Tool 17: Outcomes-based home care service commissioning – simple guide

What is outcomes-based commissioning?

Outcomes-based commissioning is based on the model of seeking and paying for a service based on the desired outcomes being identified and achieved by the person using the service. For Home Care services an outcome based approach means that the service provider concentrates less on the tasks associated with addressing individual needs (e.g. the need for help getting dressed) but should aim to enable people with high support needs to maximise and maintain their wellbeing and have an improved quality of life. for example, getting dressed, getting out, doing things that make life enjoyable for them.

Are you contracting for outcomes?

Establishing outcomes as the basis for a commissioning strategy is important, but explicitly linking the payment of providers to the outcomes, rather than the outputs that they deliver, is a more powerful tool. Giving providers the right target will help to improve the efficiency of the service and result in better outcomes for the individual.

The characteristics of outcomes based contracts

Multiple organisations involved in delivering health and social care services covered by a single contract covering an individual or a defined population group.

Supporting people in different, more appropriate, ways, because of improved co-ordination and flexibility within contracts

Increased involvement and engagement of citizens in the design, delivery and improvement of services

New funding and contracting arrangements, such as capitated, incentivised budgets/payments and, longer-term contracts, are used depending on the scope of the contract.

Key themes of outcomes based commissioning

1. Invest time in defining desired outcomes, and putting users and communities at the heart of services.
2. Understand the types of risk taking that are required to innovate and improve outcomes, and ensure they are incentivised.
3. Create the conditions for flexibility, shifting from excessively short contracts to create greater certainty and scope for flexibility allows providers to plan and invest in building capability and improving services.
4. Cost-constrained contracts allow for incremental innovation within specific services but rarely lead to radical innovations to meet multiple outcomes and complex needs.
5. Specify the types of innovation being sought and incentivise these in partnership models, and payment and funding arrangements.
6. With or without payment by results, providers can be more successfully incentivised to deliver outcomes if the authority can relinquish close control of support planning and to be clear that their role is to be focused on assessment and quality assurance.

Models of outcomes based commissioning

Set out below are the three models of outcomes-based commissioning being considered within this toolkit and an overview of how they might affect home care services.

Model 1: Outcome Based Care Planning: (Using outcomes as the basis for planning and reviewing a care package)

Adoption of this model should lead to a change in thinking and practice within home care services, with the service being more aware of the need to achieve outcomes rather than just carrying out designated tasks.

There would be opportunity for more flexibility in terms of how and when the services is provided, and more negotiation between the provider and the service user about how to support the individual in achieving their outcomes. It may increase the complexity of the role of the home care worker, and require a greater degree of skill and on their part and a greater range of competencies.

Model 2: Reward for Achieving Outcomes and customer satisfaction: Individual focused but concentrating on the financial aspects of meeting outcomes.

Adoption of this model would require all the changes outlined in Model 1 and also add a considerable of complexity to the financial arrangements between the commissioner and the provider. There would be a need to identify precisely if, and when, reward related-outcomes have been achieved.
There would need to be agreement on what proportion of the payment is related to the achievement of the outcomes, and when it should be paid. There may well need to be procedures to 'review' the feasibility of the outcomes identified when they are not met, and the contribution home care has made towards meeting those outcomes.
Also, it remains the case that where providers do support a person to achieve greater independence they may be diminishing the volume of work on offer to them, and this may mean there is a need for 'profit-sharing' between commissioners and providers when this is achieved.

Model 3: Option 3: Population based accountability for Outcomes: Responsibility for the provider(s) for meeting the outcomes of a group of people across a defined geographic area.

The adoption of this model would require some significant changes both to the commissioning & payment arrangements for home care and to the role and responsibility of the provider.
There would be a need to identify the relevant outcomes to be set and to agree what proportion of the payments to the provider would be linked to the achievement of those outcomes.
Providers would have to be able to think more strategically and there may be implications for the local market as it would not be possible for more than one provider top operate in a locality (potentially denying choice to service users).
However, the adoption of a more strategic approach to home care could have significant benefits for the population as a whole.