Tool 5: A guide to step change commissioning of outcomes-based home care

This document is part of the Home Care Outcomes-based Commissioning Toolkit developed by the National Commissioning Board for Wales to assist home care commissioners and providers to move the home care service towards a more outcomes-based approach. This is an outline document that will be developed further as the project moves forward.

1 Core Material: Overarching principles of this toolkit

The provision of social services in Wales is governed by the Social Services and Well-Being (Wales) Act 2014. The Act is accompanied by a Code of Practice and guidance on the exercise of social services functions and partnership arrangements. The Code of practice stipulates that:

"In order to seek to promote the well-being of people who need care and support and carers who need support, local authorities need to understand what matters to people and the personal outcomes they wish to achieve".

The provision of health services in Wales is the remit of NHS Wales under the direction of the Welsh Government. Local Health Boards have responsibility for all commissioning and provision of health services in their area. The Welsh Government has produced an Outcomes Framework for the NHS in Wales that it describes on its website as follows:

"The NHS outcomes framework includes only outcomes and outcome indicators that have been determined to measure health related well-being. A delivery framework is in place to support the delivery of health and well-being by health boards and health trusts. "

Generally, the toolkit identifies that there are three models of outcome-based commissioning:

- **Model 1: Outcome Based Care Planning:** (Using outcomes as the basis for planning and reviewing a care package)
- **Model 2: Reward for Achieving Outcomes and customer satisfaction:** Again, Individual focused but concentrating on the financial aspects of meeting outcomes.

- **Model 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

2 Purpose of this tool

The purpose of this tool is to assist home care commissioners in carrying out a step change in their commissioning of home care by moving from a traditional time and task approach to one of the outcome-based models described above. The guide is built around the IPC Commissioning Cycle (as set out below), identifying and expanding upon some key elements.

3 The Commissioning Cycle

There are a number of versions of the Commissioning Cycle. This one, developed by IPC seeks to incorporate procurement as an integral part of the Commissioning process.

The Institute for Government (2015) identified three key trends in the commissioning of public services:

- The shift to outcomes-based contracts.
- Transferring financial risk.
- Changing relationships.

They developed each of these major themes, with the following suggestions highlighted:

Outcomes

- Invest time in defining desired outcomes, and putting users and communities at the heart of services.
- Understand the Community.
- Co-produce outcomes.
- Embed this into public service contracts.

Risk and innovation

- Understand the types of risk taking that are required to innovate and improve outcomes, and ensure they are incentivised.
- Balance risk for the social sector.
- Create the conditions for flexibility.
- Create new investment partnerships.

Relationships

- Recognise that it takes time to build trust and true collaborative relationships, and create the policy conditions and governance models to support this.
- Value social relationships.
- Collaborate to improve outcomes.
- Use new policy levers for change.

These recommendations reflect the fact that delivering outcomes-based commissioning requires an overall change in the approach to commissioning, and it cannot be seen as a 'bolt-on' to existing arrangements. The NAO in 2015b produced a paper on Payment by Results (which is linked to outcomes) in which they identified the features of a service suited to PbR.

Service feature	Why it matters
Clear overall objectives, capable of being translated into a defined set of measurable outcomes	Well-defined, measurable outcomes make transparent the extent of the provider's success, enabling commissioners to monitor the programme and calculate payments due.
Clearly identifiable cohort/population	Before the scheme starts commissioners need to specify which individuals they are targeting, so they can track the impact of the intervention.
Ability to clearly attribute outcomes to provider interventions	Commissioners need to be sure they are rewarding providers for their genuine contribution to desired outcomes. If external factors such as economic conditions are largely responsible for changes PBR may not be appropriate.
Data available to set baseline	To show the impact of the scheme and set effective financial incentives, commissioners need to determine a clear baseline of performance before providers start work.
An appropriate counterfactual can be constructed	To determine the effectiveness of the scheme, commissioners need a clear counterfactual to confirm it is the intervention that is driving improvements rather than exogenous factors (e.g. improvements in the economy).
Services are non-essential and	Commissioners are likely to want closer control than PBR allows of essential services where failure could have consequences for public safety
underperformance or failure can be tolerated	Commissioners will not be able to let the contract if providers do not bid.
Providers exist who are prepared to take the contract at the price and risk	If providers are not motivated by financial incentives, commissioners should question the appropriateness of PbR as a mechanism for delivering the service.
Relatively short gap between provider intervention and evidence of outcome	If there is no clear evidence about the activities that are effective in achieving outcomes, providers may be unable to estimate the costs to them of seeking to achieve outcomes, and commissioners will find it harder to price the contract.

4 Step-Change Commissioning

Set out in the table below are the relevant elements of the commissioning cycle, with key steps highlighted and expanded upon for the move from traditional time-and-task

commissioning of home care through to one of these models of outcome-based home care.

	Model 1: Outcome Based Care Planning: (Using outcomes as the basis for planning and reviewing the success of a care package)	Model 2: Reward for Achieving Outcomes and customer satisfaction: (Again, Individual focused but concentrating on the financial aspects of meeting outcomes)	Model 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)
'Analyse'			
Resource analysis	The resource analysis needs to cover not only the availability of resources, but also the capacity for change to deliver a new approach. The areas that need to be included are: **1.** Commissioning (shifting to a new model as well as any re-procurement that takes place will require additional commissioner input) **2.** Assessment and Care Management staff (ACM staff need to be engaged with the process and able to micro-commission the new service **3.** Workforce The homecare/re-aliment workforce needs to be trained and capable in	As with Model 1, but also need to be clear about; **1.** Capacity of monitoring systems to cope with new model **2.** Capacity of finance systems to link with monitoring systems to cope with the new model and ensure providers are paid in a timely and accurate way. **3.** Ability of Finance staff to understand and operate the new system	An understanding of the wider resources that will be being brought to bear to deliver on the population-based targets being used as outcome measures. Possibly construction of logic models showing how each of these resources will interact with the others and impact upon the achievement of the population outcomes.

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	delivering the new model of service. Where the new model is being introduced in conjunction with a re-commissioning a time delay may be needed before introducing the new model. Also, need to be clear about what services, if any will be de-commissioned as part of this process		
Assess individual needs/outcomes	Each person receiving the outcome-based service will need to have their individual needs re-assessed and their desired/intended outcomes from receiving the service agreed. As part of this process it will be helpful to be clear also about how the service is intended to deliver on those outcomes.	As with Model 1, but with clarity about how the achievement of identified outcomes will trigger any outcomes-based payments.	Assessment of individual needs may remain the same. Seeking to identify outcomes for individuals may form part of a wider logic model developed to establish how this service (perhaps along with others) will contribute to achieving the population level outcomes

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Analyse providers/market	Seeking to move to an outcomes-based model would be fruitless if the providers/potential providers within the market are not in a position to deliver or develop and deliver the right sort of service, with the back-office capability to support that delivery. The market analysis needs to have a strong emphasis upon whether or not the market can deliver this aspect, and if not, what is required to assist it to be able to do so. The market analysis should also	As with Model 1, but with a further emphasis upon the ability of the providers in the market to effectively undertake the necessary back office functions needed at a transactional level to make the new approach work. Home care and reablement services have often broken down not because staff cannot deliver the service, but because the providers cannot organise them to do so.	There needs to be assurance that providers are clear about the new approach, how it will operate and the scope of their responsibilities and accountability.
'Plan'			
Commissioning Strategy/Prospectus	The Commissioning strategy/prospectus needs to set out the proposed new approach in some detail. The introduction of an outcomes-based approach	As with model, with additional reference to the linking of payment and finance.	Whilst the overall strategy to deliver population level outcomes may be much wider, there will be a need to set out clearly the approach with home

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	will be a step-change and is likely to be disruptive in a variety of different ways. Prospective providers and other stakeholders need to be very clear about what delivering the service will entail and the expectations and requirements that will be placed upon them. It will be helpful for the strategy to incorporate FAQs and the publication of the strategy should be accompanied by a wider approach to engagement. Any implications with regard to de-commissioning existing services will need to be clearly set out.		care/reablement services –even if it is part of a wider package of services being commissioned (From a single provider, a consortium of providers or a range of different providers). Again, it will be helpful for the strategy to incorporate FAQs and the publication of the strategy should be accompanied by a wider approach to engagement. Any implications with regard to de-commissioning existing services will need to be clearly set out also.
Develop specification	With performance in terms of outcomes delivery not being part of the financial arrangements the specification for a service using this model is particularly important.	Again, all aspects as apply to Model 12, apply here also. In addition, for this model the specification needs to set out	The specification for this model could take a wide variety of forms and will, to some extent, depend upon the overall programme being put into place to deliver the population level

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	It needs to specify clearly both what is meant by outcomes, how these will be agreed and the requirements placed upon the provider and how these will be monitored. Whilst outcomes will be the measure of success it is likely that the specification will also need to contain reference to both inputs and outputs as these will continue to be essential to quality assuring the service. Also, it needs to be co-produced with all stakeholders especially providers and potential providers along with service users and carers (How the new service will work needs to be readily accessible to all three groups and so their involvement in the design and detail will be crucial).	clearly the financial arrangements that will apply. It is unlikely that these will be solely outcomes-based (too risky for providers), but it is that element that is likely to be new and unfamiliar to providers and will need to be carefully detailed. The specification may also need to take account of any possible time-lags between delivery of the service, achievement of the outcomes and payment to the provider.	outcomes. The specification may be very broad and may include home care or re-aliment only as options, rather than as requirements. Because of the nature of this model it is less likely that there will be as much detail with regard to monitoring inputs and outputs and the provider will have a greater degree of overall responsibility for the shape of the services being delivered and the achievement of the outcomes.

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Design Service	In an outcomes-based model the design of the service is generally seen as less of a concern to the commissioner, who has a focus upon the achievement of the outcomes, leaving the design of the service more to the provider than was previously the case. This may be the longer-term intention. However, initially commissioners may want to retain some control and oversight of the design of the service, at least until there is some confidence that providers understand the new approach are able to deliver effectively on the required outcomes. Also, the detailed design of the model must fit with the wider approach to identifying and meeting outcomes that is being followed by the commissioner. This part of the system has to	Same as Model 1	Again, the design of the service is likely to rest much more with the provider.

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	mesh with other aspects of it send cannot be designed and developed outside of wider local approaches to delivering outcomes for service users and carers.		
'Do'			
Secure Service	The procurement options for an outcomes-based service will not be too dissimilar to those for a traditional time-and-task service, and will be determined by the resource and market analyses carried out in the earlier part of the cycle. Block contracts, Framework Agreements and Dynamic Purchasing systems may all feature. However, it is likely that the approach will be to work with a small number of providers in order to ensure that the new approach is properly understood and delivered.	As for Model 1.	The procurement approach is likely to cover a number of services, not just those for home care and reablement. With the possible involvement of Health Boards the arrangement may be through a service level agreement with an in-house service or some form of accountable care arrangement.

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Contract Management	Contract management needs to focus first and foremost on the achievement of the required outcomes for service users and carers. However, quality assurance will also play a part and, in the early stages at least, there may need to be considerable input into supporting the provider to deliver the new service and to managing some of the new and complex relationships that will emerge as a consequence (e.g. with assessment and care management staff). As with all new contracts, and especially those for new services the contact between commissioners and providers is likely to be quite intensive in the initial period.	As with Model 1, but with additional emphasis on monitoring the financial aspects of the contract(s), particularly those elements that relate to the delivery of outcomes. Providers may initially struggle to deliver on the outcomes and financial instability could occur as a result. Commissioners will want to hold providers to the contractual arrangements whilst seeking to support them to deliver the required outcomes.	Here, contract management is likely to focus only upon the achievement of the required population level outcomes, particularly where the design of the services has been largely left to the discretion of the provider. However, where there are individual service users and carers involved, who may be dissatisfied with the services they are receiving, it will be important to have mechanisms in place to monitor and address that where necessary.

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Manage providers' relationships	As indicated above the effectiveness of an outcomes-based approach for home care or reablement is likely to depend upon the relationships that providers have with each other, service users and carers commissioners and assessment and care management staff. Commissioners need to 'hold the ring' with regard to this and to keep a close eye upon existing and developing relationships. Also, however, they need to be ready to intervene where those relationships are affecting the ability of the providers to deliver the required outcomes. 'Managing behaviours' can be the key to maintaining and developing good relationships and commissioners need to have a range of interventions at their disposal.	Largely as with Model 1. However, the addition of a clear link between outcomes and payment is likely to impact upon providers, their behaviour and their relationships. Whilst it may focus them more clearly on the required outcomes it may also increase the number of disputes and levels of anxiety by raising the stakes financially.	Again, with this model it is likely that providers will have a greater degree of autonomy and responsibility for the services they provide and for developing and maintaining whatever relationships they need to have in place.

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'Review'			
Review individual outcomes	Individual outcomes are at the core of this model and achievement of them needs to be monitored continuously and reviewed on a regular basis, particularly at the outset when the approach is new to all concerned. Whilst important in terms of commissioning, the achievement of individual outcomes is primarily important for the well-being of those people receiving the services. This needs to be kept in sight and there need to be in place clear processes for monitoring and reviewing that operate at an individual level. Again, this emphasises the importance of assessment and care management services when implementing an outcomes-based approach.	Again, as with Model 1 with the addition that the review of induvial outcomes must also play into the payment schedule for the provider. Accordingly, there need to be information systems and processes in place that facilitate that, recording the achievement of outcomes and allowing that to be translated into payments to the provider.	Whilst important for the well-being of individuals, outcomes at this level play no part in this model of commissioning services.

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	Finally, commissioners will want to be able to consider whether the outcomes being set and achieved (or not) are both genuine (in terms of being agreed with service users and addressing their needs) and realistic (do-able for the provider).		
Review market performance	As well as reviewing individual outcomes and the performance of each provider organisation commissioners will need to look at how the market as a whole is operating, considering questions such as whether: ▪ each provider has sufficient business to effectively adjust their approach ▪ each provider can manage the volume of business they have or should have	As with Model 1, but with an additional focus on the financial aspects of the model, including whether: ▪ Overall spend has increased or decreased with the new model in place ▪ Individual provider organisations are being paid than anticipated when the service was commissioned ▪ The systems and processes with regard to payment are operating effectively.	The key question with this model is whether the identified population outcomes are being met. However, commissioners will also need to be mindful of the broader perceptions of the service as to whether it is: ▪ Being effective or not ▪ Hitting identified population-based outcomes but leaving dissatisfied those who receive (or expect to receive) the service

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	▪ there is sufficient choice and flexibility within the system ▪ different providers are achieving different levels of success ▪ commissioners can effectively contract manage all providers operating under this approach ▪ there needs to be more or fewer providers or a different process for allocating work		These additional factors must be taken into account.
Evaluation of services	Evaluation of the service must focus firstly on whether the required outcomes are being achieved. However, there does need to be a further consideration of performance in a wider sense. This can be crucial in some instances. If a service is hitting the required outcomes by manipulating some part of the system, for example, or literally by good fortune or by	As with Model 1, with the addition of some consideration as to how the financial aspects of the arrangement are working. Are the systems put in place robust and secure for example? Is the provider receiving than had been anticipated and budgeted for? Is this approach creating financial problems elsewhere in the system? Local circumstances will throw up a	Again, whilst achievement of the outcomes must be the first consideration, even with this model wider issues about the service(s) in question must be part of the overall evaluation. This may include consideration as to whether the indicators chosen were the right ones and whether or they need to remain or be changed

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	accident (which can happen) or despite growing concerns about their ability to continue to deliver, then these factors also need to be taken into account by commissioners.	range of issues to be identified and addressed as part of the evaluation process. These need to be logged and dealt with either at the time or later as part of the more structured evaluation process.	

5 Examples

5.1 Calderdale Council – Commissioning Home Care and ISFs[1]

In 2013 Calderdale Council embarked upon a home care re-commissioning exercise. In doing so they worked to a set of issues identified by Sawyer and Lewis[2].

- Highly prescriptive, short, task oriented visits commissioned which militate against providers' ability to respond flexibly to the changing needs of service users.
- Inability to promote or maximize independence.
- Need for greater autonomy for providers so that the relationship between providers and individuals becomes paramount rather than the relationship between providers and purchasers which tends to marginalise service users.
- System is so demotivating and dissatisfying for staff that could well be contributing to the current crisis in staff recruitment and retention.

The existing position in Calderdale was:

- 12 Care Providers; 6 preferred providers and 8 spot providers.
- 11,044* weekly home care hours. Slight increase from October, total hours stable at around 11,000 since April 2012.
- 1,070* weekly service users. Number of service users increasing; 42 more since April 2012.
- Average care package reduced down to 10 hours 19 minutes. Average package sizes reduced by 27 minutes since April 2012.

They wanted to consider a move to a future model of Support at Home that:

- Combined community capacity: home care, assistive technology, equipment, housing options, adaptation and some personal care skills.
- Some enhanced health capability, (knowledge of medical risk, medication, 'fast track' when needed).
- Focus on improving mobility (physiotherapy, Occupational Therapy, personal trainers).
- Focus on improving diet and nutrition (dental?).
- Delivering social contact to maintain networks of friends/family.
- Welfare benefits and income maximization.

They engaged a team of staff:

[1] Details taken from a Presentation to TLAP by Elaine James – '*Calderdale Case Study Commissioning Home Care & Developing ISFs*'
[2] Lewis J, Sawyer L, 2001 '*Rediscovering the Community Care Approach*'

- To tell people that the home care contracts would be changing.
- How this may affect them.
- What options were available to them to take control of their situation.
- To find out what is important to them about their support.
- From their perspective, what makes a good life.

Subsequently the choice given to people was either to:

- Move to a Direct Payment.
- Take up an Individual Service fund.
- Accept whatever provider the local authority commissioned on their behalf.

Significant numbers of people opted for the first two options and the local authority was able to clarify its approach to the procurement of home care services and commission a reduced number of providers, working in much closer collaboration with them to deliver on outcomes.

Transforming home care: seeking quality of life in care at home in Southwark with stakeholders (Taken from SCIE Guide 54: 'Commissioning home care for older people', SCIE, 2014).

'How do you achieve quality of life through home care and raise its value and status? That is a question Southwark Council asked itself in the light of the publication of 'UNISON's Ethical Care Charter' [21] and a slew of press coverage of zero-hours contracts, 15-minute care visits and a lack of pay for travelling time that typify the jobs of many home care workers in Britain.

In summer 2013, Southwark Council explored ways to transform home care and improve users' experiences. It started by convening a series of stakeholder/user meetings to create a vision of what quality of life in home care looks like, what the values are that underpin this and what the ideal behaviours should be. The discussions started with the views of users and their carers, and continued around the themes from 'My Home Life' [22] and 'The Senses Framework' [23], which underpin 'relationship-centred' care and were shown to work in home care.

From the discussions, it was identified that home care providers are crucial in fostering the right conditions for a relationship-centred approach to the delivery of care alongside better working conditions. Both are necessary to deliver improvements in the quality of care. To achieve this, the council recognised that it would have to change its commissioning practice to support the providers to change, as well as try to influence a change of attitude towards home care workers.

One of the other conclusions of the 'visioning' work was that home care services as they currently exist and are commissioned need to be valued as part of a wider system. So, the relationship that home care has to wider community health services, and activity in general practice and hospitals, is crucial to consider. These relationships are an important part in valuing home care and its workforce. As a

result, Southwark has changed the language it uses to describe home care and now calls it 'integrated community support'.

The vision and values that emerged from the discussions were put to Cabinet, who agreed that they should drive a new commissioning strategy for home care in Southwark that would honour the Ethical Care Charter and raise the bar for home care.

The exercise showed that by using existing models and work already done by other organisations as a starting point, it is possible not to reinvent the wheel. The work done in Southwark is the foundation for a wider culture change programme and a new way of commissioning home care.'
http://www.scie.org.uk/publications/guides/guide54/practice-examples.asp

5.2 Wigan Council – Commissioning ethical Home Care Home Care

Wigan Council has sought to transform its Reablement and home care services. Having established a Reablement service they wanted to make this approach to supporting people's independence universal.

The council met regularly with providers and actively developed organisational development and quality standards for all its home care services. It co-designed improvement standards for home care with the providers, asking them to self-assess regularly and evidence improvement outcomes.

Wigan has also changed its assessment process to one which is entirely outcome focused, and established a team of brokers who are able to use the outcomes that customers have agreed they want, as the basis of helping someone plan their support. Along with this, an indicative allocation of money is calculated.

So the request for home care is not, for example, based on specifying the number of visits, time of day and tasks to be done, but the outcomes the customer has agreed they want delivered for them personally and the indicative amount of money available to provide the service. Proposals from providers can then be reviewed and agreed based on the best offer that the social worker and customer feel will meet their need. Wigan has now procured an on-line market place where providers will be able to advertise their services, prices and options. (Taken from 'Outcomes Matter: Effective commissioning in Domiciliary Care, LGIU 2012).

In December 2016 Wigan went out to tender to re-commission its home care services. The tender documentation was explicit about the kind of service Wigan wished to commission stating:

'The Ethical Provision of Home Care will deliver a transformed model of ethical, asset based care and support, meeting the needs and aspirations of people to live fulfilled lives in their own home avoiding inappropriate admissions to hospital and residential care.

All providers delivering Home Care will demonstrate:

- That people have real control over their care and support, actively engaging residents, carers, local communities and partners in the co-design and development of support packages.
- The difference that they are making to people's lives through an asset based approach celebrating and facilitating people's gifts, talents and aspirations.
- That they seek solutions that actively plan to avoid or overcome crisis and focus on people within their natural communities, rather than service and organisational boundaries.
- That they enable people to develop networks of support in their local communities and increase community connections.
- That they take time to listen to a person's own voice, particularly those whose views are not easily heard.
- That they fully consider the needs of the family and carers when planning support and care.
- That they ensure that support is culturally sensitive and relevant to diverse communities.
- That they take into account a person's whole life, including their physical, mental, emotional, and spiritual qualities.

The care and support will be delivered by skilled and compassionate workers, employed by providers who offer excellent services to Wigan residents based on responsible and supportive employment practise, in return for a comprehensive reward and support package.' – Taken **from 'TENDER**: Wigan 129 - Ethical Provision of Home Care (Lot 1).

5.3 Camden Mental Health Services

In a different Service area NEF describe their work with Camden Mental Health Services as follows:

'We have worked alongside several local authorities over the past decade to implement a new approach to commissioning for outcomes. It started with the re-commissioning of a Mental Health Day Service in Camden. Since then, our work has developed and tested different ways of commissioning that involve a greater focus on well-being and prevention, and that provide a stronger role for people intended to bene t from the service in the commissioning process itself.

- *Shifting to an outcomes-focused approach, promoting co-production and measuring value across the triple bottom line were all central to the new vision of what mental health support in Camden might look like. The commissioning approach radically changed the tendering and procurement process, including:*
- *Developing an outcomes framework that included social, environmental and economic outcomes for people who used the service and for the wider community. These outcomes included, for example, increased access to skills and employment, supporting people to lead healthier lives and creating a sustainable social infrastructure.*

- *specifying that co-production should be a key feature of the service and that providers should show how they would work with people using the service, and with the wider community.*
- *tendering by using the outcomes framework and a set of quality characteristics to help re ne the offer, and asking prospective providers to design the activities and support that would achieve the required outcomes.*
- *monitoring and evaluating outcomes, rather than outputs, throughout the duration of the contract.*

The winning tender was a consortium of Camden-based third sector organisations: MIND in Camden, Holy Cross Centre Trust (HCCT) and Camden Volunteer Bureau, a mainstream volunteering organisation. Their vision of how co-production could transform the local offer has resulted in one of the most innovative examples of co-production in the UK, described in several case studies previously published by NEF. Camden is now using the outcome model to commission a range of services across different directorates and building it into the new council-wide procurement operating model. These are considered to be vital steps in bringing about wider cultural and operational change'.

6 Other materials

Health Services Management Centre Institute of Local Government Studies - *'Commissioning for Better Outcomes: A Route Map'* (2014)

HSMC: website for the Health Service Management Centre, at the University of Birmingham is the leading UK centre, which provides a combination of research, teaching, professional development and consultancy to health and social care agencies.

HousingLin Website - Market Shaping: Commissioning and procurement of care and support at home.

IPC: Institute of Public Care at Oxford Brookes University has resources with a focus on improving the quality and performance of services across health and social care, education, housing and welfare.

NEF: The New Economics Foundation is an independent think tank provides resources and examples of innovative solutions to promote social, economic and environmental justice.

NESTA: describes itself as an innovation charity and undertakes in-depth research and practical programmes to test out new ideas to improve the quality of people's lives.

SCIE: Social Care Institute for Excellence provides good practice guidance and case studies in social care, and related services.

TLAP: Think Local Act Personal has a range of resources with a particular focus on transforming health and care through personalisation and community-based support.

NICE: National Institute for Health and Care Excellence provides national guidance, quality standards and indicators and advice to improve health and social care. See:

The NICE Into Practice Guide has been developed for people involved in commissioning or providing high quality care and improvement in health and social care organisations. The guide provides practical advice on how to use NICE guidance and related quality standards to achieve high quality care.

THE NICE Home Care Baseline Assessment tool can be used to evaluate whether practice is in line with the recommendations in Home care. It can also help to plan activity to meet the recommendations.

Strategic Commissioning - Smarter Commissioning briefing paper Briefing Paper 11: Commissioning Homecare services, Impact Change Solutions

Institute for Government – *'Beyond Big contracts - - Commissioning Public Services for Better outcomes'* (2015).

Heginbotham, C. & Newbigging, K. (2013). Commissioning health and wellbeing. London: Sage. Local Government and Improvement (2010). The role of local government in promoting wellbeing

Think Local Act Personal (2012). Stronger partnership for better outcomes: A protocol for market relations

Dickinson, H. et al (2013) Joint commissioning in health and social care: an exploration of definitions, processes, services and outcomes

DASS. Top Tips for Directors: Commissioning and Arranging Home Care Services [online].

Developing Care Markets for Quality and Choice (DCMQC) a national programme from Department of Health, ADASS and IPC to help local authorities develop their social care market shaping capacity, including the development of Market Position Statements. See: Institute of Public Care. (n.d.) Implementing the care act. Developing care markets for quality and choice [online]. Available at:

IPC (2014). Developing a Market Position Statement: A Commissioner's Toolkit.

Chartered Institute of Finance and Benchmarking (2014). Social Care Benchmarking: improve services and identify efficiencies.
Ageing and Aged Care (Australia) Changing Home Care Providers (A different system but useful practicalities)

NEF –'Commissioning for Outcomes and Co-production' (2014)

National Audit Office – Payment by Results: analytical framework for decision-makers