Tool 16: Risk Management

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 have 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, this 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

1.1 Purpose of this tool

This tool provides advice and guidance for both commissioners and providers in identifying, considering and managing risks associated with the three models of outcomes based commissioning.

2 Managing risk within Models 1 & 2: Outcomes based care planning and reward for achieving outcomes and customer satisfaction

Outcomes based commissioning (OBC) is still highly variable. Commissioners are conscious of the challenges of OBC. The process of developing and procuring outcome contracts can sometimes be technically challenging.
The structure and organisation of the homecare sector can pose challenges. For example, it is largely hierarchical and, despite good intentions, still, in some cases, operates within silos or time and task systems. Developing OBC using outcomes as the basis for planning and reviewing care packages often requires 'going against the grain' of established practice.

Commissioners often talk about risk in the context of OBC. They hint at the need for a different attitude towards risk within the statutory sector, and different ways of 'holding' and managing the risks. Risk assessment and risk management have become strict regimes in many statutory services and organisations and, in these contexts, risk is conceptualised and understood in negative terms. There are also deep contradictions in relation to whether risks are managed at the individual or collective levels. The issue of 'who holds what risks' is highly pertinent in this context.

Other risks often cited in the commissioning on outcomes for planning and reviewing care packages are that it is hard to obtain clarity in the desired outcomes that can be effectively measured, the model requires effective and constructive customer engagement from the start.

Practitioners will need to ensure that stated outcomes in each case will be neither too cautious nor to ambitious. Practitioners, providers and service users and carers will all need to understand the basics of the payment system (For Model 2) because of the extent to which the success of such a system will depend upon the reported outcomes from these three groups.

Also, if there are new providers then commissioners must allow them time to secure themselves in the care market before asking them to deliver a full service. All providers need time to secure staff and to have them trained and supported in the way required. The risks if an appropriate amount of time is not granted include providers face ever increasing difficulty in gaining capacity to deliver services.

This means that the focus in planning care packages on individual outcomes (including financial rewards for meeting outcomes) moves away from delivering outcomes and more on the straight forward task of getting the care worker to the right customer at the right time.

In both models, the outcomes can be initially determined between the assessor and the customer. These outcomes are then put to the provider who agrees with the customer how they will be delivered through a support plan. The payment is then calculated through a combination of a pre-set fee level for each described outcome and the detail of the support plan. There is no specific reward as such for delivering an outcome. However, if a provider delivers an outcome earlier than was anticipated, they are still paid the full amount.

However, the design and specifying of outcomes for each person can be a complex task. It will be important that staff are appropriately trained and are supported by the right paperwork and forms to assist them in undertaking outcomes-based assessments. In addition, there is a cost for all parties (commissioners, providers, assessors and maybe customers) in delivering the services in this way. These need to be considered when setting up the processes. To this end, the process needs to be made as simple and as straightforward as is possible.

There is also a risk that individual outcomes cannot always be delivered by one provider. Sometimes it requires a range of providers to work collaboratively with individuals to meet their desired outcomes. This can be complex but incredibly rewarding when achieved. This particularly refers to both the NHS (who needs to be part of the thinking as the scheme develops) and for the community and voluntary sector who are again often uniquely placed to ensure that the model is delivered.

Each person will require a unique set of interventions to maximise their potential and there is a risk that this is hard to achieve at the scale that may be required.

One way to reduce the risk may be in the potential to reframe the way we look at outcomes. In England, for example, the Sustainability and Transformation Plans (STP) agendas high level principles and vision underpinning it can be used to open up a wider discussion around “outcomes for whom?”.

Commissioners, Clinical Commissioning Groups who have used the STP agenda to embrace a wider perspective on outcomes, in particular to involve service users in co-defining ‘what success looks like’, over and above any system-level benefits, even if these may not result in ‘cashable’ savings. Regional Partnership Boards could adopt a similar approach in Wales.

3 Model 3: Managing risks associated in commissioning by population based accountability for outcomes.

Another approach that is being developed as a way of commissioning on outcomes is to pay for outcomes for populations rather than for individuals. In this model, a council can commission a service with a clear expectation that the service will deliver a set of specified outcomes for a wider population.

It is necessary to identify segments of the population that have similar characteristics. These would include shared service or treatment needs or support, and could be defined by medical condition or key demographic data such as age. By segmenting the population in this way, it is possible to identify common clinical and functional outcomes that are of importance to people within the target group.

One example of this is an emerging view of how to commission a range of Intermediate Care Services (often jointly commissioned between NHS and Councils). These are services that assist older people who have been discharged from hospital or to offer help in a way which avoids a hospital admission. The common feature of these services is that there are often quite high volumes which need to be met but a key risk is that outcomes can vary so much if the services are not designed and set up in the right way.

So, having a set of measures that ensures speed of discharge from hospital for older people that is backed up with low admissions to residential care and limited long term needs for domiciliary care is a set of outcomes a service (or set of services) may be asked to deliver. Good intermediate care can deliver speedy discharge without an increase in unexpected longer term demand for social care services.

Overall, the model appears to work best when both those assessing for services and providers are focusing on helping people to gain more independence. This might seem very straightforward but it is rare to observe this in practice.

One of the features of the model is the way that risk is managed. There is scope for tension between commissioners and providers, with the latter the more likely to be aggrieved if they begin to perceive the identified outcomes as excessive, falling outside the scope of what they can affect or being adversely affected by other parties and/or circumstances beyond their control.

From another risk perspective, it is important that the population segments are of the same kind in enough to be able to share a set of outcomes that are meaningful to everyone, but not so narrowly defined that that the contract value does not effectively incentivise transformation and innovation within the health and social care system.

Another risk relates to the way in which some key players (e.g. the NHS) respond to their customers e.g. at the time of hospital discharge. There does have to be work undertaken with NHS and other colleagues to ensure that they understand and can contribute to the approach. For many older people, it is ensuring that they are getting the right help for their health needs that make a significant difference to the outcomes that are possible for them. This particularly involves NHS resources to be allocated to therapists and community nurses.

There is also a risk in adopting the principles and processes of this model too quickly. It is widely accepted that transformation at this scale cannot be achieved at once. Commissioners will be expected to identify pathways of care and segments of the population to prioritise, and must support the provider and market development necessary to achieve best value for the population.

This could become a process of discovery and not design and requires work collaboratively between commissioners with providers and share some of the risk associated with this level of transformation to stimulate innovation and proceed at the pace necessary to meet the financial challenges faced in the local health and social care economy.

Another important aspect of managing and reducing the risks associated with this model relates to determining contract cost.

This is a complex process based on the current price paid, the true cost of care and the opportunity for increasing value through improved quality, collaboration, innovation and prevention.

This process will require a deep understanding of the population and potentially additional actuarial support to forecast and predict clinical and financial risk across the system, including changing population demographics, cost and utilisation. It is recognised that understanding costs and predicting risk in this way across an entire pathway or part of the population will be a challenging process. As such, it may be necessary to engage independent external support to work with providers and commissioners to provide specialist expertise in determining the cost of contracts.

Consideration will need to be given as to what analytical support is needed to ensure the outcomes in these contracts can be effectively measured and monitored. This is likely to involve significant organisational and workforce development for both providers and commissioners. This will need to be appropriately considered as part of development plans and budgeting arrangements.

Of equal importance is contracting with providers collectively to deliver a shared set of outcomes identified as important by specific segments of the population that will be an enabler to achieving more integrated, innovative services.
Whole-pathway contracting potentially has significant benefits, it also carries inherent risks, not least because, for many providers, it would be an entirely new way of working.

Recognition needs to be given that to commission outcomes based on a group of people within a geographical area can take time to both set up and deliver, However, to ensure that commissioners are able to maximise impact, the segments that could be chosen to prioritise initially would be those that would most benefit from an integrated approach to improve the quality of outcomes and experience. Specific examples that could be considered are:

- People approaching the end of their life.
- People with mental health problems.
- People with diabetes – and possibly other long-term conditions.
- People who are over 75 years old.
- People who are experiencing breathlessness as their primary symptom.

4 Other materials

A useful toolkit for commissioning overall can be found at the National Audit Office (NAO) website, which provides advice and guidance on how to secure value for money through better financial relationships with third sector organisations
Successful Commissioning Toolkit

The New Local Government Network have produced a guide that raises the scoring for social value in the commissioning process on how local government works with its partners and on the outcomes, it is able to deliver for citizens.
All Together Now: Whole Systems Commissioning for Councils and the Voluntary Sector.

North Wales Domiciliary Care held a range of development workshops in 2015 and produced a report on the outcomes from the three Domiciliary Care Development Workshops. These were commissioned by the North Wales Social Services Improvement Collaborative (NWSSIC), with the aims of developing the domiciliary care market and ensuring that care & support services provided in people's homes:

- Are person centred,
- Focus on achievement of service and individual outcomes
- Deliver community benefits, and
- Involve service recipients and/or their representatives in service design and delivery

This report is designed to be read and used by everyone, by assessors (including social care workers and nurses); people who commission or regulate care and support services; those that provide it and people supported by domiciliary agencies.
North Wales Domiciliary Care Development workshops

The Institute of Care (IPC) research paper entitled 'Emerging practice in outcome-based commissioning for social care' is a progress report exploring the lessons learnt from a variety of approaches taken by councils to "outcome-based commissioning" in adult social care (sometimes called 'payment by results'). It considers some of the opportunities and risks that arise from taking this approach.
Emerging practice in outcome-based commissioning for social care

Outcomes based healthcare's technical paper offers an understanding of the different contracting, reimbursement and incentive mechanisms available to deliver Value and Outcomes-Based Healthcare in a UK context.
Contracting for Outcomes: A value based approach