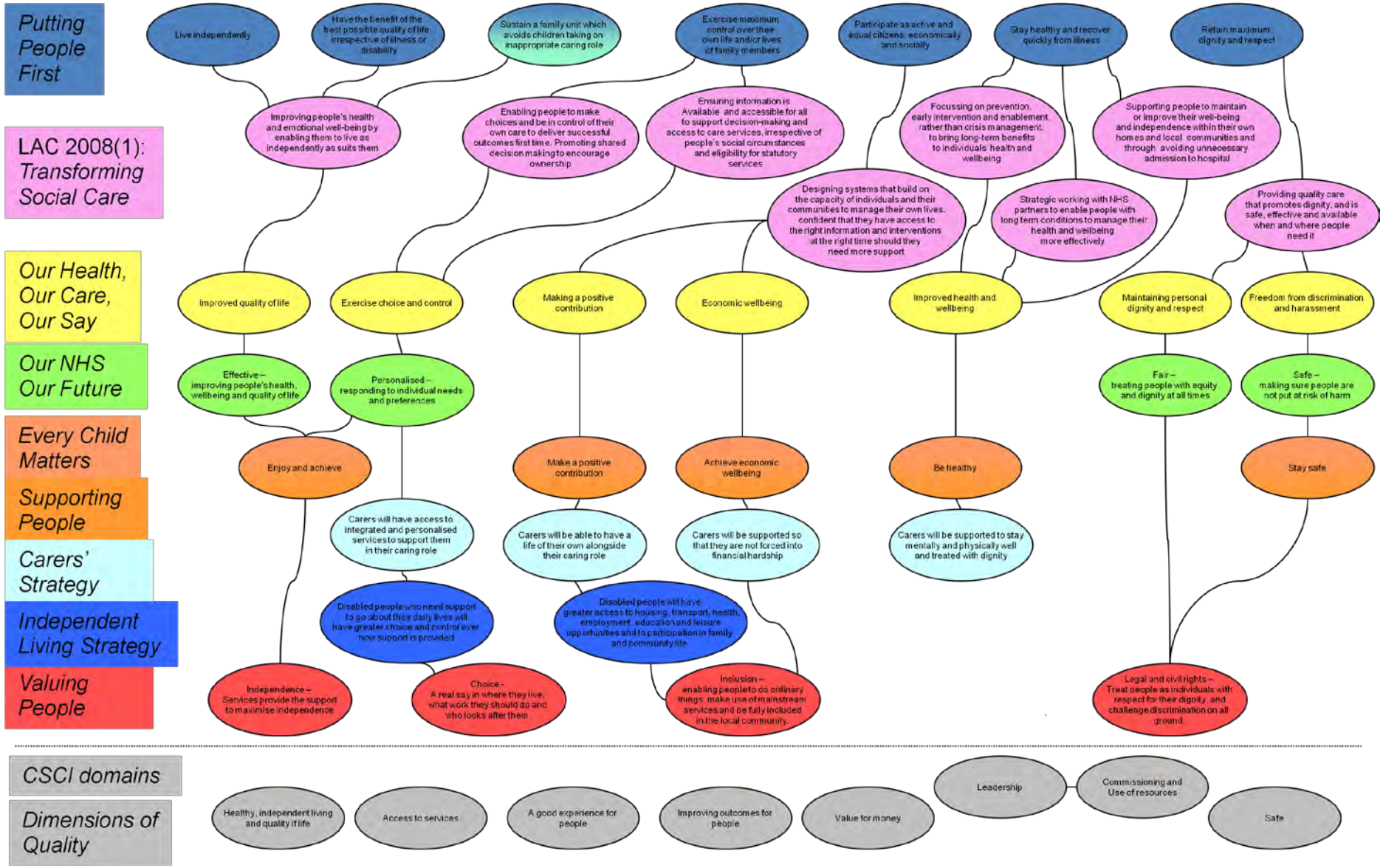
It has deliberately been designed to be a mechanistic tool which can be completed quickly without the need to resort to service user input (which takes time). We also see no reason why, under self-directed support, the service user themselves could not complete it.

This framework is seen as just part of the bigger process. We envisage the framework being used in three distinct ways:

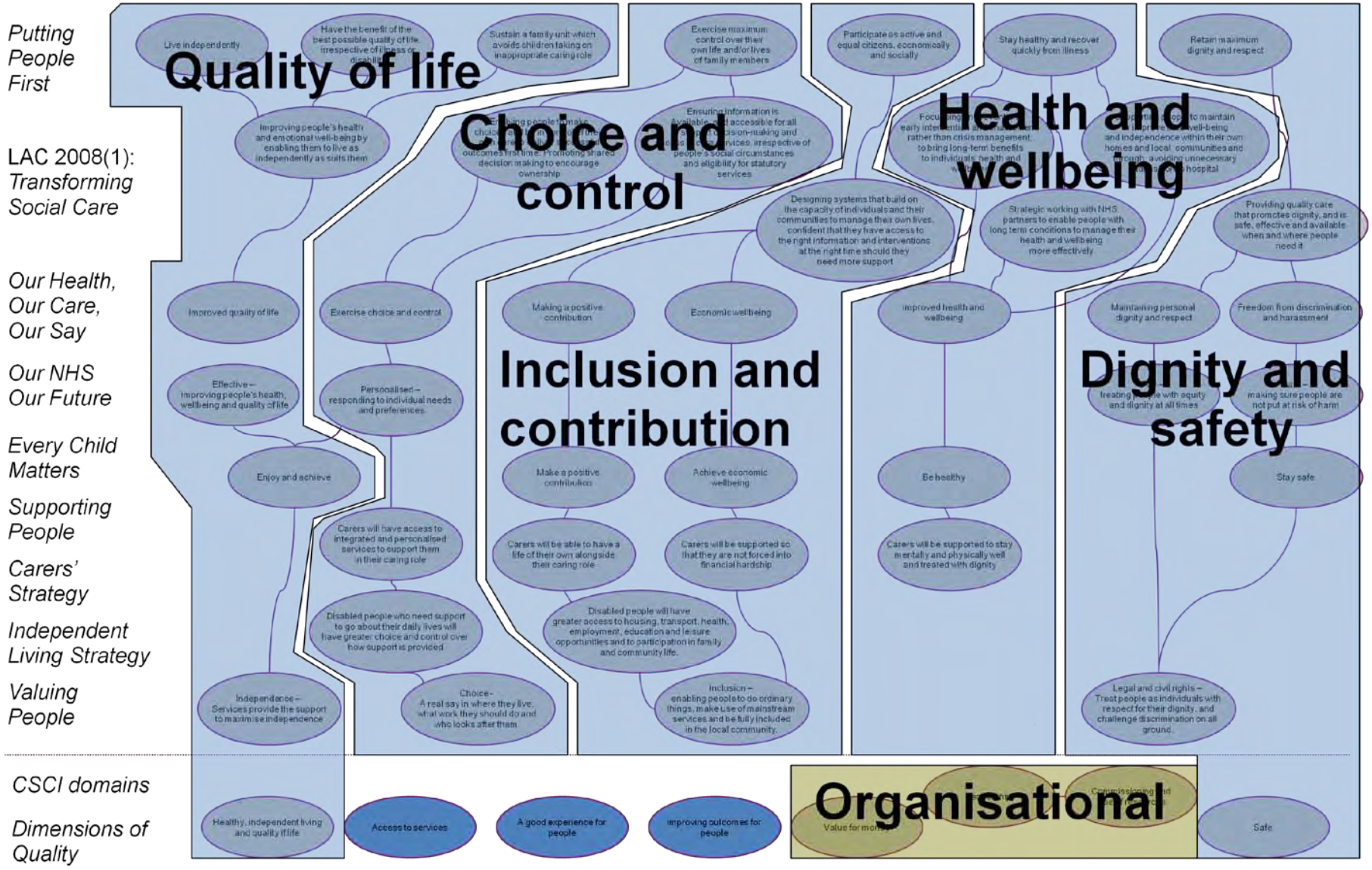
- As a kind a checklist, to ensure that the support planning process covers all of the potential dimensions;
- As the means of capturing, in a concise and analytically compatible way, the conclusions of the support planning process; and
- As the basis for ongoing monitoring of progress against the agreed results (whether this be maintenance or change). In this capacity it can serve to highlight when further intervention may be required.

We see the support planning process itself and subsequent review / *experience* collection mechanisms as being the key to the 'human' dimension inferred above.

Appendix A1 : Mapping the aspirations of key strategies



Appendix A2 : Identifying the Common Themes



Summary : Some Key Points

In this paper we have argued the case for:

- Clearly differentiating between *results*, *experience*, *performance* and that it is a balanced approach to all of these which leads to in positive outcomes;
- Aligning the detailed operational measures so that they can be aggregated to the various National outcomes frameworks;
- Using *results* as a primary determinant within the Resource Allocation System process (versus needs alone);
- Using *results* as the basis for individual placements in order to create flexibility for service delivery for the provider (but still maintaining the traditional mechanisms of performance monitoring and reimbursement at the higher level).
- Using *results*, independent of specific service inputs and outputs, as a means of comparing the cost effectiveness of different service options; and
- Ensuring that a *results* framework has the characteristics, independently of the nature of client, for scoring the relative impact of care related interventions.

Related CSED Activities (see the web)

- Demand Forecasting and Capacity Planning
- Homecare Re-ablement
- Integrated Care and Support Pathway Planning
- Supported Related Housing (and Assistive Technology)
- Crisis Response Services

Next Steps

We have referred to this as our contribution to the outcomes debate. This is because there are many initiatives looking at outcomes and this is but one.

We will continue to evolve this model as we receive feedback from interested parties (the reason for publishing it).

This model, and any associated feedback, will feed into regional and national events being organised to discuss outcomes and we are therefore keen to receive such feedback.

Thank you, in advance, for any contribution.

Developed with providers

The following providers very kindly supported the development of the original results framework (some of whom are now piloting it):

- The Avenues Trust
- Consensus (Caring Home Group)
- Surrey and Borders Partnership NHS Foundation Trust
- Heritage Care
- Care Management Group
- Southside Partnership Group

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For more information, visit CSED at www.dhcarenetworks.org.uk/csed