NHS

DH Department of Health

EAST MIDLANDS WORKSHOP REPORT:

CONTRACTING FOR PERSONALISED OUTCOMES

4th February 2010

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East Midlands Improvement and Efficiency Partnership

Regional Workshop: Contracting for Personalised Outcomes East Midlands Region, Nottingham, 4th February 2010

Background

In August 2009, the Department of Health Putting People First (PPF) Delivery Programme published *Contracting for personalised outcomes: learning from emerging practice* following a research project conducted in partnership with the Office for Public Management (OPM).[1] The report draws on learning from six councils with high numbers of personal budgets who have begun to reshape their contracts, their commissioning approach and their relationships with the provider market to ensure that personalised services are available to people with support needs. It provides a snapshot of each council's progress and is intended to support other commissioners and providers from across the sector to learn from what works and apply this locally. While concentrating on personalising domiciliary services, the key messages in the *contracting for personalised outcomes* are transferable to other contexts.

Recognising that it is often difficult to reach key audiences through publications alone, the PPF Delivery Programme worked with Joint Improvement Partnership Programmes to deliver 7 regional workshops to actively disseminate learning from the report and explore its local application. Mixed delegations of commissioners and providers were invited from councils and additional delegate places were made available to members of the United Kingdom Home Care Association (UKHCA).

This short report summarises discussion at the East Midlands Region event, held in Nottingham on 4th February 2010. It picks out headline issues, challenges and ways forward and is provided both as a record of the event for delegates and others and a spur for possible further regional work. The report was written with OPM who also supported delivery of the event. In addition to this regionally specific report, a final report will be published later in the year drawing upon outputs from all 7 regional events and the national action learning set that has been running in parallel.

Summary messages from the report

Contracting for personalised outcomes makes clear that where innovative practice is happening and where significant progress is being made this has involved a transformation in relationships between commissioners and the market:

> *A common feature underpinning changes in each council has been a shift from traditional and often adversarial relationships towards collaborative and constructive partnerships between commissioners and providers*

A key message from the report is therefore that striving for greater trust, understanding and genuine partnership between commissioners and providers is crucial to realising the vision of Putting People First.

The report starts from the assumption that the current mix of predominantly block and spot contracts for domiciliary care, specifying specific times and tasks and let on a cost and

[1] The report can be downloaded here: http://www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/General/?parent=2734&child=6052

volume basis, are probably not fit for purpose under personalisation for a number of reasons, including:

The possibility of double funding as personal budget holders start to “shop elsewhere”;

Possible limitations to personal budget holders’ choice of service or provider;

Possible limitations to providers’ ability to respond flexibly to individual user needs and preferences;

Possible exclusion of small scale (or micro) providers, especially when these contracts are let on a large scale.

While part of this challenge has been met through the introduction of different approaches to contracting, the report recognises that in reality this has meant councils implementing a range of other changes as well. In particular, it highlights three key components that need to be in place to ensure contracts are aligned with the use of personal budgets and the personalisation of services is actively encouraged. These are:

- Personal budgets;
- Outcomes based framework agreements;
- Service personalisation.

<u>Personal budgets</u>

Councils involved in the research have recognised that making personal budgets work for everyone requires a range of options for how they can be managed. This includes options for people to access managed and/or commissioned services in a personalised way without taking on money management responsibilities. One option that is being developed is the introduction of individual service funds which empower people to work with providers to determine how they will be supported under the terms of an existing or a new contract.

<u>Framework agreements</u>

Councils involved in the research have introduced outcomes based framework agreements for domiciliary care that do not specify times and tasks. In some cases these are underpinned by person-centred practises that empower people to decide how and when they are supported. The frameworks seek to guarantee supply and quality of services through the pre-selection and validation of providers (though this has been done in very different ways) and have not tended to guarantee any volume of business for providers.

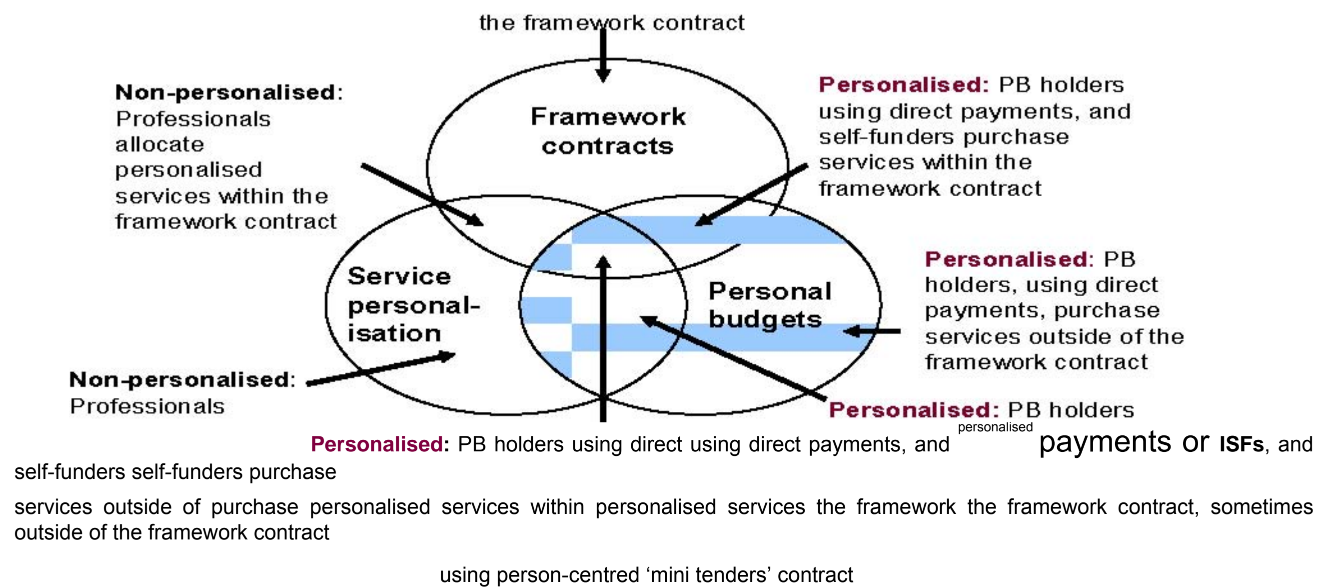
<u>Service personalisation</u>

Councils involved in the research have recognised that many providers will benefit from active engagement to understand the implications of personalisation and adapt and respond their services and businesses accordingly. In the best instances, this support has ranged from provision of joint training for provider and council staff in things like person-centred planning and reviewing, active engagement of commissioners in provider business planning and direct support with things like unit costing and risk management.

The diagram below illustrates these three components and the relationship between them.

Non-personalised: Professionals allocate quality assured services within

allocate



Personalised: PB holders using direct using direct payments, and personalised payments or **ISFs**, and self-funders self-funders purchase

services outside of purchase personalised services within personalised services the framework the framework contract, sometimes outside of the framework contract

using person-centred 'mini tenders' contract

The regional workshop

The objectives of the day were to share learning, create the space for collaboration between commissioners and providers, and to identify what will help or hinder the implementation of personalisation, including enablers and barriers to putting this learning into practice.

Participants worked in mixed groups of commissioners and providers to discuss key issues identified in *Contracting for personalised outcomes* using the case study scenario of People's Borough. In the scenario, People's Borough is implementing personalisation and has set ambitious targets for personal budgets uptake. Consequently, they are reviewing their commissioning approach and looking specifically at two crucial stages of the process of moving towards more personalised domiciliary care services: specifying a framework contract, and enabling the new approach to work effectively. Groups worked with the scenario to answer a range of questions in each of these stages and provide feedback about issues identified and possible ways forward. The remainder of the report summarises these discussions.

Stage 1 – Specifying the framework contract

Types of services provided: How should the framework specify the services to be provided?

Scenario: The aim of the framework contract is both to secure a source of supply but also to enable a move from a very traditional domiciliary care offer with tightly specified times and tasks towards a highly personalised approach that enables individual flexibility and choice. We realise that this will mean that we cannot directly specify the range of services provided without infringing on the people's choices but want to emphasise the need for personalisation. How should we approach this?

The participants felt that a framework should not specify all services, or at least shouldn't be restricted as services need to be flexible and needs-led. How would a commissioner justify the services specified? Would it be required to do this? Would this leach innovation from the tendering process?

The participants also felt specifying services could be led by political decisions- for example favouring a particular provider to screen out other competitors.

A way to overcome this was to specify outcomes rather than services and leave it to providers to demonstrate this at the tendering process. Some participants were sceptical about how this would work in domiciliary care, which they said often needs to specified by tasks to ensure end users have all their needs met.

Number and types of providers: how many providers should we include in the framework and what balance should we go for between different types of providers?

Scenario: We recognise that for the framework to be able to provide the range of choice that both budget holders and self funders will demand we should include as wide a range of providers as possible. We are concerned about our capacity to handle more providers than at present but realise that we may have to adapt. As a local authority we also want to support local providers, particularly those with strong links to the community. How should we approach this?

Again, participants felt that the number of providers should not be specified, or at least not be restricted as the aim was to develop the market and encourage smaller providers to enter. Others felt that numbers could be broadly specified, but that providers should be encouraged to sub-contract with smaller local services – some even stated this should be a compulsory requirement for larger providers as part of the tendering process, thus giving weighting to localism as part of the specification.

Sub-contracting: Do you foresee any drawbacks to sub-contracting, and if so, how could they be minimised?

Scenario: Sub contracting will be encouraged to enable the widest range of domiciliary care supports to be provided. This is also a means by which we intend to secure the services of community linked providers who often lack the capacity to engage with large scale contracting processes.

Issues arose around control and quality. How far is it the commissioners' responsibility to ensure sub contractors are appropriately accredited? There needed to be greater clarity around defining such responsibilities and how far these can be delegated down.

On the positive side, sub-contracting could be used to stimulate more providers to enter the market under the umbrella of larger, established providers. A participant felt this was predominantly an opportunity rather than a risk and that emphasising too many restrictions can deter new, innovative providers from entering the market. This would ultimately be detrimental as it would shrink the market and lead to higher prices being charged by existing providers.

There was a discussion about distinguishing between broker services and main contractor. Clarifying duty of care and other respective responsibilities for each party was seen a priority. It was felt that unless there was greater clarity around roles and responsibilities, sub contracting would lead to diluted accountability and dispersed channels of communication. A way of overcoming this would be to clarify contracts and ensure problems are anticipated as early as possible.

It was asked how the system of sub contracting would affect the role of care manager? Will they be responsible for assessing or brokering?

Participants also debated if risk could be transferred in sub-contracting - from the commissioner view, they were reluctant to involve a wide range of stakeholders as this might make it more difficult for them to discharge the council's duty of care.

Quality assurance: What approach should we take to quality assurance and why?

Scenario: The public will reasonably assume that any service providers included in the framework will be reliable and provide good quality services. However quality assurance can be delivered through a light touch or a more in depth approach. How would you suggest that we progress?

It was felt that quality was something which needed to be defined by everyone involved and should not be dictated by what the commissioner thought. For example, changing an enduser's bed linen X number of times a week did not necessarily lead to quality (although the task is done), but things like the interpersonal skills of carers who are in contact with service users also count – and that some of these aspects of quality can only be ascertained by talking to the service recipient. Participants identified one way forward as being to develop a definition and framework for quality assurance which draws on a wide range of stakeholder opinions, particularly those of the person being supported.

Other felt that the principles upon which such standards are developed should be meaningful and protect and cater for service users as well as commissioners.

Participants also considered how it might be possible to ensure quality across sub-regions while relying on it being defined by people using services in a given locality. Whilst it was recognised that each commissioner needs to draw up specific quality assurance criteria for the given service, there also had to be something in place which was generic and ensured minimum standards everywhere- this would require sub-regional collaboration between commissioners. It was generally felt that the current CQC standards were not sufficient and additional quality assurance information was needed.

Locality focus: How can choice be maximised whilst ensuring geographical coverage?

Scenario: In the past we have had difficulty in getting a good coverage of domiciliary care services across the whole of the borough. To ensure this doesn't happen in the future should we allocate different providers to different localities? Whilst this appears to be an obvious thing to do we are concerned that by doing so we would restrict budget holder's choice of both providers and potentially of services. How should we approach this?

The participants expressed the need for more local involvement networks- bringing in and supporting micro-providers who can be "kite marked" or "accredited" locally through schemes acknowledged at national level. They felt the process of attaining these standards should recognise the difficulty smaller providers have in finding the capacity to fill out copious forms and handle administration.

Services could be delivered in conjunction with other aspects of the local economy. (e.g. cleaning staff at local hotel extending their services to care homes) Some participants concluded that there can be a limited choice of services in sparsely populated areas, even when there is sufficient funding. In such a scenario it was argued that building people's social capital is particularly important and that funds could be made available to people to develop their own services, or encourage existing providers to extend and diversify their offer.

If choice is to be maximised it has to accompanied by an awareness raising strategy to encourage uptake by people with support needs. More advocacy and support for people is required so they can exert their right to ask for and access services from outside of their area.

Self funders: How can access to the framework providers be enabled for self funders whilst avoiding any reduction in choice for budget holders?

Scenario: It is our intention to make access to services via the framework contract open to self funders as well as budget holders. However, we are concerned about how to do this without reducing choice for those with personal budgets. How should we approach this?

Some felt that those who want to, and can afford to access services, do so anyway. However more research was required about what influenced their choices. Are they always well informed? Advice and support should be provided based on need rather than by differentiating between different types of funding – self or state. For example, information and support from a "hotline" run by a local authority for everyone who needs it which can signpost both budget holders and self funders to services.

Price transparency: Would you advise us to go for price transparency and if so how can we minimise the disincentive for providers to tender to be part of the framework contract?

Scenario: We would like to make price transparency a requirement of the framework contract but are concerned that this might prove controversial amongst providers and lead some, who would otherwise provide highly innovative services, not to tender to be part of the framework. How should we approach this?

This raised some anxiety amongst providers. There needed to be systems in place to ensure that price is not the only deciding factor, as "you get what you pay for" i.e. a high quality service is often more expensive. Equally the commissioners responded by asking - How do you ensure high price equals high quality and vice versa? The discussion led back to issues of how quality is defined and understood.

There was an agreement that a breakdown of price should be provided - so the unit cost is apparent, the commissioner is reassured they are not being overcharged, the provider has an opportunity to demonstrate what they will be providing and the person requiring support can make a decision about the balance between cost and quality that is right for them.

Some participants raised the prospect of bench-marking provider quotes with in-house services, however this was not considered as always possible for less standard, more innovative services.

There was a concern that price transparency would put off specialist providers, who due to their provision of niche services often have higher costs - or it may serve to unintentionally lower quality of the service.

Mini-tendering: Are there likely to be any drawbacks to a 'mini-tendering' approach? If so, how could these be overcome and are there better alternatives?

Scenario: We would like to include mini-tendering as a framework requirement as it appears to offer a useful way of enabling providers to be able to compete to make creative responses to support plans and to allow people requiring support to compare different support scenarios and costs. What would you suggest?

Participants felt that mini-tendering, or bespoke tendering at individual level was time consuming for providers - it was only considered to be worth it if the budget was particularly high - but the budget would only be very high if the needs were acute which in turn might require specialist support which inherently excludes the majority of providers from tendering.

Participants felt that mini-tendering should only be an option for very bespoke requirements.

A commissioner commented that mini tendering was commonly perceived as something ONE provider should be tendering for - surely the "mini-tender" should be open to consortia of providers (across sectors, services etc) how do you encourage providers to work in partnership and be innovative? How was it possible to communicate that whilst the overall care package was bespoke, it could be catered for by several providers, instead of just one?

Stage 3: Enabling the new approach to work effectively

Support for people: How can people using services, families and relatives best be made aware of the new possibilities and enabled to take advantage of them?

Scenario: The introduction of the framework contract takes the provision of personalised services to a new level and provides greater support to budget holders through ISFs. What else should be done to support people with care and support needs to use their budgets creatively, safely and effectively?

This question was not discussed at the workshop because the group allocated this responsibility decided to concentrate on another topic.

Provider development: What do you think the priority areas for support are likely to be and how can we meet them in a cost effective way?

Scenario: Whilst some support was given to providers to enable them to develop their proposals for personalised services and working with budget holders we recognise that continuing support will be required. What form should this take?

The providers in the group expressed the need for data monitoring/sharing so they could deliver services which were more responsive. It was felt that commissioners did not always share sufficient information about service user requirements and that outgoing providers (when a new contract is won) rarely shared information. It was not clear whether this lack of information was due to deliberate withholding, or poor monitoring. Participants felt that much provider development hinged on the establishments of strong collaborative relationships between commissioners and providers and also between providers and providers.

Provider-provider collaboration: What are the main areas in which collaboration should be encouraged and what are the best ways of encouraging providers to take part?

Scenario: Enabling providers to collaborate in both mini tendering and in the development of services and staff skills is a highly attractive proposition, how can we support it?

Participants felt that providers offering complementary services could collaborate and partner better than those in direct competition. Overall, it was felt that social care needed to partner outside of its field in recognition that wellbeing was holistic and grounded in people being supported to be active members of society (it was suggested that local points of information- such as libraries and doctors surgery's could be used to reach out to or deliver some services to people).

It was suggested that some third sector organisations would be unlikely to "tender for contracts" and be recognised as a "provider," even when they may deliver services, because contracts are perceived as funding with a limited lifespan which can impact negatively on their business planning. It was also argued that third sector organisations are sometimes unwilling to partner with public sector bodies because they are resistant to inheriting the bureaucracy that accompanies this work.

This hinges on trust. More events and opportunities to engage and network with market players in localities could help to overcome this.

Currently commissioning relationships happen on a need-to-know basis. This was not necessarily seen as a negative - in the experiences of the participants present, the best relationships were those where both parties benefitted. They would be resentful of having to form partnerships just on principle as relationship building required a lot of energy.

The importance of strategic partnerships was emphasised. These partnerships could be used to overcome skills gaps, or to pool resources to access training for example (thus reducing overall overhead costs for all partners)

Decommissioning – What issues will decommissioning raise and how should they best be managed?

Scenario: One of our previous block contracted providers was not successful in tendering for the framework contract. Its block contract is due to terminate in 12 months time – how should we manage this?

The main concerns for commissioners regarded double funding and getting providers (incoming and outgoing) to be cooperative during the transition period. It was felt that minimum cooperation happens at the moment and that this needed to be enhanced so that people using services didn't suffer.

Outgoing providers should be supported and signposted to further training, as well as being given clear information about the grounds on which they are losing the contract. Commissioners should be intelligent and take responsibility for developing a sustainable market, therefore being supportive to outgoing providers, not just diagnostic.

Some providers expressed concern that if they lose a contract it demoralises their workforce. Clear communication with the workforce was felt to be vital (not just management at provider level). Related to this, commissioners and providers wanted to know how far their obligations went – for example in relation to employment law?

Changing commissioning role – How would you describe the change in role in terms of: tasks that are no longer required; existing tasks that must be performed differently; and new tasks?

Scenario: Whilst commissioners are aware that the framework approach means they are less involved in block contracting and its management and re-provision many are unclear about what their role will look like as the framework agreements gets up and running.

Some people thought the commissioning role was to anticipate and outline problems early - this meant communicating concerns about logistics, and insurance with providers. It was felt that commissioners should do more to prepare providers for personalisation.

Commissioners should take the lead in bringing together partners across sectors and services for example via hosting provider-provider collaborations/forums. Some smaller providers and third sector organisations felt commissioners should help with providing "admin" hubs to consortia of providers and help in pooling knowledge and resources (third sector did not always have capacity to do this). This is not the norm at the moment.

The commissioning role must change and breakdown the perception of a conflict between inhouse vs. outside providers. All service delivery had to be acknowledged as the same in order for it to be quality assured in an impartial and fair manner.

Commissioners need to work with a wide range of stakeholders who cross their regional boundaries, sectors and service areas.