Home care fees: consultation and analysis for Cheshire East Council

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FINAL version v0.05

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Contents

Brief for project

RedQuadrant was commissioned by Cheshire East Council in May to make recommendations for future fee levels. Specifically we were asked

1. To carry out an independent review of fair price for care Domiciliary Care within the borough of Cheshire East and comparator authorities from Cheshire East's CIPFA family group- the "market analysis". This includes:

    a. Analysis of out of borough services for ad hoc commissioning.

    b. Review of fee sustainability in the Domiciliary Care sector during the likely term of the new agreement including an analysis of Fair Price for Care requirements and the implications of implementing the Unison Ethical Care Charter

2. To develop for consideration by the Council appropriate and fair prices for care and support fees that take account of the principles of the Care and Support and Aftercare (Choice of Accommodation) Regulations 2014 whether or not they are expressly applicable and which has regard to the Council's financial position so far as is reasonable, based on the work undertaken with care home and domiciliary care service providers and the intelligence gained during the market analysis.

3. To offer suggestions as to how to sustainably grow the market in areas where there is a current shortage of choice and provision.

4. To offer market analysis, position statement, review of fee levels and advice on the following areas:

    - Direct Payments (taking account of new pension responsibilities from April 2015)
    - Fee structures for Extra Care, Respite, other supplementary commissioned services including Shared Lives and Rapid Response Domiciliary Care
    - Setting Rates for Individual Personal Budgets for full-cost payers who wish to access a Care Account
    - Telecare banded service costs – to include a review of the free community alarm service for those aged over 85
    - A review of the impact of mandating payment of the Living Wage and the payment of travel time on fee levels and it's consequence on capacity and sustainability in the market

Purpose of this report

We have undertaken the following activities in relation to this project

- Interviewed a range of stakeholders from the Council, CCG and others
- Reviewed performance data, policy papers and other documentation
- Undertaken two workshops with local care home providers (see Appendix one)
- Prepared draft recommendations on which we have consulted with providers

- Reviewed feedback from providers (nine providers gave feedback – Rossendale, Alternative Futures, AbleWell Care, Intercare, Archangel, Eden Care, HCSS, Sure Care, Tracey Ault)

This report is our final report which summarises our findings and makes recommendations for future fee levels. The revised recommendations are now somewhat different from the draft recommendations as we have taken account of the feedback received about the local cost of care

Context

When setting fees for care home providers the Council is required to follow legislation and to take account of relevant guidance and case law. The requirements in relation to other types of care have, traditionally been far less prescriptive. However the Care Act 2014 strengthens the general duties on local authorities when setting fees. Relevant features of the Act include:

- Section 1 of the 2014 Act places a general duty on local authorities (when exercising their functions under the Act) to promote an individual's well-being. This includes the promotion of the suitability of living accommodation. The Guidance refers to this duty as 'the well-being principle' (see Chapter 1 of the Statutory Guidance).

- Section 5(1) of the 2014 Act places an obligation on local authorities to:
  "(1) ...promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market –
  (a) has a variety of providers to choose from who (taken together) provide a variety of services;
  (b) has a variety of high quality services to choose from;
  (c) has sufficient information to make an informed decision about how to meet the needs in question."

- In performing its duty under section 5(1), section 5(2) of the 2014 Act requires a local authority to have regard to a number of matters, including:

  "(b) the need to ensure that it is aware of current and likely future demand for such services and to consider how providers might meet that demand;
  ...
  (d) *the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not);"*

- Section 5(3) of the 2014 Act provides that:

  "(3) In having regard to the matters mentioned in subsection (2)(b), a local authority must also have regard to the need to ensure that sufficient services are available for meeting the needs for care and support of adults in its area and the needs for support of carers in its area."

- Chapter 4 of the Guidance states:

  "High-quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this, both through the actions it takes to directly commission services to meet needs, and the broader understanding and interactions it facilitates with the wider market, for the benefit of all local people and communities." (paragraph 4.1)

  "Market shaping means the local authority collaborating closely with other relevant partners..." (paragraph 4.6)

  *"Local authorities **must** facilitate markets that offer a diverse range of high-quality and appropriate services. In doing so, they must have regard to ensuring the continuous improvement of those services and encouraging a workforce which effectively underpins the market. The quality of services provided and the workforce providing them can have a significant effect on the wellbeing of people receiving care and support, and that of carers, and it is important to establish agreed understandable and clear criteria for quality and to ensure they are met."* (paragraph 4.21)

  *"People working in the care sector play a central role in providing high quality services. Local authorities **must** consider how to help foster, enhance and appropriately incentivise this vital workforce to underpin effective, high quality services."* (paragraph 4.28)

  "When commissioning services, local authorities should assure themselves and have evidence that service providers deliver services through staff remunerated so as to retain an effective workforce. Remuneration must be at least sufficient to comply with the national minimum wage legislation for hourly pay or equivalent salary." (paragraph 4.30)

  *"When commissioning services, local authorities should assure themselves and have evidence that contract terms, conditions and **fee levels** for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support, and allow for the service provider ability to meet statutory obligations to pay at least the national minimum wage and provide effective training and development of staff. It should also allow retention of staff commensurate with delivering services to the agreed quality, and encourage innovation and improvement."* [Emphasis added] (paragraph 4.31)

  "Local authorities should understand the business environment of the providers offering services in their area and seek to work with providers facing challenges and understand their risks." (paragraph 4.34)

  *"Local authorities **must not** undertake any actions which may threaten the sustainability of the market as a whole, that is, the pool of providers able to deliver services of an*

appropriate quality – for example, by setting fee levels below an amount which is not sustainable for provider in the long-term." (paragraph 4.35)

"The personal budget is defined as the cost to the local authority of meeting the person's needs which the local authority chooses or it required to meet. However, the local authority should take into consideration cases or circumstances where this 'cost to the local authority' may need to be adjusted to ensure that needs are met. For example, a person may have specific dietary requirements that can only be me in specific settings. ***In all cases the local authority must have regard to the actual cost of good quality care*** *in deciding the personal budget to ensure that the amount is one that reflects local market conditions. This should also reflect other factors such as the person's circumstances and the availability of provision."* [Emphasis added] (Annex A: Choice of accommodation and additional payments, paragraph 11)

Thus there is an expectation that fees set by councils for all types of care should take account both of the actual cost of good quality care and the need to ensure a diverse array of local provision. Furthermore, it is clear from the brief for this project that the expectation of the Council is that fees need to be set at such a level as to allow providers to recover reasonable costs. We have focused on understanding costs and the broader market in our approach below

Benchmarking and Comparisons

CIPFA Nearest Neighbours Comparator Group

The benchmarking exercise has been performed against the local authorities defined by CIPFA as the closest socio-economic group, taking into account such factors as population, age, unemployment and council tax bandings. The group of fifteen comparator authorities is defined as follows:

1. Cheshire West and Chester
2. Wiltshire
3. Shropshire
4. Bath and North East Somerset
5. Herefordshire
6. Solihull
7. Central Bedfordshire
8. Stockport
9. North Somerset
10. East Riding of Yorkshire
11. York
12. Bedford
13. Poole
14. Warrington
15. South Gloucestershire

Demographics

As population is one of the key drivers behind the number of people receiving social care, the population of each of the authorities was taken into account when undertaking all analysis. Using the most recent detailed data (mid 2013 estimates) from the Office of National Statistics (ONS) all data could be expressed in terms of cost or activity per population. Cheshire East is estimated to have a population of 372,707 including 219,742 adults (18-64 age bracket) and 78,035 older people (65 and over).

PSSEX Benchmarking Outcomes

Using 2013/14 PSSEX data from the Health and Social Care Information Centre (HSCIC) we were able to benchmark key data for Cheshire East against their nearest neighbour authorities, as defined by the CIPFA nearest neighbours model. The outcomes of this analysis should not be used in isolation as average figures could be significantly impacted upon should an authority have submitted inaccurate data. Additionally, the data is already over one year out of date, and therefore authorities may have very different data for the last twelve months.

The information below analyses the information at a weekly and aggregate package of care level, it is not possible from the PSSEX information to extract the comparative hourly rates. Utilising the benchmarked average unit costs, weekly average packages of care and the averages per head of population it is possible to determine the shape of the Council's care levels. All data was based on the gross cost and activity.

Home Care

1. Home care average weekly costs for older people were 13% above peers, though with activity 41.2% lower; gross costs were also 32.1% lower than expected.
2. Due to higher than average activity (26.5%) and higher than average weekly costs (38.3%), gross costs for learning disabilities were 111.7% higher than peer group.
3. Though activity was only marginally below average for mental health clients, average weekly costs were at £526.61, 138.3% higher than peers, thus increasing gross costs by 144.2%.
4. As with all home care client groups, physical disabilities had a higher than average weekly cost by 21.6%. Activity was, at 57.5%, just over half that of the comparator group.

Direct Payments

- Direct payments for older people were 53.8% higher in terms of weekly cost. Activity was also higher by 14.5%, resulting in gross costs 99.9% higher than peers.
- Learning disabilities activity was only 12.1% higher than comparator group though the weekly costs were also higher by 18.1% giving rise to gross costs 35.9% higher than the group.
- Average weekly costs of £92.21 were 24.4% lower than the comparator group for mental health, though as activity was 43.6% higher, gross costs were 98.6% higher than comparator group.
- Physical disabilities had lower than average activity (26.8%) as well as weekly costs (12.3%), thus resulting in gross costs being 34.6% lower than expected for the population size.

(Note the above analysis utilises the weekly packages of care, they do not determine or indicate comparative information about the individual unit (hourly) rates paid by the Council).

Bottom Up costing

Home care costs

As part of our review we have again carried out a 'bottom up' costing exercise for domiciliary care fees. We have used assumptions from within the UKHCA[1] model as a basis for some of the support costs methodology as outlined below. In addition we have relied on our professional judgement and experience, and wherever possible, used regional benchmarking data to enable us to the set costs at an appropriate level.

- Unison Ethical Care Charter: the Unison Ethical Care Charter[2] was launched in 2013 and is an attempt "to establish a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which a) do not routinely short-change clients and b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels."

  There are a number of components to the Charter including

  - The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients
  - The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients. Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones
  - Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time
  - Those homecare workers who are eligible must be paid statutory sick pay
  - Zero hour contracts will not be used in place of permanent contracts
  - All homecare workers will be paid at least the UK Living Wage
  - All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.

  We have followed these assumptions in our calculations below, unless otherwise stated

- Staff Salary Costs: NMDS-SC indicates that domiciliary care staff are paid an average of £7.18, compared to currently vacancies within the Cheshire East area which indicated hourly rates of between £6.70 and £7.90. It is not however known what level of experience will fall into this level of pay. We have therefore modelled the rates based on £7.20 per hour as this lies near the midpoint of current advertised roles and equates to the new national living wage (NLW)[3] of £7.20 per hour from April 2016. We have also modelled costs in relation to

[1] 'United Kingdom Homecare Association Limited – A Minimum Price for Homecare' version 3.0, July 2015
[2] https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220142.pdf
[3] 2015 budget announced new national living wage with effect from April 2016.

the current UK Living Wage (UKLW)(£7.85 per hour in 2015/16), assumed to be uplifted by 1% in April 2016 and 2% in April 2017

- Other Staffing Assumptions: The National Insurance (NI) rate has been applied at 9.5% across the board as there will be variations between full time and part time staff which will impact on the differing levels of NI payable. In the consultation version of this report we used 7% but after provider feedback have uplifted this to the figure used in the UKHCA report

A pension contribution of 1% has been applied to account for the current minimum employer contribution, which is consistent with UKHCA recommendations. National minimum employer pension contributions will increase in future years to 2% from October 2016 and 3% from October 2017, and this is taken account of in the proposed rates for 2016/17 and 2017/18.

A 'timeout' allowance of 13.6% has been applied which comprises of 28 days annual leave, 5 days sickness and 2.5 training days. This is virtually identical (0.2% lower) than the UKHCA recommendation. We have not priced an occupational sickness scheme as this is not included in the UKHCA recommendations

- Mileage Costs: An allowance of 2 miles per hour of contracted time has been allocated to the hourly fee, which is consistent with the assumptions made in a similar exercise in 2012 but less than the UKHCA assumption of 4 miles per hour of contracted time. Several providers challenged us on this point, pointing out that some journeys undertaken by carers take much longer than this: however our rationale for this is that we have been asked to set one rate to cover both rural and urban locations and this must imply an average weighting to each area of cost

- Travel Time: There will be an element of non-productive time due to staff members travelling between clients. We have used the UKHCA recommendation of 11.4 minutes for every hour which is consistent with the assumptions made in a similar exercise in 2012 (7.5 for urban locations and 15 minutes for rural locations) and assumed that this will be paid for. Our rationale for this is that we have been asked to set one rate to cover both rural and urban locations.

- Staff Support Costs: The UKHCA model assumes staff support costs totalling 27% of the total price until April 2016 and 25.5% thereafter. This budget line is assumed to include the following costs:

    - Branch staff: Registered manager, supervisors, coordinators, finance and admin staff, quality assurance costs;
    - Office costs: Rent, rates, maintenance, water, lighting and heating, insurance, cleaning and equipment hire;
    - Training etc: Induction training, external training and qualifications;

- Recruitment: Recruitment advertising, criminal record disclosures;
- IT equipment: Computer systems, telephones, electronic call monitoring; Marketing: Advertising and marketing;
- Consumables: Uniforms, personal protective equipment;
- Finance: Bank charges, interest, depreciation.
- Print and postage: Printing, postage, stationery;
- Business travel: Fuel, tax, insurance, vehicle leasing, repairs, mileage, accommodation and subsistence;
- Legal/professional: Legal, professional accountancy, registration fees;
- General: Donations, subscriptions, translation services, general expense

The UKHCA figures seem extremely high in our view. We initially applied a rate of 17%, which we believe to be more realistic for costs across all client groups: this was based on our previous experience of commissioning care services and the views expressed by commissioners of what margin they would expect to see in tendering exercises.

This area was one of the main subjects of contention in the consultation process. Many providers argued that costs in these areas had gone up considerably since the last fee increase and there were increased requirements in this area (eg the Care Certificate) that resulted in higher costs. There does seem little doubt that there are genuine cost pressures in this area. Indeed one provider quoted a KPMG cost of care exercise in Birmingham that, apparently, showed:

- "The average business costs for supported living are 31%, the median is higher.
- The average business costs for dom care is 27% - bang on the UKHCA recommendations!"

We have applied a rate of 22% in our revised model. Together with a profit margin of 3% this results in 25% of the proposed fee being paid in indirect costs. although there is evidence that actual costs are about this proportion we still consider this rate to be uncomfortably high. We suggest that an open tendering exercise would produce a lower rate in this area

- Profit Margin: A margin of 3% has been applied which is suggested by the UKHCA.

- Bottom up home care costs 15/16: The figures above result in a bottom-up cost of home care of £15.28 per hour (=25.5p per minute) for 2015/16. The impact of paying UKLW is to increase this cost to £16.57 per hour

- Bottom up home care costs 16/17: As the 15/16 figure is based on a £7.20 hourly pay rate for home care and this is the level at which the NLW for 2016/17 is set we have used this figure as the basis for the 16/17 costs also. With the impact of pension increases we calculate £15.32 as the cost for 16/17. The impact of paying UKLW is to increase this cost to £16.80 per hour

- Bottom up home care costs 17/18: we estimate that the NLW will increase to £7.65 in 2017/18; previously we had modelled costs based on only 75% of staff being over 25 and thus entitled to NLW but this was felt to be invidious, impossible to implement in practice and inconsistent with the Council's own approach to employees. Using NLW for all employees leads to a fee rate of £16.38 for 2017/18. The impact of paying UKLW is to increase this cost to £17.27 for 2017/18

- Impact of bottom-up costs: At present Cheshire East are using a 15 minute fee structure for all domiciliary care. There are also two sets of fees for the east and south of the Borough. For the future the authority intends to use a standard hourly rate which will be pro- rataed to reflect the time of the appointment. Current rates are set out below as is the impact of setting fees using the bottom-up costs and one standard rate

Appointment time	South Rate per call	East Rate per call	Blended E/W Rate per Call	Bottom-up calculation	Diff bottom-up/blended	Diff bottom-up/East	Diff bottom-up/South
15 minutes	£5.52	£5.77	£5.63	£3.83	-32%	-34%	-31%
30 minutes	£7.67	£8.03	£7.82	£7.66	-2%	-5%	0%
45 minutes	£9.92	£11.41	£10.67	£11.49	8%	1%	16%
60 minutes	£11.22	£12.55	£11.97	£15.32	28%	22%	37%

- 2015/16 costs and fees: The bottom-up figures above are based on one rate being set across the Borough with no differential rates for 15, 30, 45 and 60 minute calls. This approach will bring greater clarity both for providers and commissioners. However, in practice implementing this rate would require considerable changes to current arrangements and it is unlikely that these changes can be implemented this financial year. Thus there is a question as to whether any increase should be offered for this financial year. The table above shows that bottom-up costs are significantly less than the rates paid for 15 minute calls, slightly less than the rates paid for 30 minute calls in the south and considerably more than the rate for 45 minute calls in the south and all 60 minute calls. The decision on whether an increase should be offered thus depends on the ratio of 15, 30, 45 and 60 minute calls amongst providers: this will vary considerably amongst providers thus meaning that a fair overall increase is impossible to calculate. However as there has been a decision to no longer commission 15 minute calls this discrepancy should disappear over time as presumably these are then re-provided as 30 minute calls. The impact of this change on the fees paid to providers for 15 and 30 minute calls was greater in the consultation version of this proposal and attracted negative comment from providers but the figures above, effectively show a very modest impact on one call category and considerable increases in other categories

Direct Payments

We have calculated Direct Payment costs in two different ways:

1. We have used the same methods for building up costs as detailed above for domiciliary care. However we have not included travel time and mileage costs – arguably these should not be considered in the DP calculation. Furthermore where Direct Payments are used to purchase personal assistants there should be less need for support cost overheads so we have reduced these to 5% to cover insurance. There should also be no need for profit margin when employing Pas. Where Direct Payments are used to purchase care via an agency it is reasonable for the agency to expect a similar contribution towards overhead costs and margin – we have modelled this at 25% as with commissioned home care
2. We have done the same calculation as in 1 but we have based the pay costs on the UKLW of £7.93 per hour (£7.85 plus 1%) for 16/17 and £8.09 (plus 2%) for 17/18

The impact of these two different methods is shown below

Method 1	2015/16	2016/17	2017/18
DP agency rate	£12.05	£12.11	£12.98
DP PA rate	£9.82	£9.87	£10.58
Method 2			
DP agency rate	£13.14	£13.33	£13.72
DP PA rate	£10.37	£10.53	£11.19

Both methods can be defended: method two has the advantage of allowing care workers to be paid more than NLW.

It could, however also be argued that the DP agency rate should be set at the rate for commissioned home care as otherwise there is no incentive for providers to provide care in this way

Supported living

At present the same rates are used for home care (which we are defining here as episodic care being provided to people living in their own home, usually to older people and typically non-intensive) and supported living (which we are defining here as continuous/near continuous care being provided to people living in supported living arrangements, usually to adults with learning disabilities and typically intensive). Using the same cost-bases for both types of service cannot be defended when the home care rate is set as above, because the home care costs includes a substantial component of cost for travel time and mileage which obviously do not apply in supported living settings. Effectively the supported living and DP rates thus should be the same on this argument. One provider argued that

"Your report has not taken into account that Customers requiring round the clock support are more complex and therefore more likely to require the intervention of Senior Branch Staff. These staff will be in addition to the rostered staff member/s already supporting the Customer, and are an extra cost with no additional revenue available for the intervention they provide."

The point of course does not take account of the areas where indirect costs might be lower eg the rostering and co-ordination of peripatetic home care workers is more complex than for workers in supported living. The same provider reported the KPMG cost of care exercise in Birmingham as showing 31% of costs in complex placements were indirect, implying that 34% of the fee should go on indirect costs. We think (based on our experience of commissioning supported living in a variety

of settings) that this is a very high ratio of indirect costs, that a tendered pricing exercise would result in providers quoting at below this rate and thus to expect the Council to pay this level is not reasonable. Thus we recommend continuing to price supported living based on a 25% indirect costs ratio

Sleep-ins

The council currently pays £45.44 per night for sleep-ins, equivalent to £5.05 per hour assuming a 9 hour shift.

There were two legal cases in relation to sleep-ins in 2014 which changed practice in this area. Their impact was summarised by PinsentMasons as follows:

> "…the legal position [now]seems fairly settled – for a sleep-in shift of this type, the entire shift will count as working time for NMW [National Minimum Wage] purposes.
>
> How does this fit with the practice of paying a fixed fee for sleep-in shifts? The simple answer is that it doesn't (subject to the point set out below). It therefore remains to be seen whether employers in the care sector continue to flout the law and hope for the best, or whether they will start to pay in line with NMW. If the latter, the big question is this: who will dare to jump first? It is worth stressing that the above cases do not necessarily mean that employers will have to pay sleep-in shifts at NMW rate. What they mean is that the time spent on a sleep-in shift will count as working time for the purposes of the NMW calculation"[4]

Thus a set rate for sleep-ins that is below the minimum wage is only applicable if the workers undertaking the sleep-in are earning enough above the minimum wage to take their total income to above minimum wage for the payment period

It seems likely that many people undertaking sleep-ins will be paid at or near minimum wage , particularly from April 2016: thus the seems little alternative to increasing sleep-in rates to NMW/NLW levels in this scenario (plus associated NI and leave costs), although the rate could be maintained at the present level for people doing sleep-ins who earn more than this

Comparison of fee levels with other authorities

We have attempted to compare current fees paid by Cheshire East with those paid by others. All of the comparator authorities in the CIPFA comparator group were contacted in order to establish their current fees. In addition to this three further local authorities – Flintshire, Denbighshire and Wrexham - were also included to ensure that the comparison size included neighbouring authorities. To date we have gained the fees from nine of the eighteen identified authorities. Where authorities had a range of rates for one particular area, an average rate has been used in the analysis. In some cases there are no fees noted as they may vary between clients/providers. The results are discussed below by client group.

[4] http://www.pinsentmasons.com/ELP/The%20rising%20costs%20of%20a%20quiet%20'sleep-in'.pdf

Domiciliary Care

The table below shows the costs paid for domiciliary care by comparator authorities:

Council	Older People	Learning Disabilities	Physical Disabilities	Mental Health
Cheshire East	£11.97 - 60 min £10.52 - 45 min £7.82 - 30 min £5.63 - 15 min			
Wiltshire	Commission outcomes not hours	£13.00 to £23.78	£13.00 to £23.78 per hour	£15.00
Poole	£14.28	£14.00	£14.28	£14.28
Warrington	£11.37 - 60 min £11.68 – 45 min £12.18 – 30 min £19.76 – 15 min			
Herefordshire	£13.98			
Flintshire	£14.78 - 60 min £11.09 - 45 min £9.82 - 30 min			
East Riding	Average £14.28 (provider prices used), with an additional cost of £0 - £10 per hour for rural locations			
Bedford Borough	£14.70 (average) for home care			
South Gloucestershire	Home care varies according to provider from £14.16 to £21.04 per hour. If a domiciliary care package is particularly hard to place, we may offer an enhanced hourly rate. Sleep ins vary according to provider.			
Central Bedfordshire	Home care varies according to provider from £11.75 to £19.00 per hour.			

Cheshire East are not the only authority to be currently paying fees on 15 minute blocks, with Warrington and Flintshire also doing so. Compared to those authorities who pay on an hourly rate the Cheshire East fee is lower than its peers, with the closest hourly rate being £13.00, which is 8.6% higher than Cheshire East. The majority of respondents have hourly rates within the range of £14-£15.

Direct Payments

Council	Direct Payments Hourly Rate			
	Older People	Learning Disabilities	Physical Disabilities	Mental Health
Cheshire East	£12.55	£12.55	£12.55	£12.55
Wiltshire	Range from £15.32-£17.22	£16.06 per hour	£16.06 per hour	£16.06 per hour

Poole	£14.28	£14.28	£14.28	£14.28
Warrington	£10.61			
Herefordshire	If Direct Payment for Domiciliary Care then based on standard rate, otherwise on need.			
Flintshire	Variable by negotiation			
East Riding	The usual rate for 2014/15 was £11.00 per hour but this is increased high needs.			
Bedford	Between £10.13 and £12.53 per hour.			
South Gloucestershire	£17.80	£17.80	£17.80	£17.80
Central Bedfordshire	£14.10	£14.10	£14.10	£14.10

Personal Assistants

Council	Personal Assistants			
	Older People	Learning Disabilities	Physical Disabilities	Mental Health
Cheshire East	£12.55	£12.55	£12.55	£12.55
Wiltshire	£11.84 - £13.65	£11.84 - £13.65	£11.84 - £13.65	£11.84 - £13.65
Poole	n/a			
Warrington	n/a			
Herefordshire	n/a			
Flintshire	FCC provides £10.56 per hour for people to employ PA's. Includes employment on costs.			
East Riding	n/a			
Bedford	£7.50 per hour (payable to the PA)			
South Gloucestershire	£11	£11	£11	£11
Central Bedfordshire	£7.89 ph (payable to the PA)			

Outcome based commissioning

Outcome-based commissioning is widely regarded as an important aspect of the personalisation agenda (see Appendix 2 for more information). Commissioning on the basis of individual outcomes, rather than placements, shifts the emphasis away from systems and processes, and onto the quality of the service and the impact on the SU. It focuses on reducing the care needs of SUs, improving their quality of life and maximising their independence.

With growing pressure on adult social care resources, the goal of promoting efficient, outcome-focused services has never been more important. As the Care Act introduces market shaping and commissioning responsibilities, and a greater focus on outcomes within assessments, the use of outcomes based commissioning has considerable merit.

Benefits of an outcome based commissioning model

The benefits of an outcome based commissioning model are:

1. It is person-centred and focuses on the outcomes that service users (SUs) say matter most to them.
2. It maximises SUs capabilities, delaying or reducing the need for services, and promoting their independence.
3. It empowers SUs to have choice and control in their lives and over their care and support.
4. It minimises costs by reducing the long term needs of SUs.
5. It reduces waste and helps to improve the financial efficiency of the service.
6. It holds providers directly to account for the service they provide.
7. It maximises SUs support within their communities from family, friends and community and voluntary sector providers.
8. It incentivises providers:
    - to look at the most efficient and effective way of delivering what the SU needs, which may include community and voluntary sector providers or other services;
    - not to create dependency; and
    - to invest in their staff who will need support and training to work in a way in which they enable SUs to achieve the outcomes they have identified that they want to achieve.
9. It supports providers to pay care workers (CWs) at least the UKLW and guaranteed hours contracts because they have agreed volumes of work in a geographical area.
10. Providers have a geographical area in which they provide services to all the SUs so they can make economies of scale, and reduce CWs travelling time between SUs. This makes the work more attractive to CWs.
11. It supports collaborative working and sharing between providers, because they are not in competition with each other for SUs or for CWs.
12. Having one provider for both re-ablement support and home care services would improve the continuity of care for SUs and reduce administrative costs and information sharing issues.
13. It is consistent with the increased focus on outcomes and payment by results/use of tariffs within the NHS.
14. It is consistent with the national policy drive towards payment by results as seen in a number of major policy areas (e.g. substance misuse treatment, offender rehabilitation, employment services).

Consultation with Domiciliary Care Providers

The Council has 90 domiciliary care providers on its list of providers, and commissions 70 to provide domiciliary care for approximately 1,150 people.

Domiciliary care provider feedback from the workshops

We held two workshops with domiciliary care providers. They were attended by 27 representatives from 21 domiciliary care provider organisations. These were: Care Connect, SureCare Cheshire East, Intercare Services, Valleywood Care, You Like Your Way, Alice Chilton In-Home Care Services Ltd,

Care Needs Ltd, Kare Plus, Cheshire and Staffordshire Homecare Ltd, Quality Care (Staffordshire) Ltd, Lantern Care Services Crewe, AR1 Homecare, Insafehands, Lady Verdin Trust, Evolving Care Ltd, Embrace Group, Homecare4u, Salopian Care, Spiritual Inspiration Ltd, SOS Homecare Ltd and Lantern Care Services (see Appendix 2 for detailed feedback).

Workshop One was attended by representatives from Care Connect, SureCare Cheshire East, Intercare Services, Valleywood Care, You Like Your Way, Alice Chilton In-Home Care Services Ltd, Care Needs Ltd, and Kare Plus.
The key issues raised by members of the workshop were:

- Recruitment and retention is very difficult, because of the salary levels they pay to domiciliary care workers. This is compounded when they do not pay travel time between calls;
- Providers risk having to hand work back to the Council because they cannot recruit staff to do it;
- They have cost pressures;
- Provider forums are not held regularly and are poorly attended; they suggested that they could be improved by allowing providers to put forward agenda items, and having senior Council staff attend;
- They are paid two different rates, depending on the geographical area, which they disagree with;
- It is difficult to get a package of care changed when a service user's needs change;
- Allowing service user's to choose their provider makes it difficult for providers to make economies of scale by caring for a number of service users living near to each other;
- Social workers specifying what time a service user should have, for example, breakfast, makes it difficult for providers to meet the demand at that time – they need to be able to negotiate this with the service user;
- The Council has stopped commissioning 15 minute calls, but these are needed for some tasks, for example, giving eye drops, so it should be the service user's decision;
- There was some interest in outcome based commissioning as a way of dealing with these issues, but some scepticism that it would make any difference; and
- Better crisis management, and planning for the end of reablement would reduce the number of requests for providers to deliver emergency domiciliary care.

Workshop Two was attended by representatives from Cheshire and Staffordshire Homecare Ltd, Quality Care (Staffordshire) Ltd, Lantern Care Services Crewe, AR1 Homecare, Insafehands, Lady Verdin Trust, Evolving Care Ltd, Embrace Group, Homecare4u, Salopian Care, Spiritual Inspiration Ltd, SOS Homecare Ltd and Lantern Care Services.

The key issues raised by members of the workshop were:

- Recruitment and retention – this is not necessarily improved by offering travel time and a higher hourly rate;
- Providers are unable to take work because they cannot recruit the staff to do it;
- It is particularly hard to recruit in rural areas because care staff want to work where they live, and this is not necessarily where the service user is;
- It is hard to recruit staff for palliative care because they are only required for a short period of time for a service user;

- Providers are experiencing cost pressures as a result of the increasing cost of living;
- There has been an increase in the amount of administration involved in running a domiciliary care agency;
- It is difficult to get a package of care changed when a service user's needs change;
- A fixed allowance of time per day does not give providers the flexibility to deal with people whose needs are fluctuating on a daily basis;
- They were positive about outcome based commissioning as a way to deal with the issues they are experiencing, and some had had experience of this in other areas;
- They were concerned that outcome based commissioning may result in the use of fewer domiciliary care providers, but service users who do not want to use the provider delivering domiciliary care in their area can commission their own care from another provider using Direct Payments; and
- The Council pays them promptly which is good.

Conclusions

The issues raised in the two workshops were very similar, with both of them highlighting the difficulty in recruiting and retaining staff when they could obtain higher paid work elsewhere; the cost pressures providers were experiencing as a result of the increasing cost of living; the difficulties involved in getting a package of care changed; and the issues associated with providing a service across a geographical area that is flexible enough to meet service user needs, at a competitive price. Workshop Two included people who had experience of using outcome based commissioning elsewhere and were positive about it. However, Workshop One did not have anyone with any experience of it and was a bit sceptical that a change to outcome based commissioning would help to address the issues they were experiencing. (See Appendix 3 for more information on outcome based commissioning).

Discussion and recommendations for fee levels

Home care, supported living and Direct Payments

The Council needs to take account both of the actual cost of care and the need to retain market diversity when setting home care fees. There are a number of factors to consider

1. Home care average weekly costs for older people are significantly above comparators; this seems to be due to greater commissioning of hours as rates are not out-of-kilter with comparator authorities
2. Direct Payment average weekly costs and activity are both greater than comparators; again this seems to be due to greater commissioning of hours as rates are not out-of-kilter with comparator authorities
3. The current rates are overall probably a little below average compared to comparator authorities although like-for-like comparisons are hard to make
4. There are geographic pockets within the Borough where placements are increasingly difficult to make

5. Providers are claiming a high proportion of cost relating to indirect costs. We believe these costs to be largely genuine but we strongly query a model of provision of care where a third to a quarter of all costs are in back-office and indirect functions rather than directly associated with carer costs
6. the current practice of the Council setting fees based on actual costs of care, combined with the current time and task approach to commissioning care will lead to greatly increased costs in this area in the future: provider costs will continue to increase and there are few incentives currently in the system to reduce the number of hours commissioned

We recommend the following in relation to fees:

1. The Council moves to paying a single rate for home care across the Borough with no east/south split in pricing and no differential rates for 15, 30 and 45 minute packages
2. This will be quite a complex process to implement: we therefore recommend that new arrangements for home care should be introduced from 1st April 2016 and the rate of £15.32 per hour set until 31st March 2017
3. There should be separates rates for personal assistants at £10.53 and other Direct Payments at £13.33 for 2016/17
4. The rates for 2017/18 should be £16.38 for home care, £11.19 for personal assistants and £13.72 for Direct Payments respectively
5. Providers should be allowed the option of proposing higher rates for Direct Payment clients on a case by case basis provided they can give a clear rationale for this and with a ceiling of the home care rate
6. Supported living rates should be £13.33 for 2106/17 and £13.72 for 2017/18; these should be set as ceilings
7. The Council should not increase fees for 2014/15 but should be prepared to listen to arguments from individual providers for fee increases, provided that provider costs are shown on an open-book basis
8. The Council should develop its plans to introduced outcome-based commissioning of home care and include providers in this process
9. The sleep-in rate should be calculated as the NLW hourly rate (plus NI and leave on-costs) multiplied by 9 hours where workers are being paid at NLW levels; the rate should remain the same as at present otherwise

We recommend the following in relation to commissioning:

10. The Council should move towards developing an outcome-based approach to commissioning of home care as soon as possible. The current time and task approach to commissioning will prove very expensive if allowed to continue
11. as part of this approach the Council should tender for a much smaller number of providers to provide home care (with the tender evaluation partly based on price), perhaps on a cost and volume basis as in Wiltshire and perhaps within geographically based localities as is Wiltshire and Cheshire West and Chester
12. Alongside this the Council should strongly promote the use of DPs and. in particular, PAs as an alternative way of meeting care needs. PAs in particular can offer better outcomes

at lower cost and with more money going to the carer; this will require some investment in infrastructure to support PAs and a review of current assessment and placement practices

13. Supported living packages should be retendered on an outcome-focused basis with the aim of reducing the number of commissioned hours where safe and appropriate to do so and with part of the tender evaluation being based on price

Appendix 1: Feedback from consultation with domiciliary care providers

Workshop 1

It was attended by ten domiciliary care providers:

- Richard Wyatt, Littleton Hall Ltd, Care Connect
- Sue Ritchie, SureCare Cheshire East
- Paul Brandrick, SureCare Cheshire East
- Mike Doherty, Intercare Services
- Stuart Coxon, Valleywood Care
- Grace Moffitt, You Like Your Way
- Karen Perry, Alice Chilton In-Home Care Services Ltd
- Andy Wardle, Care Needs Ltd
- Lesley Crowe, Kare Plus
- Jamie Hickson, Kare Plus.

They made the following comments:

- Recruitment is their biggest problem. They risk having to hand work back to the Council because they can't get the staff, because they go to other jobs where they can be paid more. It is especially an issue when they do not pay travel time. It is more of an issue in Crewe, but not in Bury.
- Retention is also a big issue.
- Recruitment and retention are both harder now than 6 yrs ago, even when they pay travel time.
- Current position is unsustainable because providers can't pay staff enough because the Council doesn't give them enough money;
- Some can't bid for work because they have not got staff to do it.
- The skill level drops because good staff leave.
- No collective feedback from the Council from the previous consultation 3 years ago, and they have been unable to get feedback when they have approached the Council individually.
- They don't do whole hours of care they do parts of an hour.
- The length of calls has reduced.
- 1 provider does 1 hour calls only so it doesn't pick up LA work.
- Provider forums not well attended so one provider said they didn't go because it was not well represented by the market.
- Provider forums supposed to be quarterly but they are not held quarterly, and not attended by senior Council people. Providers should be allowed to put forward agenda items.
- Their relationships with care arrangers are ok.
- It is difficult if they need to increase the package of care (POC). They have to contact the duty team because SWs have closed the case. This takes longer and the duty team don't know the case.
- When they get the package increased it is often not reflected in the contract, so they have to push for the money to be backdated.
- They have to wait 3 weeks before an increase will be considered. SWs say they don't increase the POC until they contact them with a decision, but the extra is required earlier.

- This also works the other way when they need to reduce the POC; they email SWs to say need to reduce the POC.
- Short calls are a false economy. 1 provider had done an analysis of it and had wanted to discuss it with the Council but the Council was not interested.
- Paid more in Congleton than Crewe /hr and they don't think it is right.
- SWs define what time they want the call, which makes it hard to provide the call at that time.
- Block contracts assume that the service user is willing to accept the provider /carer on offer. But choice of where to go destroys the provider's ability to manage geographical areas.
- Cheshire West & Cheshire pay the minimum wage + travel time.
- They all need to look at things differently.
- Crisis management, re-ablement and planning for when it ends, and better care would help avoid requests for emergency domiciliary care.
- Council staff changes lead to inconsistent ways of doing things.
- Some cynicism about outcome based commissioning (OBC) – 'is another way to pay them less'.
- Insulting to staff to pay them to do the work and not pay travel time. They need to pay carers more /hour.

Workshop 2

It was attended by 17 domiciliary care providers:

- Clair Scott, Cheshire and Staffordshire Homecare Ltd
- John Mussell, Cheshire and Staffordshire Homecare Ltd
- Paul Ravenscroft, Quality Care (Staffordshire) Ltd
- Kirsty Burns, Lantern Care Services Crewe
- Irene Merricks, AR1 Homecare
- Rachel Wright, Insafehands
- Charlotte Parton, Insafehands
- Chris Yearsley, Lady Verdin Trust
- Carol Vickers, Evolving Care Ltd
- Jenny Payne, Embrace Group
- Ryan Brummitt, Embrace Group
- Stephanie Roberts, Homecare4u
- Heather Haley, Salopian Care
- Tracy Ault, Spiritual Inspiration Ltd
- Richard Jackson, SOS Homecare Ltd
- Chris Atherton, SOS Homecare Ltd
- Moira Mccumskey, Lantern Care Services.

They made the following comments:

- They have recruitment issues. It is not just about salary. They have tried offering £12.00 / hour and still only got four applicants – normally they pay £8.30 / hour.
- Zero based contracts are an issue for some people but others don't want contracts.

- People are not applying for jobs. Low unemployment locally so there is a limited pool of people. All potential staff have been round all the agencies and decided where they want to work.
- Petrol price is an issue, so that people don't want to go out of their own area.
- Providers can't take on more hours because they can't recruit staff.
- In Staffordshire the Council offered better terms and conditions and one provider lost 4 staff to the Council. Providers can't compete with this but it has not happened in Cheshire East.
- There are people on a Council list that they can't provide care for.
- All service users want breakfast at the same time, and providers can't do it.
- Increasing numbers of domiciliary care providers.
- Travel time is an issue.
- For palliative care, and end of life the Council will pay whatever the domiciliary care providers ask for the last 2-3 weeks of life.
- Providers can do as much palliative care as they want – a list of people needing it goes out every day, but staff don't want to go out to rural areas, and staff are only required for short period of time, so it is hard to recruit them.
- Self-funders come from word of mouth.
- Providers charge the same rate for Council funded service users and self-funders. The self-funders ring the Council to check the price before they ring the domiciliary care agency and ask for the same rate.
- Cost pressures – 1 provider pays double time on bank holidays to keep staff but they don't get the money from the Council.
- One said they had spoken to their company solicitor who had said they will be breaking the law if they don't pay travel time.
- When new care agencies open they are using the same group of carers – it is someone deciding to set up on own, whilst others close.
- Schools had stopped doing health and social care courses so young people have not been doing care, and older workers are retiring so there is a staff shortage; colleges /schools have now started to do them again this year.
- Low status of carers – you only hear about nurses pay in the media and not social care pay.
- Perception that care is an easy thing to go into, but when the young people start and see the training and NVQ they have to do when they are people who have already failed academically, it puts them off.
- CQC now use key lines of enquiry (KLOEs) – this has increased workload for providers.
- Care Certificate – it must be obtained within a specified number of weeks, so their practice has to be observed.
- Extra documentation is required for CQC.
- Fees have to cover staff in the office to meet the regulations as well as provide care. The mount of administration has increased significantly.
- The Council has stopped commissioning 15 min calls, but it is needed for some calls, e.g. giving eye drops. Thinks the Council should not take a blanket approach – it should be at the service user's request.
- 15 min calls should be paid proportionally more because of travel time involved, and because two 15 min calls is double the admin of a 30 min call.

- Outcome based commissioning (OBC) would be better because people's needs fluctuate.
- Unless they have pods of carers in different places, it takes longer to travel to rural areas.
- Don't want rural 15 min calls because of travel time and admin costs involved.
- Pay enhanced sleep in rate which is higher than the Council pays – other councils recognise this following legal challenge.
- Travel time has to be counted as part of the minimum wage – HMRC has said so and they are blitzing care companies, asking them to do it.
- One provider had experience of OBC in South Wales – 'it is brilliant': the provider meets the assessor to write the POC, and then the provider can change it, and so long as they deliver the agreed number of hours/week they are all happy. The provider talks to the service user to talk about how they should deliver the hours. The SW is not there, but provisionally accepts it, depending on the discussions with the service user about times, etc.
- Under current arrangements, when the provider meets the service user to talk about delivering the care, and family wants breakfast at a different time to what the service user has agreed with the SW, the provider has to go back to the SW to agree the change. OBC would cut out all that to'ing and fro'ing.
- Once the POC has been in place for 6 weeks, the SW closes the case and the provider has to go back through the duty team if there are any problems or the package needs changing; this takes extra time. They have to wait 2 weeks before get a response. It is difficult to get an assessor. They get paid when the case is assessed and agreed by the SW manager even though they are already providing the extra care. Some others are done within the same day. So the time it takes is variable. If it needs reducing they get an immediate response.
- Current way of being given times to call on the service users is not sensible because their needs vary on a daily basis.
- In Newcastle they are looking at swopping service users into geographical areas, so e.g. if 4 domiciliary care agencies are going to 1 block, they would swop service users so they all go into one.
- Staffordshire say that all the work has to go on the framework first – it can't just be swopped form 1 domiciliary care agency to another.
- In another area they have put proximity to another service user as a criterion for winning the tender.
- With OBC - how would the Council assess whether the outcome has been achieved – in South Wales it is: 'is the SU happy?'
- OBC is better for the service user than task based commissioning and better for the agency – there was no opposition in the room to it.
- There are a lot of providers here so reducing them to approx. six for OBC would mean that a lot will go out of business.
- There is a risk of the price going down to the lowest and company folding.
- Paying in advance would remove the uncertainty about when providers are paid; some LA's pay weekly, monthly, some 3 months in arrears; all were happy with the Council's approach.
- It would need to be transparent and monitored for OBC to work properly.
- It is harder to develop outcomes for older people, easier for LD and MH.
- OBC is good for people with dementia because the care is flexible to meet their need; the flexibility if they are bed bound and need a hoist is not an issue.

- Positive about OBC.
- If a service user doesn't want the provider under OBC they can take a DP; this allows other agencies to exist.
- The Council's rate is low, but they pay promptly which is good.
- For some service users providers wait for payment whilst the SW puts it on the portal.
- The Council can pay a salary enhancement for reablement, etc, which they provide in house and which providers cannot compete with. But the Council has to pay inherited terms and conditions, and also the Council is the provider of last choice for service users who cannot be placed with any other provider.

Appendix 2 Outcome Based Commissioning

Outcomes Based Accountability

Outcomes Based Accountability (OBA) is an approach to planning services and assessing their performance that focuses attention on the results – or outcomes – that the services are intended to achieve. It was developed by Mark Friedman and described in his book, 'Trying Hard Is Not Good Enough', in 2009. OBA is the basis for Outcomes Based Commissioning. The OBA model has been used in the USA and several countries worldwide as a way of structuring planning to improve outcomes for whole populations and for improving services. It is seen as more than a tool for planning effective services. It can become a way of securing strategic and cultural change: moving organisations away from a focus on 'efficiency' and 'process' as the arbiters of value in their services, and towards making better outcomes as the primary purpose of their organisation and its employees.

Key features of OBA include:

- population accountability, which is about improving outcomes for a particular population within a defined geographical area; and
- performance accountability, which is about the performance of a service and improving outcomes for a defined group of service users.

The approach involves:

- The use of simple and clear language;
- The collection and use of relevant data;
- The involvement of stakeholders, including service users and the wider community, in achieving better outcomes; and
- The distinction between accountability for performance of services or programmes on the one hand, and accountability for outcomes among a particular population on the other.

What are Outcomes?

An outcome is 'an impact on quality of life conditions for people or communities'. There are three types of performance measure in OBA:

1. How much did we do? (our traditional pre-occupation)
2. How well did we do it? (important, but not as important as…)
3. Is anyone better off/what difference did we make?

Answering the third question has driven recent work on outcome based commissioning within Adult Social Care (ASC), most notably in Wiltshire Council with its Help to Live at Home Service.

There are two types of outcomes in OBA:

1. Individual outcomes; and
2. Broader community or service level outcomes, in which providers are paid to reduce the number of SUs going into residential care in a year.

Outcomes Based Commissioning

The use of outcomes in local government is developed by Richard Selwyn, in his book, 'Outcomes & Efficiency: Leadership Handbook', 2012. This describes how to implement a new outcomes and efficiency model to build a resilient government organisation that is able to radically and quickly transform. It includes designing the system of services, partners and citizens; implementing a full commissioning model to manage the system; and realising the benefits through dynamic change management.

Outcome-based commissioning is widely regarded as an important aspect of the personalisation agenda. Commissioning on the basis of individual outcomes, rather than outputs, shifts the emphasis away from systems and processes, and onto the quality of the service and the impact on the SU.

Most outcomes have value, both 'soft' (improved SU well-being) and 'hard' (financial). Therefore, investing in them may initially increase expenditure in the short term but deliver subsequent and sustainable larger saving in the medium term. Most outcomes can be realised in the short or at least medium term – often within a year and potentially in time for the next regular care review. If this is implemented well, then the net cost in one budget year should be similar to earlier commissioning budgets. In subsequent years, savings will accumulate and deliver against Council expenditure targets and/or in part, fund more invest to save initiatives in social care, in concert with health partners.

Outcomes Based Commissioning and Payment by Results

The process of paying providers on the basis of the outcomes they achieve is less widely used than outcomes based commissioning. Payment by Results (PbR) can be introduced into new outcomes based frameworks in pre-declared phases, initially monitored and reported in shadow format ("if PbR were already live this would have been your payment"), and ultimately as a major component of payment, allowing a modest guaranteed element to cover basic staff costs. This approach to payment was introduced in Wiltshire in 2012 in the Help to Live at Home Project.

The Care Act: Market Shaping and Commissioning

The Care Act introduces new duties on local authorities to facilitate a vibrant, diverse and sustainable market for high quality care and support in their area, for the benefit of their whole local population, regardless of how the services are funded. The Council's commissioning and procurement practices must take account of these wider 'market shaping' duties. These relate to the market shaping and commissioning section of the regulations and guidance for implementation of part one of the Care Act in 2015/16.

To support these developments, Birmingham University has published, 'Commissioning for Better Outcomes – a Route Map'. This was commissioned by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). The standards are designed to drive improvement, and provide a framework for councils to self-assess their progress against best practice in commissioning and enable them to identify areas for further improvement. It is being piloted by a small number of local authorities and will be rolled out in January 2015.

With the Care Act requiring a greater focus on outcomes within assessments the use of outcomes based commissioning has considerable merit. Many councils are introducing it. However, it requires considerable change to ASC assessment and care planning arrangements, supporting systems, the providers' approaches to delivering care, the expectations of SUs and carers, and the expectations of community and voluntary sector organisations.

Benefits of an Outcomes Based Commissioning Model

The benefits of an outcome based commissioning model are:

1. It is person-centred and focuses on the outcomes that SUs say matter most to them.
2. It maximises SUs capabilities, delaying or reducing the need for services, and promoting their independence.
3. It empowers SUs to have choice and control in their lives and over their care and support.
4. It minimises costs by reducing the long term needs of SUs.
5. It reduces waste, and helps to improve the financial efficiency of the service.
6. It holds providers directly to account for the service they provide.
7. It maximises SUs support within their communities from family, friends and community and voluntary sector providers.
8. It incentivises providers to:
   - look at the most efficient and effective way of delivering what the SU needs - which may include community and voluntary sector providers or other services;
   - not to create dependency; and
   - to invest in their staff who will need support and training to work in a way in which they enable SUs to achieve the outcomes they have identified that they want to achieve.
9. The Council aims to ensure an integrated approach to commissioning health and social care services; this is a fundamental part of the council's vision to become a commissioning authority. A key focus is on achieving positive agreed outcomes with service users that increase their independence and wellbeing.
10. It is consistent with the national policy drive towards payment by results as seen in a number of major policy areas (e.g. substance misuse treatment, offender rehabilitation, employment services).