Development of outcomes-based contracting for out of home care and other human services provision: health and human services summary report

NSW Government

Building a better working world

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Development of Outcomes-Based Contracting for Out-of-Home Care and other Human Services Provision – Health and Human Services summary report

Dear Sir,

I am pleased to provide you with our Report that summarises the content in our earlier report on the development of outcomes-based contracting for Out-of-Home Care (OOHC) and other human services provision in NSW.

Purpose of the report and restrictions on its use

The purpose of our report is limited to the objectives set out in our scope of work agreed 15 May 2015, and additional scope agreed on 10 June 2015 and 14 September 2015, and should not be used for purposes other than providing evidence of best practice in outcome-based contracting that may inform the application of outcome-based contracting for health and human services.

This report may only be relied upon by the NSW Government, pursuant to the terms and conditions outlined in our scope of work. If the NSW Government wishes to provide a third party with copies of the Report, then our prior written consent must be obtained.

EY disclaims all liability to any party other than the NSW Government for all costs, loss, damage and liability that the third party may suffer or incur arising from or relating to or in any way connected with the provision of the report to the third party. The report should be read in its entirety with reference to both the scope and the limitations outlined in this letter and in the report.

Any commercial decisions taken by NSW Government are not within the scope of our duty of care and in making such decisions NSW Government should take into account the limitations of our scope of work and other factors of which NSW Government should be aware from sources other than our work.

Limitations of our work

A number of limitations and constraints have influenced the content of the report. These limitations include:

- Reliance has been placed on publicly available desktop research and data provided by FACS and NSW Treasury, supplemented by consultation and representations made by international practitioners and key stakeholders. These data and representations have not been independently verified or validated by EY. EY does not accept any responsibility or liability for independently verifying any information we have obtained, nor do we make any representation as to the accuracy or completeness of the information.
- The content of the report is, by necessity, limited and qualified to reflect the limited time available to undertake the report, the terms of reference as set out in your Request for

Proposal and agreed in the 'Project Overview', and the reliance being placed on information provided by key stakeholders. The scope of our analysis has been limited by data availability.

Please contact me if you have any questions about the contents of the report.

Yours sincerely

Amanda Evans
Partner

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Executive Summary

This report provides an overview of a range of outcomes-based contracting approaches that have been taken in Australia and internationally. It focuses on employment services, government services for "clients with high needs", and a number of approaches to Out-of-Home Care (OOHC) commissioning, all of which have involved contracting with non-government organisations. The analysis is based on a range of case studies

Key lessons from the case studies include:

- In most countries, contracting for outcomes is still in the early stages of development. Aside from social impact bonds, which are targeted, limited pilots, most human services contracts use a blended payment regime including outputs, and sometimes activities.
- The first step in a commissioning process is to undertake a strategic assessment of the demand, nature of the service, and capabilities of providers. Outcomes-based contracting should not be the only model that is considered - is just one lever available.
- Outcomes should focus on client outcomes to drive service and funding integration around individuals' needs.
- Demand analysis and forecasting is critical to ensure referral, performance and incentive systems are designed to prevent gaming and incentivise performance.
- Measures need to be designed carefully to ensure the right targets and thresholds are set, to account for attribution and provide a counterfactual.
- The most successful systems have a small number of performance measures and manageable reporting requirements.
- There are a wide range of financial and non-financial incentives which commissioners can deploy to drive performance improvement within and around the contracts, but financial incentives can be the most powerful lever. Developing a model that includes competitive tension is one way of imposing financial incentives for performance.
- Outcomes-based contracting needs to be undertaken with due consideration to the maturity of the market – both provider and commissioner capacity and capability.
- Market development requires ongoing engagement with providers, and certainty regarding the long term vision and milestones for service reform.
- In new markets, the emphasis should be investment in collaboration and capacity/capability building, rather than competition.
- Outcomes-based contracts require independent assurance of data quality and submissions, as well as independent evaluation of outcomes.
- Commissioners have a responsibility to actively manage the performance of providers and overall market health: this is a relatively immature function of government in human services.
- Consideration of models to facilitate staff transfer is critical to ensuring service continuity in some contestable health and human services markets, where ongoing staff/client relations are essential for effective outcomes.

1. About this report

1.1 Context and purpose

As governments around the world are seeking to meet growing public expectations and demand for services, at a time when budgets are being squeezed, interest in outcomes-based contracting has grown. The NSW Government is no exception – it has shown significant interest in strategic commissioning approaches in pursuit of better service delivery and efficiency gains.[1] It has also pioneered the first two Social Benefit Bonds used in public service delivery in Australia, both of which are in the child protection policy space.[2]

In this context, Ernst and Young (EY) was engaged by the NSW Government to provide advice on the application of outcomes-based contracting and procurement for out-of-home care (OOHC) services, and provide an evidence base for the application of outcomes-based contracting for other human services in NSW. This report summarises key lessons revealed through that work applicable to outcomes-based contracting for human services in NSW.

1.2 Objectives, Scope and Methodology

The report presents a range of findings in respect of lessons learned from the experience in service system commissioning and outcomes-based contracting in agreed sectors of focus (employment services, delivery of services to people with high support needs, the UK and US health systems, and OOHC)

The project was conducted over a 10 week period, and was primarily desktop research based. However, the work was also informed by:

- interviews with nine OOHC providers and two peak bodies
- interviews with NSW Government staff members
- interviews with international outcomes-based contracting specialists
- interviews with EY sector practitioners, and
- data supplied by the Department of Family and Community Services (FACS) – the Department responsible for OOHC services, and NSW Treasury.

EY conducted a review of agreed national and international case studies of outcome-based contracting, and conducted a qualitative analysis of the current OOHC system in NSW, drawing on global evidence in both the OOHC sector and wider human service areas.

[1] NSW Government *Competition Policy Review: NSW Government Submission* 2014, page 2

[2] These types of bonds are referred to more generically in the report as 'social impact bonds.'

2. Best practice in outcomes-based contracting

2.1 Introduction

This chapter sets out the findings from national and international evidence on best practice in outcomes-based contracting. It provides a framework and definitions for discussing different forms of contracting, and identifies other levers and incentives available to commissioners to improve outcomes. It sets the evidence in the context of global government trends in outcome-based contracting, and draws key lessons for human services commissioning in NSW. It also summarises the relevant lessons from the OOHC case studies.

2.2 Taking an outcomes focus

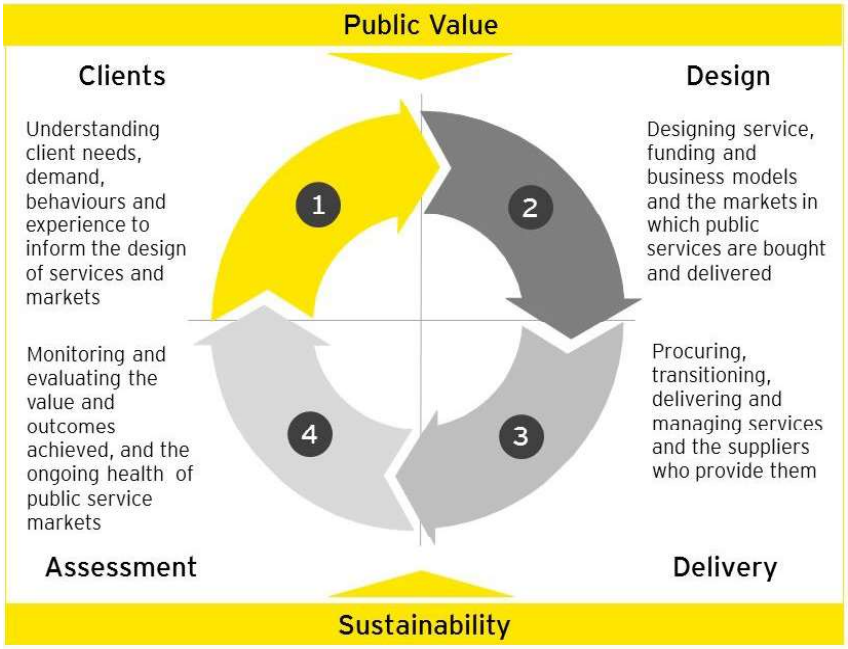
Outcomes-based contracting is just one tool in the broad approach to strategic commissioning of health and human services, and must therefore be deployed in the context of a broad, strategic approach to system and service development. A definition of outcomes-based contracting and commissioning, as well as other related terms, is provided at Appendix C.

The key lessons from the research have been organised around EY's Strategic Commissioning Framework, which sets out at a high level the key components required in developing public sector markets. The lifecycle, as a guide to commissioning services, is divided into four quadrants:

- Client needs: the commissioning of services should place the client or 'user' of the system at the heart of service design and delivery. This requires the commissioner to understand the needs of its clients, the demand for services, and the way overall demand and individual clients will be likely to respond to service provision.
- Defining and designing services: once client need and demand is well understood, the services, funding and commercial approach should be designed around those needs. This includes designing a plan for interacting with markets, and shaping them where appropriate. Service design should consider the respective desired roles of government and providers in current and future delivery. Evaluation, data collection and reporting functions need to be designed at this stage to support future delivery and assessment.
- Delivering services: this activity refers to the engagement, development, procurement, transition, delivery and management of services and the organisations who provide them.
- Assessment: evaluating outcomes achieved by services, including whether value for money is being achieved, is essential to ensure public services are meeting client's needs. Ongoing assessment and evaluation (independent where possible) should inform both future policies and ongoing management of existing services. Ongoing assessment allows for active market management where required – e.g. ensuring providers are financially viable.

These are shown in Figure 2.1 below.

Figure 2.1 - The commissioning lifecycle



'Outcomes-based contracting' can refer to a range of approaches to step 3 in the process – procuring and delivering services (typically from non-government providers). It is often also referred to as 'payment by results' (UK), performance based acquisition (US), payment for success (US) or performance based contracting.

Funding and contractual models of outcomes-based contracts can vary across a number of dimensions, including: the degree to which funding can be linked to inputs, outputs and outcomes or other measures; prospective or retrospective funding; length of contract; scope of contract; purchase model (e.g. broker, individualised entitlements); contractual governance model; and the level of competition pursued. The dimensions of different models are shown in table 2.1 below.

Table 2.1: Dimensions of funding and contractual models

Feature	Description
The degree to which funding is linked	Increments on historical funding; capitation-based funding linked to need-adjusted population serviced; funding for inputs used; funding for outputs delivered; funding for performance measures achieved; funding for intermediate outcomes achieved; funding for final outcomes achieved
Prospective or retrospective funding	Prospective payment fixed; prospective payment varies on past performance; retrospective adjustment to payment in advance for actual performance; retrospective payment in arrears.
Length of contract	Once-off fee for service; short-term; long-term
Scope of contract	Contract for individual service; contract for pathway of services; contract across a number of providers for a range of services (e.g. prime contractor or alliance contract)

Feature	Description
Purchaser of services	Agency on behalf of clients; broker assigned by agency on behalf of client; broker chosen by client on behalf of client; individual clients (using voucher, personal budget or entitlement)
Governance model	Transactional; relational contracting
Level of price competition	Price determined through bids in the market; maximum price set with provider able to make lower bids; fixed prices with bidding based on non-price factors

There is no one model that should be used in all circumstances. As a result, the actual funding and contracting model needs to blend the various features appropriately, based on: the outcome sought; the nature of the client and service; and maturity of the commissioners and provider market. Examples of how this has been done in practice are shown in the fact sheets in Appendix A. While there is no 'off the shelf' outcomes-based contracting model, it will necessarily involve a degree of funding linked to the achievement of outcomes (whether intermediate or final), and a degree of retrospective payment (or some other mechanism for sharing outcome risk).

The framework in Figure 2.2 below provides a spectrum of funding and contracting models that is aligned with NSW Treasury's results and services guidance, and which includes dimensions of various funding and contractual models.[3] The journey from left to right represents the transition path from historic to outcome-based funding, and sets this on a continuum of market and commissioner maturity, defining the key features at each stage of transition. Mapped onto this framework are a range of examples of contracting approaches drawn from the case studies developed during the research phase of this project.

The major lessons from the case studies are then described in the following section.

[3] NSW Treasury *An Agency Guide to Defining Results & Services (TP 06-9)* 2006

Figure 2.2: Funding and Contracting Spectrum

	Block funding	Payment for Inputs	Payment for outputs	Payment for performance	Payment for outcomes
Contract Features	Payment linked to historic funding or needs based population serviced	Payment linked to resources (labour, material, facilities) used to deliver services	Payment linked to end products of services	Payment linked to intermediate outcomes – i.e. short/medium objectives that contribute to longer term objectives	Payment linked to intended impacts of service on clients and the community
	Prospective – to cover input costs	Prospective – to cover costs	Retrospective - payment contingent on achieving certain performance-based outputs	Retrospective – payment contingent on achieving certain performance criteria	Retrospective – payment contingent on achieving outcomes
	Limited clawback KPIs included, but limited measurement requirements and limited mechanisms if not met	Price transparency Some KPIs built into service specification	Price transparency		
	Risk is with provider when payment does not vary with activity or demand	Risk allocated or shared on a demand basis but most likely to be with purchaser paying for varying volumes of input	Risk allocated or shared on a demand basis, e.g. purchaser risk if price varies with volume change	Providers might take more financial risk Shared performance and reputational risk	Significant financial and performance risk transferred to providers Shared reputational risk
	Loose to tight specification of service / activity	Tight specification of activity	Tight specification of results, flexibility to tailor solution	Tight specification of results, greater flexibility to tailor solution	Full flexibility in service provision (subject to minimum standards)
Provider Requirements	Mainly mission-driven NFPs	Mix of NFPs and for profit	Growing mix of providers	Comprehensive mix of providers	Mix of providers: NFPs, for profit, social ventures, partnerships
	Low requirements for commercial capability	Efficiency-driven Financial focus	Performance-driven contracting Greater commercial focus	Performance-driven contracting Strong commercial focus	Impact-driven
Commissioning/ Regulatory Features	Focus on activity/program/ cost	Focus on efficiency	Focus on output performance measurement and efficiency	Focus on performance measures leading to social outcomes	Focus on outcomes and impact
	Low requirements for commercial capability (limited to policy)	Investment in capacity and capability Greater financial capability	Commercial awareness Greater use of payment for output performance to drive behaviour change	High commercial awareness Incentives are used to drive behaviour change	High commercial awareness Deep understanding of market responses and sensitivities Sophisticated use of incentives
	Limited visibility of value for money Limited visibility of impact	Greater visibility of cost	High visibility of cost and performance		High visibility of cost, performance and impact
	Administrative management of payments	Compliance-based contract management	Collaborative contract management		System stewardship
Market Features	Low requirements for competition	Greater consolidation, evidence of supply chains Some cost-based competition	More complex supply chains Potential for price-per-output based competition	Complex and sophisticated supply chains Potential for performance-based competition	Mature, complex supply chains Potential for outcome-based competition
	Independent financial review		Independent review (performance and finance)	Independent regulator and evaluation	
Our understanding of where the case studies fit on the spectrum	Newquay Pathfinder (UK)	OOHC in the UK OOHC NSW (AUS)	Whanau Ora (NZ) Residential care in Illinois (US)	Foster care in Illinois (US) Work Programme (UK) JSA (AUS) Essex Social Impact Bond (UK) OOHC in ACT (AUS) Troubled families (UK) ACT OOHC (AUS) Newquay Pathfinder (UK)	London Homelessness Social Impact Bond (UK) Workforce Investment Act (US) Manchester Social Impact Bond (UK) Transforming rehabilitation (UK) Drug and alcohol recovery pilots (UK) Children's Centres (UK) Benevolent society Social Benefit Bond (AUS) Newpin Social Benefit Bond (AUS)

2.3 Australia and NSW – an increasing emphasis on commissioning, consistent with the global trend

2.3.1 The broad global trend towards outcome-based contracting

Outcomes-based contracting has been developing globally over the last 40 to 50 years – starting with more transactional services (e.g. asset management/maintenance, facilities and other 'back of house' operations) and gradually moving into other public services. Over time, outcomes-based contracting has been introduced in employment services, health and neighbourhood management. Outcomes-based contracting is one of a range of measures that can be taken to drive reforms in public services and should be seen in the context of a broader suite of activities required to create public service markets, often termed 'strategic commissioning'.

Typically, there are a common set of conditions which cause governments to deploy strategic commissioning and outcomes-based contracting approaches in human services. These include:

- Performance failures and inefficiencies in traditional, monopolistic service systems
- Financial imperatives to reduce spending, coupled with the limitations of typical cost reduction strategies which result in cuts to services
- Flexibility in aligning service delivery as outcome measures are updated
- Evidence from other sectors that 'marketisation' works (e.g. competition in prison management in the UK has delivered comparable quality at significantly lower cost in both public and private prisons)[4]
- The potential to drive significant social reform and transform the quality of life for the most vulnerable
- The potential for greater clarity, transparency and accountability for public spending and the creation of public value

2.3.2 Current policy in Australia and NSW

Over the last 30 years, there has been an increasing drive to introduce strategic commissioning into client-facing Australian public services. This drive has followed the more general evolution set out above, beginning with transactional services (e.g. Service First) and employment services (Job Services Australia) initially; and moving to the major reforms currently underway in disability services (NDIS), aged care (introduction of Consumer Directed Care), and health services (e.g. Primary Healthcare Networks).

In the 2015 Competition Policy Review, Harper et al. specifically commented on the applicability of strategic commissioning to the human services sector. One of a number of Harper's recommendations is that user choice should be placed at the centre of service delivery, noting that "governments commissioning human services should do so… with a clear focus on outcomes."[5] In parallel, the recent Review of Australia's Welfare System (the "McClure" Review) highlights the applicability of the strategic commissioning framework in improving employment and social outcomes in an environment of fiscal constraints, with many of the aspects of the strategic commissioning cycle reflected in the recommendations, including "adopting the principles of co-design" and "monitoring of service outcomes… for evaluations."[6]

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[4] Sturgess, G. *Contestability in Public Services: An Alternative to Outsourcing.* 2015

[5] Australian Government *Competition Policy Review Final Report.* 2015 page 8

[6] Department of Social Services *A New System for Better Employment and Social Outcomes - Interim Report of the Reference Group on Welfare Reform to the Minister for Social Services.* 2015

This approach was championed in NSW in the 2012 Commission of Audit Report, which recommended further devolution of services and funding to focus on local needs, greater focus on collaboration and partnership in delivery and a strong focus on delivering evidence based policy.[7] The 2014 NSW Government submission to the Competition Policy Review stated that "Increased competition and innovation in public service provision can result in significant benefits, and the NSW Government believes that strategic commissioning is the most effective way to realise those benefits".[8]

Alongside this, NSW is pioneering a greater focus on achieving better outcomes for citizens and value for money for taxpayers, through social impact investment approaches. These approaches can be applied to a broad range of priority health and human services, particularly where there are clients with complex or unmet needs, or where societal problems are entrenched.

The remainder of this chapter provides a summary of the approaches taken in Australia and internationally in respect to strategic commissioning and outcomes-based contracting in employment services and in respect to services for clients with multiple and complex needs. It then draws out some key lessons for human services commissioning and OOHC in NSW, based on the research.

2.4 Major findings from the research

In most sectors around the world, 'genuine' outcomes-based contracting is in its infancy, and in most cases has either only been trialled on a small scale (e.g. social impact investment pilots) or is a small component of the overall funding arrangements.[9] This is particularly the case in human services, which typically involves complex service systems, multiple funding streams and outcomes which are hard to define and measure. Nevertheless, many of the case studies demonstrated promising early results. Where pilots have not been successful, there are still important lessons, for example, about system design and measurement. Programs included in our research are shown in table 2.2 below.

Table 2.2 – Case studies included in the research

Program	Jurisdiction	When launched
Children's Centres	UK	2011
Department for Work and Pensions Innovation Fund – 10 Social Impact Bonds	UK	2011
Drug and Alcohol Recovery Pilots	UK	2011
London Homelessness Social Impact Bond	UK	2012
Newquay Pathfinder for Integrated Care	UK	2012
Transforming Rehabilitation Program	UK	2013
Whanau Ora (Healthy Families)	New Zealand	2014
Job Services Australia	Australia	1996
The Work Program	UK	2011
Workforce Investment Act	US	1998
UK health programs – composite case study	UK	Varied

[7] NSW Government *Commission of Audit Final Report, Government Expenditure*. 2012 page 9.

[8] NSW Government *Competition Policy Review – NSW Government Submission.* 2014 page 2

[9] 'Genuine' outcomes based contracting could be defined as contracting models where the majority of service delivery payments are at risk, based on the achievement of final outcomes.

Program	Jurisdiction	When launched
US health systems – composite case study	US	Varied

The major lessons described in this chapter have been categorised against the four quadrants of EY's Strategic Commissioning Framework, summarised at Appendix A. The four quadrants are: client needs, defining and designing services, delivering services, and assessment.

2.4.1 Client outcomes

The commissioning of services should place the client or 'end-user' of the system at the heart of service design and delivery. There were three key learnings from the research in relation to outcomes for clients, which are set out below.

- Define the outcomes early and collaboratively: the most successful examples of outcomes-based contracting had a core focus on defining client outcomes at the start of the process, through deep consultation, or a 'co-design' process, with clients, providers and other stakeholders.
- Have an upfront investment in measurement – what gets measured gets done: the research demonstrates the importance of having a robust and analytically sophisticated approach to outcomes measurement, balanced with manageable reporting requirements. There needs to be an evidence base linking individual measures to the achievement of longer-term outcomes. Critical success factors for setting outcome measures included:
  - Establishing appropriate measures
  - Establishing the counterfactual
  - Understanding the extent to which providers can influence the outcome
  - Calibrating data collection and publication requirement
  - Investment in independent assurance of data quality and performance
  - Measuring and tending to overall market health/performance
- Demand analysis is critical: the research shows that careful and detailed analysis of client characteristics, volumes and current service experience are critical to ensure that the service system is designed around clients' needs and that providers are paid flexibly and according to need (i.e. level and type of service required). The latter is particularly important in outcomes-based payment systems, where a failure to compensate providers sufficiently for the costs of working with high need clients can lead to 'parking' (i.e. ignoring 'difficult' cases) and/or 'cream skimming' (i.e. focusing on achieving performance targets by focusing on 'easy' cases), and create financial stress for providers.

2.4.2 Design

Once client need and demand is well understood, the services, funding and commercial approach should be designed around those needs. The key lessons from the research in respect of designing services are described below.

- Clear, upfront design of roles and responsibilities are critical: large scale outcomes-based contracting programs have all entailed extensive system design to determine the purchaser/provider split and the respective roles and responsibilities of system managers, providers, regulators and clients. This is critical to ensure that the allocation of responsibility, accountability and risk is clear for all participants in the system. Without this, incentives in the system will not be aligned to promote value for money and outcomes for clients, the government is unable to transfer delivery responsibility, and providers are unlikely to accept financial risk for outcomes they are not able to influence.
- High quality programs put clients at the centre: successful programs put clients at the centre by integrating services tailored to individuals' needs, which enables a greater focus on

prevention and early intervention. They may also feature flexible funding models – including pooled funding models across services, which have worked well for clients with complex needs, including individualised budgets which give people choice and control.

- Manage the pace of change carefully: developing services by adding new service requirements incrementally can allow more time for providers to respond, rather than attempting wholesale redesign in one step.
- Allow flexibility, but balanced by evidence and minimum standards: while allowing service flexibility, there is still a need to specify evidence-based interventions and minimum service standards. Most successful examples specified quality through minimum accreditation standards, with a complementary performance management regime expressed through contracts.
- Client referral processes need to support a focus on outcomes: the research shows that the way in which cases are referred to providers in human service systems is crucial to ensuring the market is fair and transparent. Options include: mandatory referrals; weighting outcomes and funding according to provider caseloads; and capping the caseload mix.
- Service continuity needs to be balanced against credible contestability: service continuity in commissioned human service systems can be a major challenge, due to the disproportionate importance of maintaining client/provider relationships for some services, whether that be a health visitor, carer, employment support worker or probation manager. While there will be times when it is in the best interests of the client for the relationship to be broken, the research suggests that the most effective contracts facilitate staff transfers to maintain carer/client relationships, whilst replacing management teams and organisational structures which are failing or under-performing.[10]
- Use a balance of financial and non-financial incentives: the research showed the most successful approaches have used a mixture of levers and incentives to drive performance outcomes and value for money, including: contractual volumes and revenue; contract length; reputation (e.g. awards, prizes); transparency and accountability; (e.g. league tables, publication of performance data, client feedback), licensing and regulation.
- The use of financial incentives needs to be carefully calibrated to the type of service, and the performance information available: key lessons from the research regarding the application of financial incentives include:
    - Baseline data and performance measurement are absolute pre-requisites for an effective outcomes-based contracting approach.
    - Payments can be applied to activity, outputs, intermediate outcomes and final outcomes. This is best determined by the maturity of the system and the provider market.
    - Payments can be blended in a contract across activities, outputs and intermediate outcomes. This particularly applies in new markets where providers need time to adjust to a new payment regime.
    - Genuine outcomes can be lengthy and hard to achieve with complex clients. To ensure an ongoing income to providers working with these groups, it may be necessary to (i) apply proxy measures; and (ii) allocate a lower proportion of the contract price to payment for outcomes related to complex behaviours.
    - Payments need to take the complexity of cases into account: both the base payment for activity and the performance payment. This can be done using measures which take account of individual's progress, typically known as 'distance travelled' measures.
    - Where human services markets are in their infancy, it may not be feasible to put funding at risk. In these cases, it may be better to incentivise outputs/outcomes through bonus payments.

[10] Sturgess, G. *Contestability in Public Services: An Alternative to Outsourcing.* 2015

2.4.3 Delivery

This activity refers to the engagement, development, procurement, transition, delivery and management of services and the organisations who provide them. There were five key lessons that emerged from the research, set out below.

- A tailored market approach is required: outcomes-based contracting needs to be undertaken with due consideration to the maturity of the market – both provider and commissioner capacity and capability.
- Consistent and clear signalling from government is essential: a clear message from government as it procures and manages service delivery is necessary to create long term confidence among providers, and develop a deep and shared understanding of the systemic changes required.
- Commissioners need to take a proactive approach to market shaping: and should have a view on the characteristics of the provider market that are desirable to meet the demand, and develop strategies to develop these characteristics. Characteristics for consideration include the geographical spread of provision, the number of providers, the level of competition, and so forth. This includes taking a view of how the market should develop in both the short and longer term. In particular, new markets will require investment and capacity building.
- High quality services take an integrated approach: clients with complex needs have multiple touch points with government services. The best programs ensure that services are coordinated, enabling providers to work together co-operatively to achieve outcomes.
- Effort and attention needs to be paid to developing commissioning capability within government: this goes beyond contract management to managing the system, the market and relationships with providers. In early stages of market development, contract management activity should be a collaborative partnership. In addition the case studies show that implementing these approaches requires significant analytical capability and ring-fenced resources (both people and funding).

2.4.4 Assessment

Assessment involves evaluating outcomes achieved by services, including whether value for money is being achieved. The research showed that assessment and evaluation are critical components of successful outcomes-based contracting. In particular:

- Assessment and monitoring should include independent assurance and evaluation: most of the case studies included a component of independent assurance of data quality and independent evaluation of the outcomes. Where independent evaluations were not available, the success of the program was typically less transparent and the rationale for policy changes was less clear.
- Assessing the system as a whole is important: in addition to measuring the performance of individual providers and ensuring service quality through system regulation, commissioners need to pay significant attention to strategic market health.

2.4.5 Benefits of pilots

Finally, the research included a number of small scale service delivery pilots. Most jurisdictions have piloted new outcomes-based approaches before implementing service or system-wide reform. The benefits of pilots can include:

- Testing approaches: pilots can create opportunities for variation and testing of approaches and measurement; lessons can be applied to national programs.
- Building evidence of what works: pilots have driven significant development work which contributes to the evidence base by creating additional service provision where services hadn't existed in the past; and/or enabling the development of service integration.

- Establishing a baseline of performance: for new cohorts, pilots can demonstrate what is possible (albeit at a small scale).
- Creating new finance options: by operating at a small scale and calibrating risk, some pilots have created new vehicles for additional finance (e.g. social impact investment products).
- Stimulating innovation and new market entrants: innovation can best be stimulated through separate funds or pilots that create the 'freedom to fail', rather than introducing additional risk to the mainstream service.

2.5 Summary of findings from the OOHC research

In addition to research of national and international examples of broader human services commissioning, EY reviewed a number of OOHC services including: Illinois (US), Alberta (Canada), Victoria, and the ACT (Australia), the national UK system, social impact bonds from Essex (UK), Manchester (UK), and Social Benefit Bonds in New South Wales. Fact sheets summarising each of the OOHC case studies are provided at Appendix B.

Across the out-of-home care (OOHC) case studies included in this project, a number of consistent themes emerged.

- Contestability is increasing and there is increasing evidence that OOHC services are being delivered by, or being transitioned to, the non-government sector. An exception is the UK, where the majority of OOHC services are still provided by the Government.
- OOHC needs to be considered in terms of the wider child protection system. For example, Illinois had a strong focus on adoption and led to agencies providing both foster care and adoption services.
- The pace of reform must be carefully considered and collaboration between the commissioner and providers and carers must be a priority. Most systems have embarked on a 5 year (or longer) reform trajectory.
- Strong communication between the commissioner and provider and carers is essential to ensure the market that develops is stable, appropriately funded, and working as expected. For example, Illinois had a joint provider/government working group.
- It is important to measure and publish results. As well as monitoring permanency, Illinois measured and published a number of child outcomes. These were eventually linked to a funding stream in some jurisdictions.
- There is a clear focus on placing children in safe, permanent, stable homes. In particular, the US State of Illinois had a clear focus on achieving permanency by reducing the number of children in care, and was successful in doing so.
- Australian case studies demonstrate the importance of giving special consideration to Aboriginal providers given the over-representation of Aboriginal children in care, and the commensurate need for additional capacity.

2.6 Conclusion – considerations for NSW Health and Human Services

The experience in Australia and internationally in both large scale commissioned services and smaller scale social impact investment pilots shows there is considerable potential for outcomes-based contracting to contribute to the improvement in outcomes for individuals and value for citizens. However, this is by no means guaranteed. Understanding client needs and behaviours, designing the market and service system (including calibration of the range of levers and incentives), and developing the provider market and commissioners, are all critical to success. The case studies show that outcomes-based contracting is an evolutionary process, which needs to be done in a staged, transparent and collaborative way; iteratively; and informed by data and experience and backed by strong political direction.

Appendices

Appendix A High Needs Clients and Employment Case Studies: Summaries and Fact Sheets

This appendix comprises a summary of each of the high needs and employment case studies, as well as a short summary of the research methodology.

Approach to the research

The objectives of the research were to:

- Define outcomes-based contracting
- Identify programs and initiatives where outcomes-based contracting had been piloted or implemented
- Understand the objectives and rationale for the approach taken
- Describe the target cohort(s), desired outcomes, program intervention(s) and theory of change, measurement framework (including metrics and targets), contractual arrangements (including performance and payment thresholds, and financial incentives and sanctions), other incentives and sanctions, market maturity and commissioner characteristics
- Report on the success of the pilot or program
- Identify key lessons learned which could be applied in the commissioning of NSW human services in general and OOHC in particular.

The research was conducted in two phases:

- A broad sweep of the international evidence, to identify relevant services in Australia and other jurisdictions
- Detailed investigation of services which met the following criteria:
  - The value and/or scale of the contracted service is comparable to the OOHC service in NSW, or larger (with the exception of pilots/social impact bonds)
  - There was a payment for results or an outcomes-based element to the contracts or performance frameworks (where non-financial incentives were attached)
  - The approach had been in operation for at least 12 months
  - The service has characteristics similar to human services and OOHC, (e.g. those targeting clients with complex needs) and exists in a jurisdiction with similar legal and regulatory frameworks
  - While it was considered desirable that an independent evaluation should be available, this was balanced against the need to consider commissioning approaches that would contain lessons relevant to the project.

As a result, the following services were selected for more detailed investigation:

- Services for families and individuals with complex needs (troubled families, drug and alcohol misuse, homelessness, services for vulnerable children, offender management)
- Employment services
- UK and US health services
- Out of home care services

The research to develop the case studies included: desktop research of publicly available information; interviews with academics, independent observers, commissioners and providers; EY's existing research base; and internal NSW Government research and analysis.

Summary of case studies

a) Overview 'high needs clients' case studies

Clients with multiple needs (which may include comorbidities of drug and alcohol misuse, poor physical and mental health, poverty, homelessness, victims of crime, prevalence of family violence) typically require support across a number of different service systems, and are high users of these services over an extended period of time. Outcome payment pilots for such cohorts studied in this project are summarised below.

London Homelessness Social Impact Bond (HSIB) – UK - 2012

The HSIB was a pilot designed to attract new finance and innovation to tackling the needs of entrenched rough sleepers. A three-year program, it included a range of socially-relevant outcome metrics including: reduced rough sleeping, sustained and stable accommodation, sustained reconnection (to a home country for non-EU nationals), employability and employment, and better managed health. HSIB performance data includes targets set in provider contracts. The approach was personalised (each client had a 'Navigator' as their single point of contact). Early results showed variable performance, with over and underperformance with respect to individual measures.

Newquay Pathfinder for Integrated Care (NPIC) – UK - 2012

Piloted by the National Health Service with support from Age UK, this program aims to bring together voluntary, health and care services in order to keep older people out of hospital and living independently. Like the London Homelessness SIB, the system used a personal advisor (an Age UK member of staff) as a key worker, to link clients in to appropriate health and care services in their area. Outcome measures included improved wellbeing and quality of life, integrated working, and reduced costs across the system. Payment was based on a fee-per-service model, with upfront block funding. An early evaluation showed promising results, with a 40 per cent drop in acute readmissions for long term conditions, and an above expected financial return for every pound invested.

Transforming Rehabilitation Program – UK - 2013

This program comprised a significant reform of probation services, which replaced 35 regional Probation Trusts (PTs) with a single National Probation Service and 21 Community Rehabilitation Companies. The new providers became responsible for the management of low to medium risk offender and for offering a new service to those who have received sentences of less than 12 months in prison. The market was opened up to prime and sub-contractors from diverse backgrounds, i.e. the private, voluntary and social sectors (support was offered to PTs wishing to mutualise). The Ministry of Justice sought to learn lessons from the experience of the UK Work Program.

Although payment incentives were based on a 'black box' model, particular emphasis was given to cohort segmentation (based on a range of measures, from sentence length to offence type). Performance indicators included a binary metric (i.e. percentage of offenders reconvicted within 12 months of release) and a frequency measure (i.e. rate of offences committed by offenders within a 12 months period). Payment included both a fee-for-service and payment-by-results (PbR) elements. The intention is to shift the system over the first three years, from largely fee for service to PBR according to a learning curve principle. Significant thought was given to market development as part of this policy reform, with particular reference to not-for-profit providers.

UK Drug and Alcohol Recovery Pilots (2011)

This pilot aimed to test the payment-by-results (PbR) approach by re-incentivising drug and alcohol recovery service providers. Under the scheme, a proportion of payment was linked to the achievement of outcomes including: abstinence, treatment completion, resolution of housing problems and improved quality of life. Historical and national average information was used to baseline performance levels. Pilot areas were free to set tariffs and the weighting of each outcome locally. Most chose to separate out their caseload into complexity cohorts meaning that clients with the highest need attracted the larger outcomes payments. Performance under the scheme was mixed but it was considered to have sharpened providers' focus on achieving outcomes. Criticism included the need to take into account the amount of time it would take for genuine outcomes to take effect, and the administrative burdens associated with monitoring and data collection.

UK Children's Centres (2011-2013)

This program was a trial of payment by results involving 26 areas and testing whether the payment mechanism incentivised a local focus on the core purposes of the children's centres, defined as 'improving outcomes for children and their families, with a particular focus on the most disadvantaged'. Results measures included increased breastfeeding, sustained contact and the completion of evidence based parenting programs (amongst others). Payment models were both nationally and locally based. Criticism was around the incorrect calibration of national payments (triggering a low level of reward payments) as well as regional variations in the local reward schemes.

Whānau Ora (Healthy Families) - New Zealand - 2014

This scheme involves the devolution of funding and commissioning to three new commissioning agencies. It attempted to reduce the reliance of Maori families on external social service providers. Six outcomes were defined to be measured by both activity and quality outputs and impact and effectiveness outcomes. Interestingly, the deliverables were structured across three time-frames (short, medium and long term results). Some payments were based on the periodic delivery of commissioning plans, others on results and bonuses. The scheme is in its early stages.

Department for Work and Pensions Innovation fund – 10 social impact bonds

In May 2011 the UK Department for Work and Pensions (DWP) created the £30m Youth Unemployment Innovation Fund ('the Innovation Fund') to help disadvantaged young people who are, or are at risk of becoming "not in education, employment or training" (NEET). The main objective of the Innovation Fund was to help young people to successfully participate in education or training so that they can increase their level of employability, enter employment and reduce their dependency on social benefits. Other objectives of the fund were to (i) test the capacity of the social investment model to generate savings and deliver social return on investment, and (ii) to encourage development of a social investment market. These objectives were pursued by using social impact bonds (SIBs) as the investment and delivery model.

b) Overview of employment services case studies

Job Services Australia (JSA) - Australia

JSA is delivered by a mix of private, for-profit and not-for-profit organisations, seeking to support job seekers and employers. It has existed in its current form since 2009, however the outsourcing of employment services in Australia dates back to 1996. The funding structure makes use of both service and job placement fees, as well as outcome payments for 13 and 26 week job placements. Participants are 'streamed' into different cohorts, depending on their need and level of disadvantage. Payments are calibrated to each stream.

A distinction is made between 'provider assisted' and 'provider brokered' outcomes, a change designed to incentive providers to work more closely with employers. Providers have access to a flexible pool of funding which may be used to assist job seekers to overcome their particular barriers

to work (both vocational and non-vocational). A 'star rating' system was used to inform participant choice and drive competition. One of the major criticisms of the program's administration is that wholesale re-contracting has resulted in significant costs to providers and upheaval in the system.

Another issue identified in the program is that, despite differential payments, cream skimming (of less costly job assistance candidates) and parking (of those further from the labour market) were also said to occur – this has driven continual reform and refinement of the provider incentives over time.

From July 2015, JSA will transition to Jobactive, for which providers no longer receive job placement payments. The contracts for this include a regional loading (in recognition that labour markets vary across Australia); and are targeted at specific areas of the market (including 18-30s, mature-job seekers and other high need groups).

The Workforce Investment Act (WIA) – United States

Services delivered under the WIA comprise a Federal Program offering a range of workforce development activities through state-wide and local organisations. It offers jobseekers a choice of service provider, with payments based on the percentage of clients: entering employment, remaining in employment, and enhancing their earnings, or entering subsidised employment to obtain experience or qualifications. The WIA program differs from JSA in its complexity (it assesses a wider range of metrics) and its inclusion of a 'job satisfaction index' in the commissioning process, which seeks to ensure that job-seekers are in fact satisfied with their placements. The scheme is administered at state level, which provides both flexibility, but has also led to criticism that inconsistent approaches have resulted in complexity. There has been considerable variation in implementation across states, for example, in the distribution of funds to providers.

The Work Program (WP) – United Kingdom

In 2011, the UK attempted to streamline a series of complicated 'back to work' programs. Using a prime contractor model, it referred jobseekers to a range of private, voluntary or public sector providers. The program was based on a 'black box' model, in that it was not prescriptive about which services ought to be offered to clients. Unlike the JSA, the WP did not segment clients into streams according to their distance from the labour market. Other demographics, such as age, were used. This led to criticism about the occurrence of 'skimming and parking' of clients with low or intensive needs respectively. Providers are awarded a small fee when they start working with a client. Outcome payments are made at 6 months, and then every 4 weeks after that (a sustainability payment).

More than 1 million individuals have completed their allotted time on the scheme. Of those, approximately 250,000 were still at work at the 2 year period. Payment structures were not deemed to be sufficient in terms of recognising the distance travelled (and hence rewarding success for) by some more challenging clients from the labour market. Pressure to roll out the scheme quickly meant that existing service providers, and potential new entrants, were unprepared for the scale of the roll-out.

c) Overview of Health Case Studies

Payment by outcomes – composite case study - US health systems

Payment for performance models for health have been implemented in a range of ways in both public and private health care settings in the USA for over 10 years. Recent changes implemented as part of the introduction of the Affordable Care Act are likely to increase the use of payment for performance funding models both in public and in private health settings in the US.

Payment by outcomes – composite case study UK health programs

In many ways the UK National Health Service (NHS) is at the forefront for developing payment for performance incentive schemes both in hospital and primary care settings. Multiple schemes have been trialled locally, regionally and nationally over the last 15 years. Four notable schemes included in the case study below are:

1. Quality and Outcomes Framework
2. Advancing Quality
3. Commissioning for Quality and Innovation
4. Best practice tariffs

1. Fact sheet: London Homelessness - Social Impact Bond (SIB)

1.1 Summary

The Department of Communities and Local Government (DCLG) & Greater London Authority (GLA) commissioned Social Finance and The Young Foundation to assess the feasibility of a SIB to help address the needs of entrenched rough sleepers in London. The London Homelessness Social Impact Bond (SIB) is an innovative pilot program to support entrenched rough sleepers. It was designed to bring new finance and new ways of working (use of personal keyworkers called Navigators, usage of a volunteer support system of ex-rough sleepers, etc.) to improve the outcomes for a cohort of rough sleepers whose needs were not being met by existing services and who were not being targeted by other interventions. The Social Impact Bond is a three year program and delivery began in November 2012.

1.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
High/Complex Needs	London	£5M (GBP) 4000 individuals	Commenced November 2012 Ends November 2015	Social Impact Bond

The following outlines the results of the SIB over the last two years to date.

	Yr 1 Total	Yr 2 Q1	Yr 2 Q2	Yr 2 Q3	Yr 2 Total *to Date*	Total Years 1 & 2 *to Date*
Rough sleeping (bedded down street contact) [23]						
Target below baseline	121	17	29	41	NA	NA
Baseline[24]	258	132	132	132	NA	NA
Numbers sleeping rough	176	154	136	134	NA	NA
Reduction in rough sleeping below baseline	***82***	***0***	***0***	***2***[25]	***NA***	***NA***
Stable Accommodation						
Target for entering stable accommodation	94	39	39	29	107	201
Entering stable accommodation achieved	***139***	***37***	***37***	***24***	***98***	***252***
Target for 12 month sustainment	NA	22	27	33	82	82
12 month sustainment achieved	***NA***	***30***	***37***	***52***	***119***	***119***
Target for 18 month sustainment	NA	NA	0	18	18	18
18 month sustainment achieved	***NA***	***NA***	***1***	***32***	***33***	***33***
Reconnection						
Initial reconnection target	104	13	13	12	38	142
Initial reconnection achieved	***45***	***7***	***15***	***10***	***32***	***77***
6 month sustainment target	48	24	24	11	59	107
6 month sustainment achieved	***13***	***10***	***18***	***6***	***34***	***47***
Employment						
NQF target	10	4	4	4	12	22
NQF achieved	***0***	***1***	***1***	***3***	***5***	***5***
Volunteering/self-employment 13 week target	28	15	16	16	47	75
Volunteering/self-employ 13 weeks achieved	***6***	***4***	***2***	***7***	***13***	***19***
Volunteering/self-employment 26 week target	8	6	7	6	19	27

	Yr 1 Total	Yr 2 Q1	Yr 2 Q2	Yr 2 Q3	Yr 2 Total *to Date*	Total Years 1 & 2 *to Date*
Volunteering/self-employ 26 weeks achieved	***1***	***4***	***4***	***1***	***9***	***10***
Part time 13 weeks target	9	4	4	4	12	21
Part time 13 weeks achieved	***0***	***0***	***0***	***1***	***1***	***1***
Part time 26 weeks target	5	4	3	4	11	16
Part time 26 weeks achieved	***0***	***0***	***0***	***0***	***0***	***0***
Full time 13 weeks target	4	2	2	3	7	11
Full time 13 weeks achieved	***8***	***4***	***8***	***1***	***13***	***21***
Full time 26 weeks target	3	2	2	2	6	9
Full time 26 weeks achieved	***4***	***3***	***8***	***1***	***12***	***16***
Health (annual target)					Year One	Year Two
Target below baseline					705	885
Baseline					TBC	TBC
No A and E episodes					TBC	TBC
Reduction of A & E episodes below baseline					***TBC***	***TBC***
	Yr 1 Total	Yr 2 Q1	Yr 2 Q2	Yr 2 Q3	Total Years 1 & 2 *to Date*	
Payments made as % against target	***64***	***81***	***98***	***106***	***80***	

Source: Department for Communities and Local Government, *Qualitative evaluation of the London homelessness social impact bond – Second interim report,* March 2015

1.3 Rationale

There are other programs in place that address the issue of homelessness (Fair Chance Fund, etc.) so there was no direct progression to this system. However, it did offer a different avenue for outcomes-based payments and had the added benefit of transferring risk to investors.

1.4 Outcomes and performance indicators

Metric	Definition	Cohort baseline	Measurement level
Reduced rough sleeping	Reduction in the number of individuals with bedded down street contacts, with quarterly measurement periods	Q1-4: 28% seen bedded down Q5-8: 16% seen bedded down Q8-12: 12% seen bedded down[1]	Cohort level
In stable accommodation	Confirmed sustainment of tenancy for 6 months in non-hostel setting[2] with no more than 1 bedded-down street contact in London	4.4% over the three years of intervention	Individual level
Sustained reconnection	Confirmed reconnection to destination outside of the UK with no bedded-down street contact in London in the following 6 months	8.8% of those eligible[3] over the three years of intervention	Individual level
Progress to employment	Increase in the number of individuals: • Volunteering with training 16+ hours per week sustained for 13 weeks • Employment 8-16 hours per week sustained for 13 weeks • Employment 16+ hours per week sustained for 13 weeks	4% initial employment[4]	Individual level
Better-managed health	Decrease in ratio of emergency to elective hospital admissions	3.3 average A&E episodes per member of the cohort per year	Cohort level

Source: Social Finance & Young Foundation (authorised and regulated by the Financial Service Authority) *A Social Impact Bond For Entrenched Rough Sleepers* 2012

1.1.1 Clarification note:

The Sustained Reconnection outcome: This is a measure of reconnection to the home country for non-UK nationals without a right to reside in the UK or for those who have a right to remain but choose to reconnect. These individuals have a right to remain in the UK given that they work or claim asylum. [11]

1.5 Pricing and payment model:

The costs per supported member of the cohort were calculated by estimating staff and other costs for delivering low and high intensity Navigator support. This gives indicative upper and lower levels of total costs – £11,600 per person, total cohort cost £7.6m (high intensity); and £5,700 per person, total cohort cost £3.7m (low intensity) – providing averages of £8,650 and £5.6m. Therefore, based on these figures a budget of £5m could achieve a high level of support across the cohort and if so, improved outcomes.[12]

Pay-out: Up to 6.5 per cent per annum, calculated on a quarterly basis depending on success criteria achieved in the quarter.[13]

The Payment by Results structure is as follows:

Table 1.1 The PbR structure

Goal	Metric	Payment Mechanism	Proportion of allocated funding
Reduced rough sleeping.	Reduced number of individuals rough sleeping each quarter.	Payments according to progress beyond a baseline of expected reduction.	25%
Sustained stable accommodation.	Confirmed entry to non-hostel tenancy, and sustained for 12 and 18 months (with allowance for occasional rough sleeping).	Payment on entry to accommodation, and at 12 and 18 month points.	40%
Sustained reconnection.	Confirmed reconnection outside of the UK.	Payment on reconnection and at 6 month point.	25%
Employability and employment.	Sustained full-time employment. Sustained part-time employment. Sustained volunteering. Level 2 qualification achieved.	Payments when employment or volunteering sustained for 13 and 26 weeks. Payment for achievement.	5%
Better managed health.	Reduction in Accident and Emergency episodes.	Payments for reduction in episodes against baseline.	5%

Source: Department for Communities and Local Government, *Qualitative evaluation of the London homelessness social impact bond – Second interim report,* March 2015

[11] Department for Communities and Local Government, *Qualitative evaluation of the London homelessness social impact bond – Second interim report*, 2015

[12] ICF Consulting Services, *Learning from the Development and Commissioning of the London Homelessness SIB: A summary report from the qualitative evaluation,* 2014

[13] The Early Intervention Foundation, *Introduction to Social Impact Bonds and Early Intervention,* 2014

The SIB performance data includes the targets that each provider set in their proposal for delivering the contract. The targets are important because they are fundamental to the financial model for each provider's delivery of the Payment by Results. However, it is important to note that although they represent the financial targets and the ambition of the two providers in designing their interventions, they are not performance targets set by the GLA or DCLG in commissioning the program.

1.6 Key lessons

The key lessons below have been mainly drawn from stakeholder interviews:

- Concept of a 'Navigator' is useful for a personalised approach to act as a single point of contact for the client and the services working with them. One of the providers had a single Navigator for all services whilst the other had several for each of the different service lines. The transition between Navigators was carefully handled and participants have noted that the move did not cause disruption. Ensuring that this continues to happen will be a key driver of the success of the program.[14]
- Whilst there was over-performance and underperformance with respect to individual measures, results indicated that payments have increased from 73 per cent of the budget (year 1) to 106 per cent in the most recent quarter. Therefore, it can be concluded that overall performance of the SIB is increasing.
- There were concerns from the Health and Social Care Information Centre about data protection which resulted in no data available about health performance, after it was agreed that it would be provided. This meant that neither provider nor investor knew how they were performing. To ease tensions for these stakeholders, payments were made in lieu of data being available.
- Most stakeholders highlighted a key risk going forward which revolved around the creation of exit strategies for individuals. This was particularly important for those clients who required intensive support for up to 3 years.
- There were challenges associated with the benefits system and the sanctioning process. The sanctioning process was invoked as a penalty if the disadvantaged individual failed to attend an appointment at Jobcentre Plus (for whatever reason). There were cases of sanctions being applied and as a result, housing benefits were stopped. As payments/benefits were paid to the landlord directly, many participants accrued rent arrears and in extreme cases, were threatened with eviction. There was considerable time spent by Navigators to resolve these issues.
- There are challenges associated with the reconnection metric. Whilst it provides incentives to non UK nationals and support reconnection outcomes.
- The collection of information to evidence outcomes, and so release payments, brings an associated burden. This need for detailed development brings 'transaction costs' for SIB development.[15]

[14] Department for Communities and Local Government, *Qualitative evaluation of the London homelessness social impact bond – Second interim report,* 2015

[15] ICF Consulting Services, *Learning from the Development and Commissioning of the London Homelessness SIB: A summary report from the qualitative evaluation,* 2014

2. Fact sheet: Newquay Pathfinder (Integrated Care Pathway, United Kingdom)

2.1 Summary

Newquay Pathfinder (Pathfinder) is an end-to-end integrated care pathway[16] program which has been piloted by NHS Kernow[17] in Newquay (town situated in Cornwall, United Kingdom) with the support of Age UK[18] since 2012.

Pathfinder aims to test whether a model of integrated care would:

- Help older people be more independent, stay out of hospital and achieve a better quality of life
- Enable providers to be more effective and work together more co-operatively
- Reduce activity and spend across the health and social care systems

The program brings together voluntary, health and care services to offer a combination of medical and non-medical support to older people. The Pathfinder team consists of volunteers, district nurses, community matrons, GPs, local social workers and case coordinators. Team members are co-located in a single building. They create their own charter and role definitions, and have multidisciplinary team meetings.

An Age UK staff member or a trained volunteer acts as the key link between health and care services. He or she listens to the older person's needs so that, together, they can build an individualised care plan which should help them maintain their health and well-being.

A care plan would typically include physical and mental health needs such as falls prevention support, exercise groups, social clubs and activities. Volunteers help older people build social networks, making them better connected to their community and more resilient. Volunteers may also assist older people to maximise their income through information and advice.

2.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Health and social care	Newquay, Cornwall, United Kingdom	Originally funded by pump-priming from Age UK: £100,000 106 people (majority female and over 85)	Pilot which started in 2012 and ended in 2014	Alternative model of service delivery to generate cost savings (integrated care pathway)

[16] An integrated care pathway is a multidisciplinary outline of anticipated care which aims to help a patient with a specific condition move progressively through a clinical experience to positive outcomes.

[17] NHS (National Health Service) Kernow is the clinical commissioning group for Cornwall and the Isles of Scilly (United Kingdom).

[18] Age UK is the country's largest charity dedicated to helping the over-60s.

Results	Successful pilot: ▸ An early evaluation of the pilot – based on a small sample of 25 people – suggested a £4.40 return for each £1 invested ▸ In 2013, the program won the Health Safety Journal (HSJ) award for Managing Long Term Conditions[19] ▸ Thanks to Pathfinder's success, around 1,000 people living in the Penwith area of west Cornwall will now benefit from the same tailored care[20] Outcomes: ▸ 23 per cent improvement in people's self-reported wellbeing ▸ 87 per cent of practitioners say integration is working very well and their work is meaningful ▸ 30 per cent reduction in non-elective admission cost ▸ 40 per cent drop in acute admissions for long term conditions ▸ 5 per cent cost reduction and reduction in demand for adult social care

2.3 Rationale

The United Kingdom National Health Service (NHS) has been facing unprecedented challenges regarding sustainability, with:

- Demographic pressures - an ageing population
- Rising demand – incidence of long-term conditions (LTCs) such as diabetes and dementia
- Rising expectations from patients, the public and politicians
- Failures and gross variation in quality
- Often poor and highly variable outcomes
- Widening gap between demand and resources
- Outdated and over-stretched delivery systems

As a result, in July 2013, NHS launched a national Call to Action setting out the challenges and opportunities faced by health and care systems across the country. It raised the need to find innovative ways of shifting activity and resource from the hospital sector to the community.[21]

At the same time, the Government announced fourteen pioneer sites to pilot new ways of delivering coordinated care. The aim was to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.[22]

Located in Cornwell, Newquay Pathfinder is therefore part of the Cornwell pioneer, one of the fourteen sites piloting end-to-end integrated frailty pathways.

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[19] HSJ awards are the largest celebration of healthcare in the United Kingdom.

[20] Peninsula Community Care, 'Cornwall Pioneer', viewed on 20 May 2015, <http://www.peninsulacommunityhealth.co.uk/cornwall-pioneer.htm>

[21] National Health Service, *'The NHS belongs to the people: a call to action', National Health Service, United Kingdom*, 2013

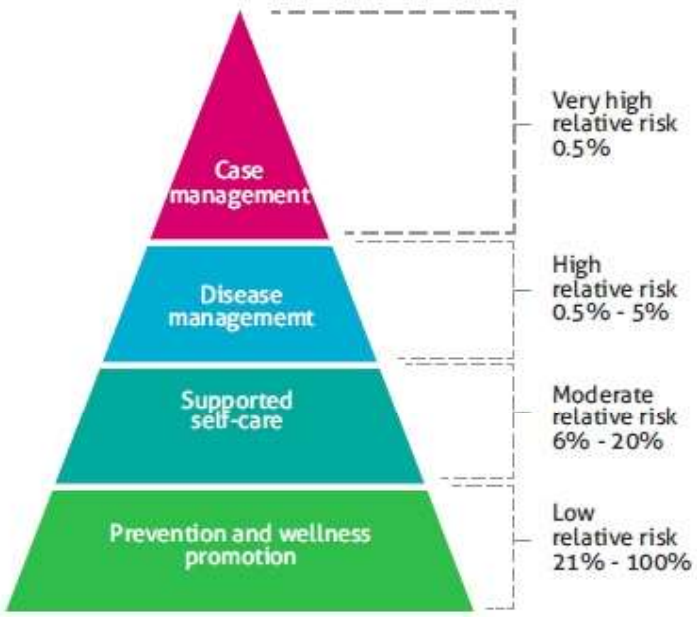
[22] National Health Service, United Kingdom, *Safe, compassionate care for frail older people using an integrated care pathway*, 2014

2.4 Outcomes and performance indicators

1.4.1 Cohort identification

The cohort participating in the pilot was identified using a primary care risk stratification tool and then matched against agreed criteria. People were selected if they had a high risk of a hospital admission and had to have at least two long term conditions that could be managed in a community setting.

Risk stratification and cost distribution



Note: Percentages represent costs to the health system

Source: Age UK, *Shaping services around people and communities through the Newquay Pathfinder*, 2014

Three outcome measures are used to evaluate the implementation of Pathfinder:

1. Improved wellbeing and quality of life
2. Integrated working works
3. Reduced cost across the whole system

1.4.2 Improved wellbeing and quality of life

Outcome incidence is measured using the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), which is comprised of a series of seven questions. Participants are asked to complete the questionnaire twice: at the first visit and after six weeks on the program. This enables to measure magnitude of change (or distance travelled) in 'improved wellbeing and quality of life'.

Pathfinder's impact on building social capital is measured by monitoring the percentage of population providing community/peer support at the start and end of the program.

This outcome focuses on the practitioners working as part of an integrated multidisciplinary team. The measurement tool is a locally-designed staff survey.

1.4.3 Reduced cost across the whole system

Does the Pathfinder approach cost the health and care systems less overall?

A. Cost of non-elective acute admissions - Two methods of analysis:
   1. Counterfactual modelling using a comparator population.
   2. Historical cost modelling using two different scenarios. Scenario 1 is to measure pre-Pathfinder days back to the point of first hospital admission for the people with long term conditions. Scenario 2 is to look back a further twelve months from the point of first hospital admission.

B. Cost of community health and number of community activity (i.e. case load management by district nurses and community matrons)

C. Cost and number of adult social care packages - Adult social care costs represent a significant proportion of the whole system public service cost for over 65s in Cornwall, hence the need to measure - using counterfactual modelling - reduction in: the cost of ongoing social care packages, and the rate of new packages of social care.

2.5 Pricing and payment model

Payment was based on a fee-for-service model with upfront block funding from Age UK (£100,000).

2.6 Key lessons

Although the Newquay Pathfinder pilot involved only 106 people in Cornwall, results are considered to be positive. The program has demonstrated that by working with people to understand their aspirations, it is possible to:

- Improve peoples' own feeling of wellbeing
- Improve practitioners' morale and the efficiency of the team
- Reduce costs across the system

A summary of key lessons and success factors is provided below:

- In order to ensure effective working and case management, it is crucial to spend time building the multidisciplinary team, as well as sharing learnings through informal social events
- Changing the language to overcome organisational and cultural boundaries (e.g. talking about people and practitioners rather than patients and professionals)
- Empowering frontline practitioners to redesign services around the individual (i.e. putting people first)
- Treating people as active participants rather than passive recipients of care
- Developing shared outcomes measures enables to share passion and commitment to finding solutions
- Having a shared vision of the future across the public and voluntary sectors

3. Fact sheet: Transforming Rehabilitation

3.1 Summary

Transforming Rehabilitation (TR) is the UK Ministry of Justice's project for the most significant overhaul of probation in the service's 107 year history. The reforms have replaced the previous 35 individual Probation Trusts with:

- A single National Probation Service (NPS) responsible for the management of high-risk offenders
- 21 Community Rehabilitation Companies (CRCs) responsible for the management of low to medium risk offenders, and for supervising short-sentence prisoners (those sentenced to less than 12 months in prison) after release

TR reforms aim to ensure that "all those who break the law are not only punished, but also receive mentoring and rehabilitation support to get their lives back on track so they do not commit crime again".[23]

Accordingly, other key components of the TR reforms are:

- Every offender released from custody – including those sentenced to less than 12 months in custody - receives statutory supervision and rehabilitation in the community
- A nationwide 'through the prison gate' resettlement service: most offenders are given continuous support by one provider from custody into the community, and most offenders are held in a prison designated to their area for at least three months before release
- Market opened up to a diverse range of new rehabilitation providers from the private, voluntary and social sectors
- New payment incentives for market providers to focus relentlessly on reforming offenders, giving providers flexibility to do what works and freedom from bureaucracy[24]

Since April 2015, the work being done by the CRCs has been contracted out by the Ministry of Justice (MoJ). The new contracts involve 3 'tiers' of potential providers:

- Tier 1: 21 CRC Lead providers contracted for 7 to 10 years with a possibility of a 3 year extension.
- Tier 2 and 3: Subcontractors - Each CRC will develop a supply chain in the months and years to come, which will consist of a range of sub-contracted providers referred to as Tier 2 and 3 organisations. Tier 2 providers are larger voluntary sector organisations, mutuals or other private sector organisations, providing a significant volume of services over a larger area. Tier 3 providers comprise smaller, local and community organisations.

[23] Ministry of Justice, United Kingdom, *Transforming Rehabilitation – A Strategy for Reform*, 2013

[24] Russell Webster, "Transforming Rehabilitation Resource Pack", viewed on 21 May 2015 <http://www.russellwebster.com/transforming-rehabilitation-resource-pack/>

3.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Justice	All of United Kingdom	Contract value of £450m per annum Creation of 21 CRCs to manage over 250,000 low/medium risk offenders 18,000 public sector staff affected	Commenced: 2013 Ends: Not applicable (on-going)	Reforms in the justice sector which include the introduction of PbR

Results	Not available yet, but business case suggests 20 per cent efficiency savings = £0.8bn over 10 years

3.3 Rationale

The MoJ spends more than £3bn a year on custodial services, and almost £1bn annually on delivering sentences in the community. Despite this, overall reoffending rates have barely changed over the past decade:

- Almost half of all offenders released from custody in 2010 reoffended within a year
- Over 6000 offenders sentenced to short custodial sentences (less than 12 months) in 2012 had previously received more than 10 community sentences

The reasons why offenders turn to crime vary widely. TR reforms are designed to enable flexibility to tailor rehabilitative work, with an emphasis on the broader life management issues that often lead offenders back to crime. In fact:

- 15 per cent of prisoners report that they were homeless before entering prison
- 25 per cent of prisoners are thought to suffer from anxiety and depression
- Unemployment and substance misuse rates are high amongst offenders relative to the general population.

3.4 Outcomes and performance indicators

3.4.1 Cohort segmentation

In order to characterise and segment the targeted cohort, the MoJ used a range of published information on offenders in England and Wales. This included official statistics as well as reports from specifically designed cohort studies such as the MoJ's Surveying Prisoner Crime Reduction Study and the Offender Management Community Cohort Study. Using these cohort studies and the system of assessment for offenders known as OASys, the MoJ developed figures on the prevalence of factors commonly associated with reoffending.[25] It also published variables predicting one-year reoffending for prisoners. These are presented below:

[25] Ministry of Justice Analytical Series, United Kingdom, *Transforming Rehabilitation: a summary of evidence on reducing reoffending,* 2013

Variable	Categories identified as significant compared with reference category (in *italics*)	Direction of odds (odds ratio)
Age	For every additional year of age	Lower (0.98)
Sentence length	*6 months or less*	
	1 year to 18 months	Lower (0.41)
	18 months to 2 years	Lower (0.22)
	2–3 years	Lower (0.25)
	3–4 years	Lower (0.31)
Offence type	*Acquisitive offence (robbery, burglary, theft and handling)*	
	Drug offences	Lower (0.38)
	Vehicle-related offences	Lower (0.54)
Copas rate (PNC)	For every unit increase on Copas index	Higher (2.53)
Whether first prison sentence	*Not first prison sentence*	
	First prison sentence	Lower (0.55)
School truanting	*Did not regularly truant*	
	Regular truanting from school	Higher (1.51)
Feelings about prison	*Not worried or confused*	
	Worried or confused	Lower (0.72)
Employment	*Not employed in 12 months pre-custody*	
	Employed in 12 months pre-custody	Lower (0.74)
Housing	*Not homeless pre-custody*	
	Homeless or temporary accommodation prior to custody	Higher (1.86)
Punishment in prison	*Did not receive additional punishment in prison*	
	Received additional punishment in prison	Higher (1.65)
Class A drug use	*Not used Class A drugs since release*	
	Class A drug user since release	Higher (1.58)

Source: Surveying Prisoner Crime Reduction Study, in Transforming Rehabilitation: a summary of evidence on reducing reoffending, Ministry of Justice (2013)

3.4.2 Performance indicators

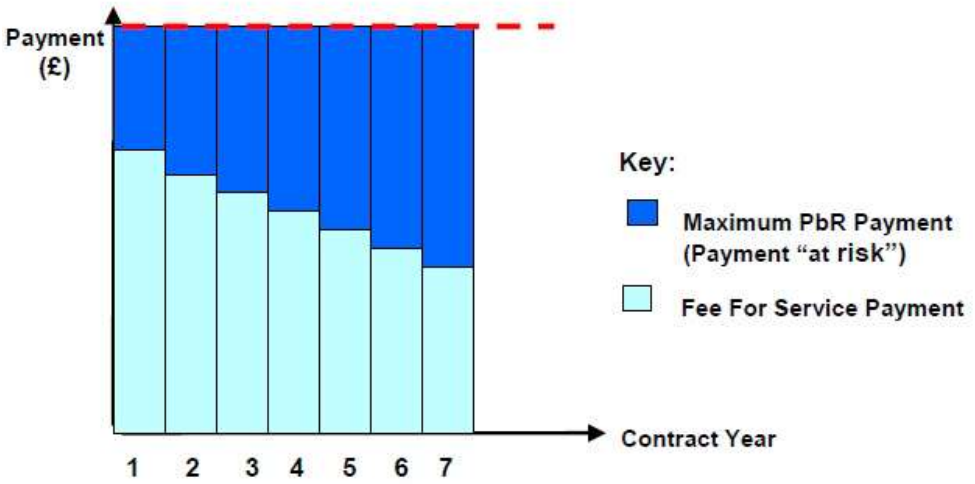
Two types of re-offending measures are used to calculate the PbR payment:

- Binary metric: percentage of offenders that are convicted of an offence within a 12 month period
- Frequency metric: rate of offences committed by offenders within a cohort within a 12 month period

3.5 Pricing and payment model

The MoJ published an indicative payment mechanism Straw Man for discussion with the market in May 2013.[26] Key points raised and refinements are provided below:

- The payment mechanism includes both Fee for Service (FFS) and PbR components.
- *FFS component* - Volume Measurement: To provide more certainty around the annual volume projections, the MoJ is considering basing volume projections for the coming year on the actual volumes experienced in the prior year, except for a narrow range of situations set out by the MoJ e.g. where new services will be commencing.
- *FFS component* - Maximum & Minimum Volume Adjustments: As at the time of writing, it is understood that the MoJ is considering amending the maximum volume increase and maximum volume decrease to 50 per cent and 30 per cent respectively (100 per cent and 50 per cent were originally suggested), before negotiation is triggered.
- *FFS to PbR* - Learning Curve Discount: A learning curve moves the allocation of the annual affordability cap from FFS payment to the PbR component. This results in the FFS component decreasing over time and a larger component of the annual affordability cap being put at risk through the PbR element. This is illustrated in the diagram below:



Source: Ministry of Justice, Transforming Rehabilitation Program - Payment Mechanism Straw Man (2013)

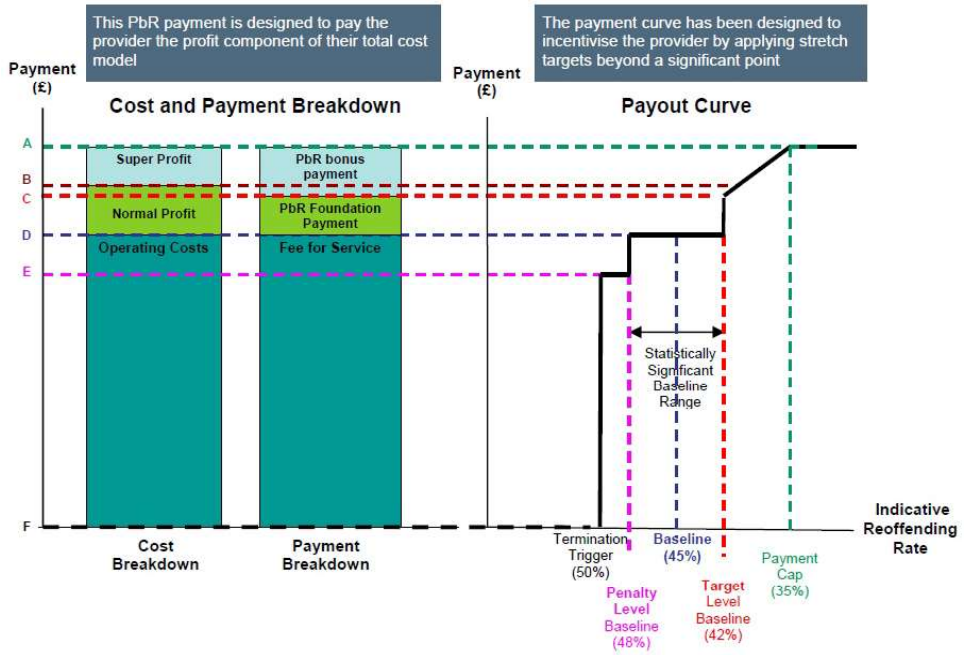
The MoJ is allowing bidders to bid the level of Learning Curve Discount, to allow providers to balance their willingness to put funds at risk against their need to cover costs over time. This aims to reflect the market's expectation of reductions in reoffending and efficiency over the contract term.

- *PbR component* – Volume Risk: To ensure that the MoJ retains a proportion of volume risk related to PbR, payments are adjusted to take account of volumes as follows:
  - Binary payout (offenders complete desistance over 12 month period) = (reduction in reoffending rate) x (unit payment) x (Number of offender starts in the cohort)
  - The unit payment for achievement on the binary metric is £4,000 per offender that desists from reoffending

[26] Ministry of Justice, United Kingdom, *Transforming Rehabilitation Programme - Payment Mechanism Straw Man*, 2013

- Frequency payout (offenders re-offences over 12 month period) = (number of offender starts in cohort) x (baseline binary reoffending rate) x (change in frequency reoffending rate) x (unit payment)
- The unit payment for achievement on the frequency metric is £1,000 per re-offence avoided

- *PbR component* – Payment Curve and Thresholds: The payment curve has been designed to incentivise the provider by applying stretch targets beyond a Statistically Significant Point (SSP), as indicated in the example below:



Note: All percentages are purely for illustrative purposes – they are bid as part of the competition process
Source: *Ministry of Justice, Transforming Rehabilitation Program - Payment Mechanism Straw Man*, 2013

This diagram demonstrates the relationship between indicative levels of performance and the associated levels of payment and expected return to providers. These various payment scenarios are further described in the following table:

Payment Curve Scenario	Description	Indicative Impact on profitability
A	The re-offending rate is improved *substantially* beyond the upper (positive) SSP	Additional profitability above a purely FFS model
B	The re-offending rate is improved beyond the upper (positive) SSP	"Normal" profit levels achieved
C	The re-offending rate is at the upper SSP	Some profit achieved but not full "normal" profits
D	The re-offending rate is within the statistically significant baseline range	0 per cent Profit
E	The re-offending rate is at or below the lower (negative) SSP	10 per cent Penalty Contract Termination
F	The re-offending rate is *substantially* below the lower (negative) SSP	Contract Termination

- Mobilisation, Transition and Transformation Funding: The MoJ recognises the importance of these costs by providing appropriate funding.[27]

3.6 Key lessons

A summary of key discussion points related to the TR reforms is provided below:

- Binary vs frequency measures - The lessons learned from the Peterborough and Doncaster social impact bonds are that it is important that PbR contains both binary (the total percentage of reoffending in a cohort) and frequency measures (the number of re-offenses per individual in the cohort) to provide both performance floors and avoid cherry picking (i.e. ignoring offenders who may continue to offend but less seriously or frequently)
- Payment structure - The PbR element of the contract is deliberately small in the first 2 – 3 years of the contract term, to allow CRCs time to restructure their business and reduce their cost base. The majority of the payment (90 per cent) is a fee for service. Early indications are that most providers are ignoring the more challenging 10 per cent results payment whilst they focus on program and service set up
- Payment mechanism - The fee structure takes into account the realities of a relatively immature market, and includes some margin in the fee for service. In other words, if providers deliver more efficiently than the full price, they will be able to retain the surplus for investment
- Performance incentives - There are incentives for contract extensions for those providers whose performance is strong in the longer term
- Service integration and expansion - There is an explicit expectation that CRCs will become hubs for other service provision in the longer term; in other words as the market matures, further service requirements will be added to the contracts with respect to delivering related health and social care
- Market development - Significant consideration was given to the shape of the market, and the need to achieve a diverse supplier base of Tier 2 and 3 providers. There were incentives, funding and support to ensure smaller NGOs and public service mutuals could participate in the market. Consideration was also given to principles of supply chain management to ensure the sustainability of Tier 2 and 3 organisations. For example, funding has been made available to Tier 1 providers to issue grants to support Tier 2 and 3 providers build capacity and capability. MoJ is providing advice to Tier 1 providers on grant-giving good practice

[27] Ministry of Justice, United Kingdom, *Transforming Rehabilitation Programme - Payment Mechanism, Market Feedback and Development Considerations*, 2013

4. Fact sheet: Drug and Alcohol Recovery Pilots

4.1 Summary

In April 2011, the Department of Health (United Kingdom) announced that eight local areas had been selected to pilot a new approach to commissioning and delivering drug and alcohol misuse treatment.

Under these Payment by Results (PbR) drug and alcohol recovery pilots, a proportion of provider payments is linked to achievement of specified outcomes related to abstinence and recovery from problems associated with drug and alcohol misuse. This approach is innovative given that previous Department of Health approaches have largely focused on payment for activity and outputs.

The pilots started in April 2012. They aimed to:

- Test a PbR approach for the delivery of drug and alcohol recovery services at local partnership level
- Incentivise local areas to enable as many people as possible to break the cycle of dependence and achieve long-term recovery (with recovery having an impact not only on the individual, but also on families and communities)
- Deliver more cost-effective services for drug and alcohol recovery

The pilot areas were supported by a cross-government team with representatives from the Department of Health and from the:

- Department of Work and Pensions
- Ministry of Justice
- Home Office
- National Treatment Agency for Substance Misuse

A Co-Design group guided the development of outcome domains and provided advice on cross-cutting issues.

4.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Health / Complex needs	8 local areas in the UK: Bracknell Forest; London Borough of Enfield; Kent; Lincolnshire; Oxfordshire; Stockport; Wakefield; and Wigan	In 2013-2014, the eight PbR pilots represented 7 per cent of commissioned drug and alcohol recovery services	Commenced: April 2012 Ended: February 2013 for 1 area; on-going for the remaining 7	Payment by Results

Results	An evaluation of the pilots which covered April 2012 to February 2013 showed that the overall performance was mixed over that period: • Improvements in abstinence from illicit drug use • Improvement in housing for some complexity groups

	• Decrease in quality of life compared to the baseline • Decrease in successful completion performance across all the five complexity groups (which was particularly concerning)[28] Seven of the eight pilot areas will continue with the PbR approach.

4.3 Rationale

Addiction and alcohol and drug abuse are a significant issue in England:

- One in 20 adults (1.6 million) is dependent on alcohol
- One in 100 adults (380,000) is addicted to heroin or crack cocaine[29]

Although drug use has dropped since 1996 (start of data collection on drug use), drug misuse continues to have a negative effect on the health, wellbeing and quality of life of people. It also drains public resources; alcohol-related harm and illicit drugs cost society over £21 billion and £15 billion a year respectively.[29]

The Drug and Alcohol Recovery pilots are the result of a commitment in the 2010 Drug Strategy which set out a vision for a locally-led, recovery-orientated drug system with the aim of not only supporting people to tackle their dependency, but also helping them to recover and rebuild their lives. The Strategy recognised that an individual's dependence on drugs and alcohol cannot be tackled in isolation.

4.4 Outcomes and performance indicators

The five outcomes used to measure the performance of pilot areas are:

- Abstinence from all presenting substances: proportion of clients who have stopped using all their presenting substances
- Successfully completed treatment: proportion of clients who became free of dependency
- Resolved housing problems: proportion of clients in the pilots who started with a housing issue (e.g. they were homeless) but can now access and sustain suitable accommodation
- Stopped injecting
- Improved quality of life: proportion of clients who have achieved a score on the Treatment Outcome Profile (TOP)[30] at or above the functional range of those clients who go on to leave treatment successfully and do not return

Two methods were used to analyse the performance of pilot areas:

- Historical baseline - Comparison between before and after the start of the pilot: Magnitude of change was assessed for each of the five outcome measures over the pilot duration (April 2012 to February 2013). It was then compared to the same period 12 months before the pilot. Service users were segmented into five complexity groups based

[28] Department of Health, United Kingdom, *Performance of Payment by Results pilot areas: April 2012 to February 2013,* 2013

[29] The Centre for Social Justice, United Kingdom, *No Quick Fix - Exposing the depth of Britain's drug and alcohol problem*, 2013

[30] The TOP measures change and progress in key areas of the lives of people being treated in drug and alcohol services. TOP consists of 20 simple questions focusing on the areas such as substance use, injecting risk behaviour, crime, health and quality of life.

on their likelihood of achieving each of the outcomes. This enabled commissioners to take into account any changes in the profile of service users.

- National average - Comparison to the rest of England: Magnitude of change was assessed for each of the five outcome measures. It was then compared to the aggregated performance for the rest of the country over the same period (results were also broken down by the five complexity groups).

4.5 Pricing and payment model

The most common approach used by all the pilot areas was to separate their caseload into complexity groups - the rationale being that clients who need greater support to achieve outcomes should therefore attract a larger outcome payment (e.g. heroin users require more input to achieve recovery outcomes than cannabis users). Separating caseload into complexity groups allows the commissioner (i.e. Department of Health) to set tariffs that encourage providers to achieve outcomes for clients from all complexity levels. Tariffs were set according to the complexity of each group.

Pilot areas were free to set the tariffs and weighting of each outcome. In determining how much to pay for each outcome, pilot areas looked to ensure that recovery outcomes remained key, whilst at the same time having enough incentive in the system to engage with clients who are least likely to achieve outcomes.

Caps and floors were used given the fixed budget and uncertainty around the likely level of achievement.

An independent agency was established to undertake assessments and referrals. The process was standardised using LASARS (local area single assessment and referral systems) to determine the complexity of participants.

4.6 Key lessons

An evaluation of the Drug and Alcohol Recovery pilots which was conducted in 2013 showed that the overall performance was mixed. A summary of key lessons and success factors for the pilots is provided below:

- Recovery and innovation: Pilots sharpened providers' focus on achieving sustained recovery for drug and alcohol users and helped to encourage innovation
- Monitoring: Commissioners and providers have had to spend a lot of time monitoring performance under PbR and it has been an administratively burdensome system
- Partnership working is essential: understanding what the data shows, sharing this information and negotiating any necessary action are all vital
- LASARS: An independent assessment and referral agency was established to prevent gaming within the treatment system. This brought additional costs and bureaucracy. Key conditions for the success of this model are that the agency must:
  - Be competent to assess and segment the treatment population
  - Be financially independent
  - Provide an element of service user advocacy
- Co-design: The Co-design process was a new way of working where central government and local areas came together to look at risks, issues and concerns as a joint team. The Co-Design approach consists of:
  1. Design a generic model for PbR which pilot areas were able to modify to suit their own aims and objectives.
  2. Through co-design, agree on the definition and measurement of a set of national

outcomes.

3. Central government departments provide baseline data for local areas on which to model future outcome-payment systems.
4. Pilot areas develop the payments attached to the agreed national outcomes-based on their local needs.

The Co-design process enabled to strike a balance between the Drug Strategy and wider Government aims being met and local areas having autonomy over designing their own models.

- Setting payment structures: Genuine outcomes can take a long time to achieve. Therefore, to secure an ongoing income for providers, some pilots allocated a lower proportion (~30 per cent) of the contract price to PbR. In addition, if the proportion of the contract paid out on a PbR basis is to increase over time (i.e. year on year), how the tariffs are divided needs to be considered up front. For example, are they paid based on the year users enter treatment or the year they leave?
- Number of outcomes: A large number of potential outcomes adds complexity to the system and may not necessarily secure extra funding for providers.
- Time required for set up: Many pilot areas recommend a 12-month "shadow PbR" that sets performance benchmarks ahead of actually linking payments to outcomes. This was beneficial as providers had the chance to develop and reach functional efficiency and therefore set more realistic benchmarks.
- Data collection is resource-intensive: Most pilots found the PbR method was data-heavy and many providers took longer than expected to manage the data collection process. It was important for them to get it right, as inaccurate recording could lead to under-payment.
- Data noise: There will always be some variation when measuring outcomes. Much is explained by known factors (e.g. the mix of users, or seasonal variations in types of crime). There is also unexplained variance called 'noise' and is typically a symptom of small scale projects, such as the drug and alcohol recovery pilots. While it is not possible to adjust measurements for noise, its size can be estimated.
    - Noise has been found in the drug and alcohol outcome data, meaning the data may not necessarily reflect providers' input.

There is a risk that the level of noise could affect providers' propensity to innovate if they are not confident that extra effort results in extra reward.

Allocating a smaller proportion of overall contract value to specified outcomes (e.g. up to 20 per cent) will reduce the financial impact of unexplained variance.

5. Fact sheet: Children's Centres

5.1 Summary

A trial of Payment by Results (PbR) in Children's Centres[31] in the United Kingdom (UK) was undertaken between September 2011 and March 2013. It involved 26 trial areas covering 27 Local Authorities (LAs) with one area consisting of a joint trial of two LAs.

Under the Childcare Act of 2006, LAs have a statutory duty to provide Children's Centre services to meet local needs. Centres must either directly provide or provide access to early childhood services including: childcare; social services; health services; and employment support, information and advice.

The main objective of the trial was to test whether PbR incentivised a local focus on the core purpose for Children's Centres, defined as, "improving outcomes for young children and their families, with a particular focus on the most disadvantaged, so children are equipped for life and ready for school, no matter what their background or family circumstances".[32] In other words, the overall aim of the trial was to improve outcomes for disadvantaged children.

Another intention of the pilot was to improve the quality of data to evidence impact of Children's Centres on children and their families.

The trial used a "two-tier" model which consisted of:

- A "national" element of PbR commissioning arrangements between the Department for Education (DfE) and LAs: DfE set national measures and improvement targets and paid financial rewards to LAs for the achievement of those targets.
- A "local" element of commissioning arrangements between LAs and Children's Centres: LAs were given the flexibility to design their own local PbR scheme, including identifying measures to incentivise and assess Children's Centre performance and deciding how to pay for performance.[33]

5.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Children's Centres (young children and families)	26 trial areas covering 27 Local Authorities in the UK	National PbR: total funding available for rewards was £2 million Local PbR: LAs were given grant funding, averaging £65,000 per LA for 2011-2012 and £123,000 per LA for 2012-2013 There 3,350 Children's Centres in the UK.	National PbR: commenced in September 2011 and ended in March 2013 Local PbR: commenced in September 2011 and is on-going	PbR

[31] Children's Centres emerged in 2002 out of the earlier Sure Start Local Programs, originally launched in 1999. The first of these programs opened in the most deprived areas of the country, but served all families in the catchment areas.

[32] Frontier Economics & the Colebrooke Centre, United Kingdom, *Payment by Results in Children's Centres Evaluation - Research report*, 2014

[33] The Children's Society, United Kingdom *Briefing Paper: Payment by Results for the Family Sector - By The Children's Society and the Family and Parenting Institute*, 2012

Results	An evaluation of the trial was undertaken by Frontier Economics & the Colebrooke Centre in June 2014 (commissioned by the Department for Education) – it showed mixed results: ▸ Ineffective national payment scheme ▸ Greater focus on the core purpose (i.e. improving outcomes for young children and their families) in a small number of LAs ▸ Enhanced partnership working with health ▸ Substantial improvements in the availability and use of local data[34] *Ultimate impacts on outcomes for children and families will only become apparent over the longer term*

5.3 Rationale

The early years are critically important for creating "solid psychological and neurological foundations to optimise lifelong social, emotional and physical health, and educational and economic achievement".[35]

Children's Centres play a key role in early intervention and are a vital source of support for young children and their families, particularly the most disadvantaged. They offer a range of activities, family services and advice, to promote school readiness, improve family outcomes and reduce inequalities in child health and development.

Children's Centres are highly valued by communities.[36] However, they require considerable investment and their overall effectiveness – in terms of improving outcomes for children and providing value for money – is regularly debated.[37]

The PbR trial was set up to enable Children's Centres:

- Improve outcomes for children (particularly the more disadvantaged ones)
- Explore the development of robust outcome measures that would help evidence the centres' impact on children and families
- Demonstrate value for money

5.4 Outcomes and performance indicators

Performance indicators fall under one of the following three outcome domains:

1. Increasing the school readiness of young children
2. Improving health and child development
3. Improving parenting skills and support provided to families in need of children's centre servicesNational PbR measures

DfE set out six national PbR measures:

- Breastfeeding: Increase breastfeeding prevalence at 6-8 weeks in the LA area over a 1 year period (output-based measure under "Improving health and child development").

[34] Frontier Economics & the Colebrooke Centre, United Kingdom *Payment by Results in Children's Centres Evaluation - Research report*, 2014

[35] The Wave Trust, United Kingdom, "Conception to age 2 - The age of opportunity", Addendum to the Government's vision for the Foundation Years: *Supporting Families in the Foundation Years*, 2013

[36] UCL Institute of Health Equity, *Measuring What Matters: A guide for children's centres*, 4Children, United Kingdom, 2014

[37] Ibid

- Early Years Foundation Stage Profile (EYFSP): Narrowing the gap between the proportion of pupils achieving a good level of development in the EYFSP that are eligible for free school meals and those that are not (outcome-based measure under "Increasing the school readiness of young children").
- Two year old take-up: Increase the proportion of disadvantaged 2 year old children taking up early education paid for by the LA (output-based measure under "Increasing the school readiness of young children").
- Sustained contact: Percentage of families in greatest need having sustained contact with children's centre services in the Local Authority area over the period 1st April 2012 to 31st March 2013 (output-based measure under "Improving parenting skills and support provided to families in need of children's centre services").
- Evidence-based parenting programs: Increase the proportion of parents with young children completing targeted evidence-based parenting programs (output-based measure under "Improving parenting skills and support provided to families in need of children's centre services").
- Three year old take-up: Increase the take up of early education for disadvantaged three year olds (output-based measure under "Increasing the school readiness of young children").

5.4.2 Local PbR measures

LAs were given the flexibility to design their own local PbR scheme, including identifying outcome measures to assess Children's Centres' performance. Examples of local measures are provided below:

One authority was considering the following local measures:

- Improved attendance at the children centres' nurseries among children living in the bottom 10 and 30 percent most deprived areas
- Children at risk of delay in communication skills – children's centres asked to complete Every Child a Talker (EcAT) assessments
- Completion of parenting programmes (explore using 4-weeks + local programmes as well as the known 'evidence-based' programmes)
- Increase in parents' aspirations and progress on pathway to work measured by 'distance travelled'
- Breastfeeding rates
- N. of families accessing activities with a prime outcome of 'Be Healthy'
- N. of families accessing antenatal services.

Another authority expected to include some/all of the following measures:

- Proportion of parents with very young children currently being engaged by children's centres
- New birth data and 12 week booking in antenatal data
- Health visitor assessment
- Healthy Child Programme reviews
- Immunisation rates
- Breastfeeding rates (initiated, still feeding at six and 12 weeks)
- Hospital admissions
- A&E attendances
- Babies and children registered as disabled or with additional needs
- DNA (do not attend) rates across health providers
- CAFs (and ecaf) and analysis of issues and data provided
- Less formal family assessments undertaken by children's centres
- EYFSP data trends by feeder settings
- Public health data including Preview
- Proportion of young children identified as in need due to maternal health is a concern
- Proportion of child protection plans and looked after children.

Source: National Children's Bureau and the National Foundation for Educational Research, UK, Feasibility study for the trials of Payment by Results for Children's Centres, 2011, p42.

As illustrated by the examples provided above, local measures were broadly in line with, and had been informed by, the national measures.

5.5 Pricing and payment model

During the timeframe of the trial, Children's Centres were funded from the Early Intervention Grant which was paid from DfE to LAs to support a full range of services for children, young people and families. The funding for Children's Centres was not ring-fenced within this grant: LAs had discretion on the amount allocated for Children's Centres from the grant.

5.5.1 National payment model

LAs were informed that national reward payments would be attached to up to two of the first three measures listed under "Outcomes and performance indicators" for each LA: breastfeeding, EYFSP and two year old take-up.

The total funding available for rewards for 2012-2013 was £2 million (an average of almost £77,000 per trial area which is approximately 1 per cent of the average LA annual budget for children's centres across the trial areas):

- The bulk of the reward fund (£1.8 million) was allocated to "standard performance rewards" which were fixed rate payments to LAs for improvements within "standard performance" thresholds.
- The remaining £200,000 was allocated for "exceptional performance rewards" to be divided among LAs who achieved above the higher threshold for the standard performance.

The reward payment amounts were LA-specific, based on the size of the under-five population for the first two measures (breastfeeding and EYFSP) and on the April allocation of places for the two year old take-up measure.

5.5.2 Local payment model

The local payment was based on both rewards and incentives (one authority even considered incentives for families).

There was significant variation between LAs in the design of the local reward scheme structure. Key elements of local reward schemes are provided below:

- Rewards applied to: individual Centres/clusters/providers
- Source of funding from: national money and/or top-slicing (withholding) of Children Centres budget and/or Early Intervention Grant
- Proportion of Centre budget subject to PbR: less than 2 per cent (6 out of 26 areas); 4 to 5 per cent (4 out of 26 areas); 5 to 15 per cent (6 out of 26 areas); 20 per cent (1 out of 26 areas); 30 per cent (1 out of 26 areas) (unknown for remaining 8 areas)
- Payment for: improvements; set targets; a mixture of both
- Reward structure: same for all Centres or tailored for Centres/clusters
- Views of centres or providers were taken into account in the design of the rewards and incentives.

5.6 Key lessons

Overall, and despite the ineffectiveness of the national payment mechanism, the Children's Centres PbR pilot generated rich learnings. A summary of key lessons is provided below:

- National payment scheme - The ineffectiveness of the national payment mechanism was mainly due to the low level of reward payments, showing that money in itself is unlikely to have an impact on LAs and reward payment amounts must be sufficiently high to generate an incentive to change local behaviour.
- Local reward scheme - There was significant variation between LAs in the design of the local reward scheme structure, which speaks in favour of a degree of localism in the design of PbR schemes for children's centres.
- Attribution challenge - A significant challenge to most LAs in the choice and design of their local measures was the need to identify local measures that were attributable to centres (i.e. measures which children's centres had a reasonable ability to influence and that changes in which could be linked to the performance of individual centres).
- Data challenge - The small size of centres means that reliable data which is not subject to large random fluctuations may not be feasible at the centre level. The small size means that changes in a measure for a very small number of children or families could have large

impacts for the centre overall, generating large random fluctuations in the measure which mask any contribution due to the actions of the centre.

- PbR implementation - Implementing PbR involved some (but generally not considerable) resource cost in most trial areas. The trial grant funding was viewed as essential to the development of PbR.
- Outcome- vs output-based measures - The outcome-based measure (EYFSP) permitted LAs considerable flexibility in achieving objectives, but the output-based measures (breastfeeding, two and three year old take-up, sustained contact and evidence-based parenting programs) were more restrictive because they prescribed more precisely the type of service to be delivered or the type of children or families to be encouraged to use services.
- Commissioned vs directly-run centres - PbR was more easily implemented in areas that predominantly commission centres. There are several possible explanations for this pattern: areas with more commissioned centres may be more innovative and quicker to adopt change regardless of the nature of that change; or the arrangements for commissioned centres may make it easier to accommodate PbR and enable faster implementation; or the concept of PbR may have fit better in commissioning areas which may be more comfortable, in political and practical terms, with the notion of paying providers for services delivered.
- Competition - Concern that by focusing on achieving centre-based targets and creating competition between centres, PbR might discourage this co-operation.
- Perverse incentives - Concern that the set of specific national measures could create "perverse incentives" for LAs to focus only on the specified measures to the detriment of other activities or other groups of families. The concern was the same for local measures; centres may focus only on the specified measures to the detriment of other activities, or other groups of families in the case of targeted measures. Centres might cherry-pick "easier" families to work with in order to meet targets to the detriment of those possibly in greater need. To address possible perverse incentives:
  - Performance management should be implemented to reduce the likelihood of neglecting other areas of work.
  - A wide range of local measures or very clearly specified measures/guidelines could be used to contribute to meeting the objectives.

6. Fact sheet: Whānau Ora (New Zealand)

6.1 Summary

The New Zealand Government launched the Whānau Ora (Healthy Families) initiative in 2010, in response to a report from the Taskforce on Whānau-Centred Initiatives. In 2014 it devolved funding and commissioning of programs to three new commissioning agencies. The program aims to work with Whānau (Maori families) to identify their strengths and aspirations, assisting them to eventually move to a level of wellbeing where they no longer require assistance from external social service providers or commissioning agencies. Services that are provided include providing access to Whānau leadership courses, assisting in cultural integration, etc. [38]

6.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
High/Complex Needs	New Zealand	Budget of $134.3 million at 2010 for the following 4 years	Commenced 2010 Ends Ongoing	Activity/Outcome-based payments

Results	Overall sample results are positive[39]

6.3 Rationale

Whānau Ora became part of government policy in November 2002, when the Ministry of Health published a strategy for Māori health. In the strategy, whānau ora meant, briefly, "healthy families". In their foreword to the strategy, the responsible Minister and Associate Minister said that achieving whānau ora would need an approach that recognises and builds on the strengths and assets of whānau to encourage whānau development. Work on the program began in 2009.

6.4 Outcomes and performance indicators

The Whānau Ora Results Commissioning Framework outlines the six (6) overarching Whānau Ora outcomes.[40]

- Whānau and families are self-managing and empowered leaders
- Whānau and families are living healthy lifestyles
- Whānau and families are fully participating in society
- Whānau and families are confidently participating in te ao Maori (in the Maori world)
- Whānau and families are economically secure and successfully involved in wealth creation
- Whānau and families are cohesive, resilient and nurturing

Commissioners use this framework to guide the development of their commissioning activities, result areas and KPIs to formulate a formal Activity Plan and KPI Plan.

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[38] Ministry of Health, *Report on the Performance of General Practices in Whānau Ora Collectives,* 2015
[39] Ibid
[40] Te Puni Kōkiri, *Whānau Ora Commissioning Agencies for the North Island and South Island,* 2013

Te Puni Kōkiri (Ministry of Maori Development) requires two streams of KPI reporting:

- Activity and quality outputs – for example, the number of whānau and family plans completed
- Impact and effectiveness outcomes – for example, the impact of the interventions, activities and programs on the proposed commissioning outcomes (i.e. the change or result achieved as a consequence of the intervention)

The proposed KPIs are structured across three time horizons:[41]

- Short-term results – focus on the establishment of the commissioning model, the identification of whānau and family needs, and the proposed reach and scale of commissioning activities.
- Medium-term results – focus on the delivery and quality of commissioning activities (e.g. of a good standard and delivered by qualified people), the extent to which these activities are effective (e.g. contribute positively to result areas) and contribute to the high-level outcome goals.
- Long-term outcomes - focus on the effectiveness of commissioning activities in contributing to the achievement of commissioning outcomes and the success of innovative approaches (e.g. approaches that result in broader or deeper reach, are more cost-effective or that contribute to outcomes that have been identified as difficult or where there is no established intervention logic).

Recognising the time it will take for medium-term result and long-term outcome KPIs to be measurable, performance monitoring initially focused on short-term results.

6.5 Pricing and payment model

The payment structure for the funds available for Commissioners is as follows:[42]

A periodic payment of commissioning funds based on commissioning plans; these funds will be determined in conjunction with the commissioning plans provided by the commissioning agency and includes coverage for operating costs.

- An incentive payment for delivering results with two components:
  - Results payment: For meeting agreed KPIs for business as usual activity and the delivery of commissioned activities.
  - Bonus payment: This payment is for areas of 'stretch' activity. It refers to commissioning agents achieving agreed KPIs on capability outcomes and innovation in areas where intervention and results achievement may be challenging. It may also result that this payment may be more than 100 per cent of the total funding available (i.e. a payment on top of the results payment and base commissioning funds payment). This will need to be negotiated with the commissioning agencies

6.6 Key lessons

The Whānau Ora program is an example of a new model for designing and commissioning human services. Given that it is in its early stages, specific outcomes and measures have yet to be determined. However, the Productivity Commission of New Zealand did an evaluation of the

[41] Te Puni Kōkiri, *Whānau Ora Commissioning Agencies for the North Island and South Island,* 2013

[42] Te Puni Kōkiri, *Whānau Ora Commissioning Agencies for the North Island and South Island,* 2013

Whānau Ora program and identified the following lessons for establishing new commissioning agencies:[43]

- "Clear allocation of roles and responsibilities, particularly the stewardship role: Decentralising Te Puni Kōkiri's commissioning function opened up a gap in the leadership of Whānau Ora.
- The culture of commissioning agencies is an important consideration in establishing programs focused on empowering individuals and families: the organisational culture within the commissioning agencies appears to be significantly different to the culture within government purchasers, particularly with regards to their attitudes on what can be done, how soon it can be done, how it can be done and how measurable the outcomes would be. This may be likely to make the commissioning agencies more responsive than the average government purchaser.
- Balancing autonomy and connectedness: Whānau Ora has benefited from having time to develop with limited influences from other social service provision. However, the disconnection from other social services may have reduced the quality of the experiences whānau have in those services.
- Harnessing tacit knowledge of what works: Several providers worked hard to build models of whānau change that link observable behaviours to identifiable progress along a pathway towards whānau wellbeing. These models are a way of translating tacit knowledge into something measurable and reportable. This kind of developmental work holds much promise."

[43] Productivity Commission of New Zealand website, viewed on 22 May 2015, < http://www.productivity.govt.nz/sites/default/files/social-services-draft-appendix-c-whanau-ora-case-study.pdf>

7. Fact sheet: UK Department for Work and Pensions (DWP) Innovation Fund - 10 Social Impact Bonds

7.1 Summary

In May 2011 the UK Department for Work and Pensions (DWP) created the £30m Youth Unemployment Innovation Fund ('the Innovation Fund') to help disadvantaged young people who are, or are at risk of becoming "not in education, employment or training" (NEET). The main objective of the Innovation Fund was to help young people to successfully participate in education or training so that they can increase their level of employability, enter employment and reduce their dependency on social benefits. Other objectives of the fund were to (i) test the capacity of the social investment model to generate savings and deliver social return on investment, and (ii) to encourage the development of a social investment market. These objectives were pursued by using social impact bonds (SIBs) as the investment and delivery model.

The Innovation Fund operated on a full payment by result basis.[44] Investors made an equity investment into an intermediary body, which was then used as initial working capital to set up the program. Subject to the program evaluation, DWP would make payments to investors based on the outcomes generated.

DWP did not specify the program design, "choosing instead to operate a 'black box' approach towards the types of interventions to be deployed".[45] The criteria for selecting projects to be funded were their diversity and innovation in achieving the fund's objectives.

The Innovation Fund was commissioned in two separate procurement rounds: six SIBs were selected in April 2012 and 4 more in November the same year.[46] See the table below. The total investment generated by investors reached around £10 million and the payments for outcomes coming from the fund was capped at approximately £30 million.[47] It was a pilot initiative, and the programs have run for 3 years.[48]

In addition, the UK Government announced in 2014 the creation of two additional schemes very similar to the Innovation Fund, involving DWP, the Cabinet Office and the Ministry of Justice.[49] This third contracting round was launched in 2015.[50]

7.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Youth employment	See table below	£30 million over three years	Commenced Mid-2011 (creation of the IF)	Fund paying on a full payment-by-results model; enabling the creation of social impact bonds.

[44] Department for Work & Pensions, *The Innovation Fund pilots qualitative evaluation: Early Implementation findings*, 2014
[45] Ibid
[46] Ibid
[47] Cabinet Office website, viewed on 10 June 2015 <http://data.gov.uk/sib_knowledge_box/department-work-and-pensions-innovation-fund>
[48] Ibid
[49] J. Ronicle, N. Stanworth, E. Hickman and T. Fox, *Social Impact Bonds: The State of Play*
[50] Interview with Cabinet Office, 2014

		In over 100 schools in the UK, and has supported over 5000 young people.	Ends Late 2015 (end of second-round SIBs)	

Contracting body	Delivery locations
APM UK Ltd	West Midlands - every Birmingham Ward
Links4Life ltd (SPV)	Stratford, Canning Town, Royal Docks (Newham), Cathall (Waltham Forest)
Indigo Project Solutions	Perthshire and Kinross
Nottingham City Council	Nottingham City
Private Equity Foundation	Shoreditch, London
Triodos New Horizons ltd (SPV)	Greater Merseyside
Prevista	West London boroughs of Brent, Ealing, Hammersmith & Fulham, Hounslow, Westminster and Haringey
3sc	Cardiff and Newport
T&T Innovation ltd (SPV)	Greater Manchester - Manchester, Salford, Bolton, Oldham, Tameside
Energise Innovation	Thames Valley - Bracknell Forest BC, Buckinghamshire CC, Milton Keynes Council, Oxfordshire CC, Reading BC, Slough BC, West Berkshire DC, Royal Borough of Windsor and Maidenhead, Wokingham BC

Source: Cabinet Office website

Results	No quantitative evaluation has been published as of June 2015. A preliminary qualitative evaluation showed the following results: "The ten IF pilots have successfully identified and engaged some of the most disadvantaged young people in society. Almost all young people interviewed were positive about the interventions [...].Schools have engaged and bought into the programs [...].The funding model has been a key driver of behaviours and has focused attention on generating starts and tracking individual participants towards the achievement of outcomes".[51]

7.3 Rationale

Historically, DWP had only intervened with NEET young people who were over 18. However analysis showed that some of the key causes of NEETs unemployment were a lack of qualifications, and exclusion from school. The Innovation Fund introduced early intervention programs to tackle the root causes of the youth unemployment; programs covered younger age groups and aimed to improve their behaviour and attendance at school.

Reducing the number of NEET young people was expected to generate significant savings. For example, a study by York University found that "the cost of failing to intervene early can result in a life of unemployment and benefit dependency, whilst participating and gaining qualifications has a positive impact in terms of employments and income. Over their lifetime, every young person who has been NEET can, on average, incur higher public finance (£56,000) and economic costs (£104,000)" than a person who hadn't been NEET. Note that public finance costs are: tax and benefits, health, welfare and criminal justice expenditure; and economic costs are: estimates of the

[51] Department for Work & Pensions, *The Innovation Fund pilots qualitative evaluation: Early Implementation findings,* 2014

loss to the economy, welfare loss to the individual and the family, as well as the impact in terms of the resources or opportunity cost to the rest of society.[52]

7.4 Outcomes and performance indicators

7.4.1 Target population and referral process

The young people targeted were aged 14 to 24 years old, and recruitment into the program varied depending on whether they were attending school or not. Those attending school were selected using background data, school management information and assessment panels of teachers, and sometimes parents were involved in their children's decision to join the program. Those who had already left school were referred to by agencies such as Jobcentre or Connexions, or by project workers who approached young people "off the street". Some self-referrals also occurred, when young people heard of the program in local community newsletters, or through word of mouth. In both cases, the selection process had to ensure that the participants were voluntarily joining the program, and that the participant's involvement was likely to produce claimable outcomes within the required timeframe.

7.4.2 Outcomes

Payments by DWP are tied to the type of outcome measured and to the round in which the program was launched. See below the maximum payment rates per outcomes as defined by DWP:

	Maximum outcome payment (££)	
Outcome measure	**Round 1**	**Round 2**
Improved attitude to school/education	none	700
Improved school attendance	1,300	1,400
Improved school behaviour	800	1,300
Qualifications and Credit Framework accredited Entry Level Qualification	none	900
Basic skills	none	900
First Level 1 National Qualifications Framework (NQF) Qualification	700	1,100
First Level 2 NQF Qualification	2,200	3,300
First Level 3 NQF Qualification	3,300	5,100
First Level 4 NQF Qualification or above	2,000	none
English for Speakers of Other Languages	1,200	none
Entry to first employment (13 weeks)	2,600	3,500
Entry to first employment (26 weeks)	1,000	2,000
Cap per individual young person	8,200	11,700

Source: Department for Work & Pensions, *Innovation Fund pilots qualitative evaluation,* 2014

7.4.3 Outcome payments

Payments for outcomes by DWP have been based on "the estimated potential benefit savings from preventing at-risk individuals from falling into long-term unemployment in the future. For round one pilots, payments were broadly based on two years of potential benefit savings to HM Treasury. This was increased to three years for round two projects".[53]

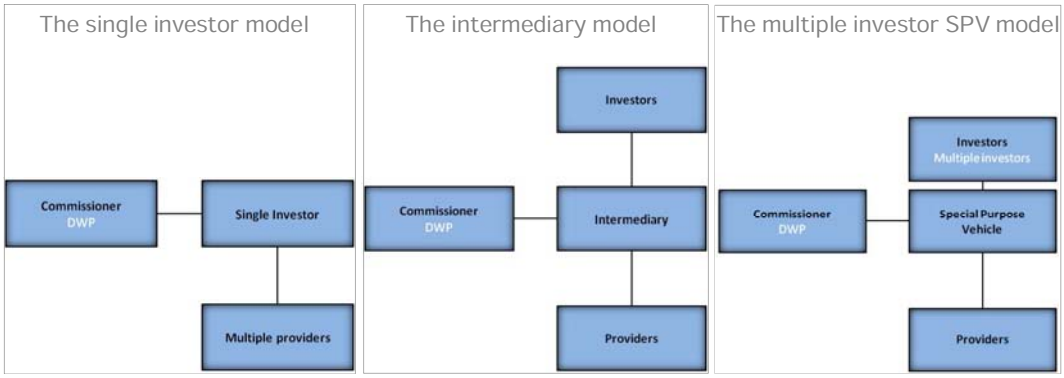
[52] DWP, *Innovation Fund: Equality impact assessment,* 2012

[53] DWP, *Innovation Fund pilots qualitative evaluation,* 2014

In order to receive monthly payments, program managers need to provide evidence that the program delivered the outcome(s) it was set to achieve. DWP provided templates to contractors to support their outcome claims.[54] Unlike for other SIBs, payments are not based on a comparison with a counterfactual. This comparison will occur during an evaluation commissioned at the end of the three years of funding.[55]

7.5 Pricing and payment model

The payment mechanisms applied as part of the Innovation Fund are diverse; they used the following three structures:



These structures included elements from the three types of SIBs:

- Philanthropic (funds raised from philanthropic trusts and foundations)
- Public sector (initial funds are provided by the local government bodies)
- Commercial (funds raised from investors primarily seeking a financial return on investment)[56]
- The range of investors involved includes social funds, businesses, private individuals and registered social landlords.[57]

7.6 Key lessons

- There was a long period of capacity building and engagement with potential providers and investors before Government issued the tenders. Despite this, qualitative feedback suggests that the interval between the two procurement rounds left insufficient time for additional partnerships to form
- The small scale of some SIBS made robust quantitative evaluation difficult
- Flexibility was key in the commissioning and contractual process.[58] For example, it was useful to select a large and flexible cohort to allow expansion if required, according to consultations with stakeholders of the programs[59]

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[54] DWP, *Innovation Fund: programme specific provider guidance,* 2014

[55] Emma Tomkinson's blog, viewed on 19 June 2015 <http://emmatomkinson.com/category/social-investment-finance/>

[56] Department for Work & Pensions (2014), *The Innovation Fund pilots qualitative evaluation: Early Implementation findings*

[57] Centre for Social Impact Bonds website, viewed on 19 June 2015 < http://data.gov.uk/sib_knowledge_box/innovation-fund>

- "Projects most comfortable with the payment by results model were those delivering more time-limited, preventative interventions with school pupils deemed to be at risk of becoming NEET. This is because outcomes and thus cash flow can be generated relatively quickly"[60]
- "Data handling systems and software had often been found to be in need of strengthening, and in several instances this had been achieved through additional resource brought in using staff and funding outside Innovation Funding budgets"[61]
- There is evidence from the 2015 round of contracting that providers are able to deliver services between 30 per cent and 40 per cent more efficiently than during the first round, and that some providers are able to scale operations based on experience and greater economies of scale[62]
- Potential participants to the program were not recruited if they were not likely to produce the expected outcomes on time. Whilst this provided investors with greater consistence, it also meant young people most in need could be excluded.

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[58] Cabinet Office website, viewed on 10 June 2015 <http://data.gov.uk/sib_knowledge_box/department-work-and-pensions-innovation-fund>

[59] Department for Work & Pensions, *The Innovation Fund pilots qualitative evaluation: Early Implementation findings*, 2014

[60] DWP, *The Innovation Fund pilots qualitative evaluation: early implementation findings*, 2014

[61] Department for Work & Pensions, *The Innovation Fund pilots qualitative evaluation: Early Implementation findings*, 2014

[62] Interview with the Cabinet Office

8. Fact sheet: (Job Services Australia)

8.1 Summary

Job Services Australia (JSA) started on 1 July 2009 and was developed to:

- Provide tailored assistance for job seekers. For example, early assistance was provided to the most disadvantaged job seekers
- Ensure that jobseekers had the skills necessary to meet the needs of employers
- Enhance opportunities for work experience
- Streamline programs and processes to reduce the burden of administration

JSA is delivered by a network of organisations funded by the Australian Government to provide employment services to job seekers and employers. The providers are a mix of large, medium and small, for-profit and not-for-profit organisations that are experienced in delivering services and support for job seekers and employers.

Employment Services in Australia has developed since 1994 with the Working Nation program. Since then, the system has undergone reform (Job Network 1, 2 and 3) and progressed to the current JSA program. The nature of the reforms varied from attempting to increase efficiency within the system to targeting social outcomes to a greater extent. From 1 July 2015, JSA is transitioning to Jobactive. The new program is designed to better meet the needs of job seekers and employers and improve job outcomes. To that end, the services that will be provided have been broken down into five segments:

- Jobactive organisations: To assist jobseekers in finding and maintaining employment.[63]
- Work for the Dole Coordinators: To be the first point of contact for organisations wishing to be involved in the Work for the Dole offer[64]
- The New Enterprise Incentive Scheme: To support jobseekers in initiating and operating a small business[65]
- Harvest Labour Services and the National Harvest Labour Information Service: To assist growers in the horticulture industry to meet harvest requirements and to assist jobseekers and travellers in finding work picking fruit and other crops[66]

Some key points pertaining to Jobactive:

- Providers no longer receive job placement payments
- There are procedures in place to ensure that jobseekers are only attending training sessions that are relevant.
- Employment services contracts are being extended from three years to five years
- A regional loading is being incorporated to recognise that labour markets vary across Australia. There are targeted programs to help specific areas of the market:[67]
  - Job Commitment Bonus: For long term unemployed aged 18 – 30

[63] Jobsearch Website, viewed on 27 May 2015, <http://jobsearch.gov.au/jobactive/faqs.aspx#1>
[64] Employment Website, viewed on 5 August 2015, <https://employment.gov.au>
[65] ibid
[66] ibid
[67] PM Website, Viewed on 29 May 2015 < https://www.pm.gov.au/media/2015-03-31/new-jobactive-services-help-more-jobseekers-work>

- Relocation Assistance to Take Up a Job: For those individuals who move to regional areas to find employment
- Restart: To employ mature-aged job seekers
- There are also outcome payments for seasonal job placements

8.2 Key facts and figures (JSA)

Sector	Locality	Program size	Key dates	Program type
Employment	Australia	$1.524 Billion	Commenced 1 July 2009 Ends 30 June 2015	Payment by outcomes to an extent (excluding wellbeing)

Results	1.25 million out of work Australians into jobs[68]

8.3 Rationale

In 2009, a new model was introduced called 'Job Services Australia' which had similarities to its predecessor, Job Network (JN) 3. Job Service Australia, however, included a more prescriptive service delivery model and was designed to integrate the JN provision with six separate specialist programs, each of which previously had their own contract specifications and procurement process.

8.4 Outcomes and performance indicators

In JSA, jobseekers are classified into one of four 'streams' based on the barriers to work they face. Each stream has 'service guarantees', or services that every organisation must provide to all jobseekers in that particular stream.

- Stream 1: Job seekers participate in activities to develop their skills in resume development, application writing, career planning, interview techniques, etc. There is an additional component of stream 1 where JSA targets those jobseekers already well placed for employment and who only need limited help. Services that are offered include assistance in creating online resumes.
- Stream 2 & 3: These job seekers are experiencing moderate and significant disadvantage (respectively). Job seekers will enter into an Employment Pathway Plan (EPP) which will include activities and assistance aimed at improving the job seekers' employability.
- Stream 4: These job seekers are assessed as having the most severe levels of disadvantage and may be affected by such things as mental health, disability, homelessness, abuse, drug/alcohol etc. JSA providers will work with the job seeker to address their most pressing issues/barriers first with the overall aim of employability

Providers have access to Employment Pathway Funds (a flexible pool of funds, which JSA providers use to assist job seekers to overcome their vocational and non-vocational barriers to employment) and receive service and job placement fees, as well as outcome payments for 13- and 26-week job placements. Those jobseekers furthest from employment (streams 3 and 4) attract higher payments.

The breakdown of payments is as follows:

[68] Jobs Australia website, viewed on 25 May 2015, < http://ja.com.au/2015>

Performance Measure	Weightings in JSA Star Ratings Model			
	Stream 4 40%	Stream 3 30%	Stream 2 20%	Stream 1 10%
13 Week Full Outcomes	20%	20%	20%	10%
13 Week Pathway Outcomes	10%	10%	10%	5%
13 Week Bonus Outcomes	15%	15%	15%	10%
Speed to 13 week Full Outcomes		5%	5%	
13 Week Outcomes Total	**45%**	**50%**	**50%**	**25%**
26 Week Full Outcomes	20%	30%	30%	10%
26 Week Pathway Outcomes	10%	10%	10%	5%
26 Week Outcomes Total	**30%**	**40%**	**40%**	**15%**
Barriers Serviced	15%			
Social Outcomes Total	**15%**			
Paid Placements	10%	10%	10%	30%
Speed to Job Placements				10%
Job Placements Total	**10%**	**10%**	**10%**	**40%**
Off Benefit				15%
Speed to Going Off Benefit				5%
Off Benefit Total				**20%**

Source: Job Services Australia website

8.5 Pricing and payment model

This provides a sample of fees charged. It indicates the increase in remuneration for harder to help groups (streams 3 and 4).

Work Ready	Disadvantaged job seekers		
Stream 1	Stream 2	Stream 3	Stream 4
53 per cent job seekers projected 2008	22 per cent job seekers projected 2008	10 per cent job seekers projected 2008	15 per cent job seekers projected 2008
Actual was 255, 776 or 31 per cent at 31 March 2010	Actual was 240,468 or 31 per cent at 31 March 2010	Actual was 197,953 or 31 per cent at 31 March 2010	Actual was 125,051 or 31 per cent at 31 March 2010
*$11 in Employment Pathway Fund	*$550 in Employment Pathway Fund	*$1100 in Employment Pathway Fund	*$1650 in Employment Pathway Fund
*$385 - $440 in job placement fees	*$385 - $2800 in job placement fees	*$385 - $6600 in job placement fees	*$385 - $6600 in job placement fees
*Up to $781 in service fees	*Up to $885 in service fees	*Up to $1120 in service fees	*Up to $2736 in service fees
Skills assessed after three months			

Source: Department of Work and Pensions, *Job Services Australia: design and implementation lessons for the British context,* 2011

The JSA payment system[69] comprises quarterly service fees paid during participation, and job placement and outcome payments. Service fees are designed to pay for specified minimum activities, such as the completion of an employment plan and a sequence of interviews, and outcome payments for seeing a jobseeker in permanent employment at 13 or 26 weeks. All payments are audited and subject to reclaim where contract managers find inappropriate and/or inadequately evidenced expenditure.

Within JSA there are 'full' and 'pathway' outcome payments which are paid on evidence that employment has been sustained for 13 and 26 weeks. The amount of the payment depends on:

- The stream in which the job seeker participated
- The reduction in a job seeker's income support
- Whether the job placement was 'assisted' or 'brokered'
  - Brokered placements were those where providers gathered vacancies are tailored their services to the jobseeker to fill that placement
  - Assisted placements are where standard services were offered to help jobseekers find any work – vacancies were not gathered beforehand

Full outcome payments are paid only when someone has ceased claiming income support payments. They may, however, be paid for parents with child care responsibilities, or people with health problems, who can legally restrict their work hours due to their circumstances. Pathway outcomes are designed to reward steps towards self-sufficiency. They may be paid if the part-time earnings of an eligible job seeker reduce their income support entitlement by at least 60 per cent over the relevant period.

The JSA payment system also distinguishes between 'provider assisted' and 'provider brokered' outcomes. The change was designed to incentivise providers to gather employer vacancies directly and tailor their services to filling those vacancies. The higher JSA fee for a brokered payment is now payable only when the provider registers a vacancy and has filled it from among their caseload.

Additional bonuses may be paid to providers who broker training and subsequent placements in a 'skill in demand' vacancy or in apprenticeships. Further, 'social outcomes' are recognised for stream 4 job seekers who, it is determined, would benefit from further six months assistance when they complete a year. This does not involve an outcome payment, but the provider will continue to receive service fees to work with the individual.

8.6 Key lessons

- 'Star ratings' systems (operating as a league table) were used to help inform participant choice and drive provider performance. The principle was to generate healthy competition in order to aid in market development.
- Re-contracting can result in significant costs. "The transition to the new system in July 2009 involved major change for job seekers with some 320,000 people having to change provider. Overall, there was considerable disruption, even for successful providers, and about half of JN sites had to be re-commissioned. One larger provider, who retained about the same overall business share, estimated that its transaction costs in the transition to JSA amounted to over $7 million." (Senate, 2009, para 4.38).
- Other evaluations suggest that, in some cases, providers may 'crowd around' less costly job search assistance or 'park' harder to place job seekers. This is addressed by offering

[69] Department of Work and Pensions, *Job Services Australia: design and implementation lessons for the British context,* 2011

higher incentive payments for those difficult to place jobseekers. However, whilst this was said to occur anecdotally, it was difficult to prove in practice.[70]

- It was difficult to train staff to deliver a whole continuum of services as was required by the new stream driven approaches.[71]
- It was noted that administrative protocols established under the JN have limited the impact of JSA. Several providers felt that the development of innovative and tailored approaches was hindered by the detailed JSA administrative, reporting and monitoring requirements.[72]
- There were instances where transitions of jobseekers between service providers caused some administrative issues. These included incorrect assessments, missed appointments, and the imposition of sanctions, including variations in how different providers handle and report non-attendance and non-compliance.[73]
- The Australian Government encouraged third sector and smaller organisations to bid for larger contracts when specialist programs were integrated into JSA provision, but there was no conscious effort to develop 'supply chains'. This should be addressed in future programs as smaller organisations help offer coverage in areas that are less attractive to larger for-profit providers, either because of location or the particular characteristics of client groups.[74]
- It was found that innovation was not only driven by contractual specification but also by transparency and diffusion through networks, particularly with staff movement between providers. The development and spread of best practices may be accelerated further by exchanges and linkages that extend beyond individual organisations and across sectors.[75]

[70] Department of Work and Pensions, *Job Services Australia: design and implementation lessons for the British context,* 2011
[71] Ibid
[72] Ibid
[73] Ibid
[74] Ibid
[75] Ibid

9. Fact sheet: Workforce Investment Act

9.1 Summary

The Federal Workforce Investment Act (WIA) built on the system of its predecessor, the Job Training Partnership Act (JTPA). Similar to the JTPA, the WIA offers a range of workforce development activities through state-wide and local organisations. Services are offered to job seekers, laid off workers, youth, incumbent workers, new entrants to the workforce, veterans, persons with disabilities, and employers. WIA is designed to promote an increase in the employment, job retention, earnings, occupational skills improvement by participants and ultimately improve the quality of the workforce.

There are notable differences between WIA and the employment services system in Australia.[76] Firstly, the WIA is more complex and assesses a wider variety of metrics. Secondly, it also incorporates a job satisfaction index to measure job-seeker's satisfaction with their placement.

9.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Employment	US	In 2009, the revenue of employment & recruiting agencies in the U.S. ranged at about 22 billion U.S. dollars	Commenced: Replaced the JTPA in 2000 Ends: Ongoing	Payment by results

Results	Considerable success however there were notable implementation issues

9.3 Rationale

In 2000, the JTPA was replaced by the Workforce Investment Act (WIA) and the following important changes were made:

- Competition for market share was introduced with jobseekers being given a choice of service provider
- The incentives system was amended. See outcomes and performance indicators
- The standard an agency must meet to be eligible for an award was no longer derived by applying a formula based on the characteristics of jobseekers served and labour market conditions. Rather, this is done by negotiation with the Department of Labor
- The payment amount given to the states now depended on the aggregated performance of their agencies. Only those states whose results exceed the standards in all areas of measured performance are now eligible for payments
- There was a need to streamline services to develop accessibility to a wide range of services for the every jobseeker, regardless of their need. This system was coined the 'One-stop' infrastructure[77]

[76] See 7.1 to 7.6

[77] 2020 Public Services Trust, *Payment-by-Outcome in Welfare to Work*, 2011

9.4 Outcomes and performance indicators

There are 17 performance measures under the WIA. The 'core' measures for adult jobseekers are:[78]

- The percentage of clients entering employment.
- The percentage of clients retaining employment for six months.
- The earnings change from six months prior to entry into the program to six months after exit.
- The percentage of clients who have entered unsubsidised employment and obtain qualifications.

The full list is as follows:[79]

i. Adult Program

1. Entry into unsubsidised employment
2. Retention in unsubsidised employment six months after entry into the employment
3. Earnings received in unsubsidised employment six months after entry into the employment
4. Attainment of a recognised credential relating to achievement of educational skills, which may include attainment of a secondary school diploma or its recognised equivalent, or occupational skills, by participants who enter unsubsidised employment

ii. Dislocated Worker Program

5. Entry into unsubsidised employment
6. Retention in unsubsidised employment six months after entry into the employment
7. Earnings received in unsubsidised employment six months after entry into the employment relative to earnings of job of dislocation
8. Attainment of a recognised credential relating to achievement of educational skills, which may include attainment of a secondary school diploma or its recognised equivalent, or occupational skills, by participants who enter unsubsidised employment

iii. Youth Programs:

- Older Youth (aged 19-21)

9. Entry into unsubsidised employment
10. Retention in unsubsidised employment six months after entry into the employment
11. Earnings received in unsubsidised employment six months after entry into the employment
12. Attainment of a recognised credential relating to achievement of educational skills, which may include attainment of a secondary school diploma or its recognised equivalent, or occupational skills, by participants who enter unsubsidised employment or who enter postsecondary education, advanced training or unsubsidised employment

- Younger Youth (aged 14-18)

13. Attainment of basic skills and, as appropriate, work readiness or occupational skills
14. Attainment of secondary school diplomas and their recognised equivalents
15. Placement and retention in postsecondary education, advanced training, military service, employment, or qualified apprenticeships

iv. Across Funding Streams

16. Customer satisfaction for participants

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[78] 2020 Public Services Trust, Payment-by-Outcome in Welfare to Work, 2011
[79] Department of Labor website, viewed on 21 May 2015, <http://www.doleta.gov/performance/quickview/WIAPMeasures.cfm>

17. Customer satisfaction for employers

9.5 Pricing and payment model

States were in charge of the funds to award to agencies. Meeting the standards was a condition for receiving an award, but states could dispense bonuses to agencies in any way they chose. In most states, agencies simply had to meet a certain standard of outcome achievement to receive an award. However, there was some variation in how funds were dispersed in different states. For example, some states gave the entire bonus to the best-performing agency while some divided it among all agencies performing above a certain threshold.[80]

Other states varied the award according to performance relative to the standards, so that agencies that far surpassed their targets received more than those that simply met their standards.

9.6 Key lessons

- The emergence of a 'One-stop' infrastructure presented with several implementation issues:
  - Varying contexts: In rural areas with low population densities and tight budgets, it was found to be difficult to establish access points with effective staff that could provide services to a wide range of customers.[81]
  - Poor reputation: Rather than One-stop centres being perceived as a platform to aid individuals back onto their feet, they were seen as 'places the poor people go.' Attempts to market themselves as otherwise were seen to only be partly successful. Local providers indicated that brand development on a national level would assist in improving the perception in the eyes of the public.[82]
  - Funding: Given that the One-stop infrastructure promised to help any jobseeker, this was limited in practice due to funding. Providers did not have the resources available to offer multiple services as was promised.[83]
  - Balancing the needs of the universal customer and a targeted group: Local providers struggled with meeting the needs of a wide customer base whilst still making training available to those who need them. In instances, this resulted in a lower quality of service to those hard-to-help jobseekers that require targeted help. Conversely, many smaller providers were ill-equipped to serve customers with other needs such as those qualified jobseekers who were simply looking for career changes.[84]
  - Computer illiteracy: Given the resource constraint on local providers, there was a reliance on self-service for many jobseekers. However, limited computer literacy did cause some disruption.[85]
  - Immigrants: Providers were also ill-equipped to deal with those jobseekers that were new immigrants and were not proficient in the English language. This further impacted on their ability to get jobs given the competitive job market. Factors such as these were not incorporated into the remuneration model.[86]

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[80] 2020 Public Services Trust, *Payment-by-Outcome in Welfare to Work,* 2011

[81] Policy Research Associates, *The Workforce Investment Act After 5 Years: Results from the national evaluation of the implementation of WIA,* 2004

[82] Ibid

[83] Ibid

[84] Ibid

[85] Policy Research Associates, *The Workforce Investment Act After 5 Years: Results from the national evaluation of the implementation of WIA,* 2004

[86] Policy Research Associates, *The Workforce Investment Act After 5 Years: Results from the national evaluation of the implementation of WIA,* 2004

- The One-stop network: Only some states to date had managed to develop a consistent chartering network and foster a brand image that conveys a consistent level of service and quality across One-stop centres. Synergies between states do not yet exist.[87]
- Self-service issues: Whilst self-service was introduced to provide equal and fair services given the funding restrictions, it has struggled to be used effectively. Providers have limited ability to track self-service including those who use the services, with which objectives in mind and to what effect. The reduction in transparency makes it difficult to know how to tailor services to better meet customer need.[88]

- There were difficulties in the formation of the partnerships of the WIA. There was pushback from state partners when they were requested to contribute to the development of the One-stop centres. As a result, local providers have found it difficult to find funds to develop the centres, in aspects such as providing self-services and staffing. Other associated issues include differences in culture, differences in visions of integration, separate performance and reporting requirements.[89]
- Performance management was complicated as performance goals were set through negotiations between individual states and the Department of Labor without any system of standardisation in place. Further, without state calibration, this was seen to disadvantage those jobseekers harder to place.[90]
- Having a local set of standards derived from high level agents who then derived their standards from a national level caused some tension as local providers felt that there was inconsistency across states. There were also findings which demonstrated that performance standards were simply seen as arbitrary numeric goals with no allowances for serving more distressed areas.[91]
- Many providers obtained waivers to set up their respective systems without operating under the official accountability measures. This was to ensure that they had an effective grasp of how the new system would work before they would be held accountable.[92]
- Other associated issues arose with regards to data collection management and who was tasked with the role. There was an expectation by WIA that reporting duties would be controlled by the state partners, who derived results from the One-stop operators. However this did cause some confusion and disagreement over definitions, with providers interpreting differently (and thus reporting differently) in order to obtain higher remuneration payments.[93]
- How states chose to distribute their funds to their providers was up to their discretion. Some chose to give all the funds to the best providing agent whilst others divided it among the providers who met certain thresholds.[94]

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[87] Ibid
[88] Ibid
[89] UpJohn Institute (2011), *The Workforce Investment Act: Implementation Experiences and Evaluation Findings*
[90] Ibid
[91] Ibid
[92] Ibid
[93] UpJohn Institute (2011), *The Workforce Investment Act: Implementation Experiences and Evaluation Findings*
[94] 2020 Public Services Trust, *Payment-by-Outcome in Welfare to Work,* 2011

10. Fact sheet: The Work Program

10.1 Summary

The Work Program, launched in 2011 by the Department of Work and Pensions (UK), helps people who have been claiming out of work benefits, or who are at risk of falling into this group. These people are referred to a range of private, voluntary and public sector organisations, known as providers, many of whom are very experienced in dealing with long-term unemployment. The services offered by providers are not prescriptive, rather providers are given leeway to innovate and tailor their solutions to individuals.

This program has similarities to the Australian employment program, Job Services Australia (JSA).[95] However, in the Work Program there is no explicit market segmentation in terms of separating out harder to help job-seekers into different categories/streams. Rather, other market segments such as groups of differing ages are identified and treated accordingly.

10.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Employment	UK	The Work Program Approx. 5 million individuals receiving out of work benefits Costs: 1372 (£m) in total as at 31 March 14'	Commenced June 2011 Ends Ongoing	Payment by results

Results	The program is roughly performing to the level of previous programs[96]

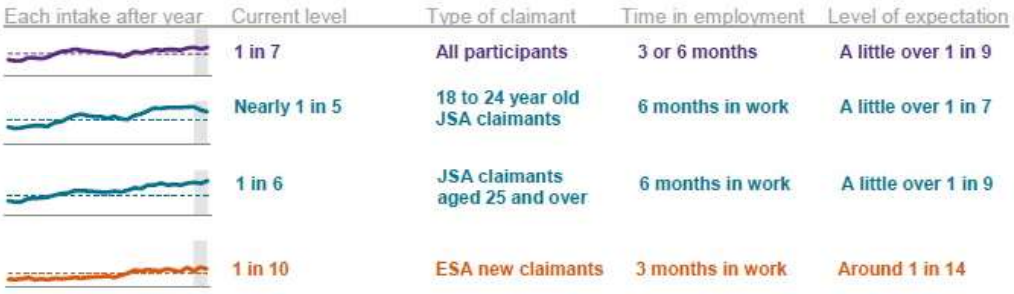
Some key results of the Work Program, as at December 2014 are shown below.

Note: The x-axis represents the month of the jobseeker intake and the y-axis represents the percentage of jobseekers of that month's intake that have been employed for 3 to 6 months. An increasing graph indicates that the percentage of jobseekers who reached 3 or 6 months of employment is higher for those who started recently than those who joined at the start of the program.

[95] See section 7.1 – 7.6

[96] National Audit Office, *The Work Program*, 2014

The dotted line indicates the expected level of movement into employment without the program.



There are several findings of note:[97]

1. Results against the Department's measures have improved since the start of the program
2. Levels of 18 – 24 year old JSA claimants have shown recent declines however are still above minimum requirements
3. The other ESA/IB are below minimum expected levels
4. At the two year point levels are above those for earliest joiners and generally above expectations more recently. However as at the one year point, levels for November and December 2012 intakes are below expectations
5. More than 1 million individuals have completed their allotted time on the scheme. Of those completing the program, approximately 250,000 were still in work at the two year point (or providers had received the maximum payments). However, this was slightly below expected levels
6. Around 7 in 10 returned to Jobcentre plus. This could be an indicator of the ineffectiveness of the program. See Key Learnings below for more detail

10.3 Rationale

Previous 'back-to-work' support in the UK was complicated; there were more than 20 different programs for jobseekers, disabled people and people with health conditions. The Work Program aims to simplify the support available by supporting both those who have claimed Jobseekers Allowance (JSA) for a long period of time and those with long term health conditions who claim Employment Support Allowance (ESA). Other groups, including young people not in employment, education or training (NEET) were now also able to access early support from the Work Program.

10.4 Outcomes and performance indicators

In the early years of the Work Program, providers get a small fee when they start working with a jobseeker, and this payment decreases to nothing in later years of the contract. They are then paid a Job Outcome Payment when they help get the participant into 6 months of employment (or 3 months for harder-to-help groups), followed by Sustainment Payments for every 4 weeks they help to keep the participant in work after that.

The results are not compared to a benchmark and so there are no sanctions for underperformance or rewards for over-performance. However, the Department of Work and Pension reserves the right to refer more participants to the better-performing provider in the area and to refer more participants to those providers delivering better results. Therefore providers who aren't helping

[97] Department of Work and Pensions, *Quarterly Work Program National Statistics to Dec 2014,* 2015

people into work are remunerated less as they aren't producing results and also receive fewer participants.

10.5 Pricing and payment model

There are three main categories of payment a provider can receive:[98]

Attachment fee – a payment made to the provider at the point of engagement. The attachment fee is paid at different rates as defined in the payment schedule for each customer group. The attachment fee will reduce over the first three years of the contract and will be nil from July 2014 until the start of year four. The profile for this payment is:

- Year 1 = 100 per cent the original amount
- Year 2 = 75 per cent of the original amount
- Year 3 = 50 per cent of the original amount
- Year 4/5 = 0 per cent of the original amount

Job Outcome Payment - A Job Outcome payment is paid when a customer has been in work for either a continuous or a cumulative period of 13 or 26 weeks, depending on the payment group to which the claimant belongs. It is paid at different rates as defined in the payment schedule for each customer group. DWP set a maximum level for each job outcome payment, and providers were invited to offer a discount on this level in their bids. For customers in payment groups 1,2 and 6 the value of the maximum Job Outcome payments will reduce by 10 percentage points of the original level each year for customer starting from year three of the contract.

Sustainment Payments – after a job outcome has been reported, a Sustainment payment can be claimed for each four week period of continuous work completed by a claimant, up to the maximum number set out in the payment schedule. While the claimant is still within the two year period that they are attached to the Work Program, there can be breaks in employment between sustainment payments. A 'break' refers to whether the jobseeker is once again unemployed or is on unemployment benefits. Once a claimant has completed this two year period and is no longer attached to the Work Program, providers can continue to claim sustainment payments up to the maximum number, so long as there is no break in employment. If there is a break of 2 days or more, then no further sustainment payments can be claimed.

The payment structure is as follows:[99]

[98] Department of Work and Pensions, *Work Program – Program Costs to 31st March 2014,* 2014

[99] Ibid

Payment Group	Customer Group	Year 1 attachment fee[1]	Job outcome fee[1] (maximum)	Job outcome paid week:	Sustainment payment per 4 weeks	Maximum number of 4 weekly sustainment payments
1	JSA 18-24	£400	£1,200	26	£170	13
2	JSA 25+	£400	£1,200	26	£215	13
3	JSA early access	£400	£1,200	13	£250	20
4	JSA ex-IB	£400	£1,200	13	£250	20
5	ESA volunteers	£400	£1,000	13	£115	20
6	New ESA claimants	£600	£1,200	13	£235	20
7	ESA ex-IB	£600	£3,500	13	£370	26
8	IB/IS (England only)	£400	£1,000	13	£145	13
9	JSA prison leavers	£400	£1,200	26	£200	20

Note: 'IB' refers to Incapacity Benefit and 'IS' refers to Income Support

10.6 Key lessons

- There was only a 6 month period of time between the Invitation of Tender for the Work Program and the Work Program going live, creating some tension for providers who were new to the market or operating in new areas. Several providers found that there was no time to overcome initiation barriers such as labour hiring or securing premises which ultimately hindered their ability to offer quality services.[100]
- There was a commitment from Ministers to the voluntary services space that they would be heavily utilised in the Work Program. However, these expectations were not met in practice. Many volunteer and community sector organisations were encouraged to join service provider supply chains (the application process of which was quite resource intensive), however were quite underutilised. There was a belief in the volunteer and

[100] Department of Work and Pensions, *Work Program Evaluation Procurement, supply chains and implementation of the commissioning model,* 2013

sector organisation community that the level of referrals received from providers would be higher.[101]

- The Work Program was run by 'black box commissioning' which enabled providers to be flexible in their service interventions with jobseekers and change them if necessary. However in practice, this caused tension between certain providers in addition to officials within the Department of Work and Pensions. On one hand, some individuals were willing to allow full flexibility in their work practices whilst others were firmer and wished to ensure that providers delivered on their bid commitments.[102]
- Service providers also had the ability to change their minimum service delivery standards, with the expectation that the changes would still be aligned with the delivery model that was specified in their bid. However there were instances when changes in delivery standards did not resonate with DWP officials. Additional problems occurred in cases when providers did not consult with their DWP account managers to confirm the changes.[103]
- The concept of differential pricing (to remunerate higher based on the difficulty of the case) whilst received positively by providers initially, was found to be difficult to accept in practice. Providers noted that a whole host of factors impacted the difficulty of the case which may not have been captured in the initial payment group classification (skills, motivation, etc.) and hence were not captured in the remuneration payment. Further, providers indicated that the difference in payments between categories was insufficient compensation for the increased costs of working with a difficult case.[104]
- The scale of economic difficulty (given that the program was incepted during the GFC) was not adequately considered when forecasting financial and operational expectations. Hence performance was obviously limited.[105]
- JobCentrePlus who received hard-to-help participants who had been through the Work Program had mixed views; however they mostly put-forward negative views. This was driven by the volume of participants that Jobcentre Plus received, indicating that the Work Program was less effective than anticipated. Furthermore, some believed that there was a sense of providers simply 'processing them and ticking boxes' without attention to personal needs and circumstances.[106]
- There were significant administrative discrepancies with the delivery of sanctions to jobseekers that did not complete mandatory activities. Findings suggested that there was poor communication between JobCentrePlus (who administered the sanctions) which undermined the effectiveness of the process. For example, a large proportion of sanctions were reported to be made erroneously because JobcentrePlus failed to update providers about changes in jobseeker circumstances.[107]
- There has been anecdotal evidence of providers opting to put more effort into jobseekers who are close to employment and ignoring those harder to place. This is perhaps indicative that the current remuneration mechanism does not place enough of a payment on those difficult to place jobseekers.[108]

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[101] Department of Work and Pensions, *Work Program Evaluation Procurement, supply chains and implementation of the commissioning model,* 2013

[102] Ibid

[103] Ibid

[104] Ibid

[105] Ibid

[106] Ibid

[107] Ibid

[108] Third Sector Research Centre, *Support for all in the UK Work Program? Differential payments, same old problem…,* 2013

11. Fact sheet: The Troubled Families payment-by-result scheme in the UK

11.1 Summary

The Troubled Families Program is a family support program, launched by UK Department for Communities and Local Government (DCLG) in 2012. It targets families characterised by the absence of a working adult in the family, by children missing school and by family members showing criminal and anti-social behaviours. The objectives are to get children back into school, reduce youth crime and anti-social behaviour, and put adults on a path back to work. The nature of the intervention has not been defined by DCLG, but is left to the discretion of the Local Authorities. Similarly, Local Authorities are responsible for identifying the families who will benefit from the program, following DCLG's guidelines. They receive payments from DCLG based on results.[109]

11.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Social services and justice (child protection, domestic violence, mental health, offences)	152 local authorities in the UK	- £4000 per family - Aimed at helping 120,000 families by 2015, but will be expanded to 400,000 more families until 2020[110]	Commenced April 2012 Ends Originally: May 2015, but will be expanded to 2020	Payment by results

Results	A national evaluation of the program is being undertaken by Ecorys UK. Results are not available yet.[111]

11.3 Rationale

"The rationale for the program, which was launched in April 2012, was the government's estimate that 120,000 of the most troubled families accounted for £9 billion of public spending. £8 billion of this was being spent on reacting to the problems these families have and can cause in their communities and only £1 billion being spent on preventing those problems from occurring in the first place."[112]

11.4 Outcomes and performance indicators

Note that no counterfactual exists to measure results, instead DCLG require self-declarations of results by the local authorities.

Successful results are defined by DCLG as follows:

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[109] Communities and Local Government, *The Troubled Families program,* 2012

[110] UK Government website, viewed on 26 May 2015 <https://www.gov.uk/government/news/troubled-families-program-expanded-to-help-younger-children>

[111] Ecorys UK website, viewed on 26 May 2015 <http://www.uk.ecorys.com/casestudy/national-evaluation-troubled-families-program-0>

[112] London Councils, *Troubled Families Program Lessons for future public service reform,* 2014

Result 1: "They achieve all 3 of the education and crime/ anti-social behaviour measures set out below where relevant:

- Each child in the family has had fewer than 3 fixed exclusions and less than 15 per cent of unauthorised absences in the last 3 school terms; and
- A 60 per cent reduction in anti-social behaviour across the family in the last 6 months; and
- Offending rate by all minors in the family reduced by at least a 33 per cent in the last 6 months".[113]

Result 2: "If they do not enter work, but achieve the 'progress to work' (one adult in the family has either volunteered for the Work Program or attached to the European Social Fund provision in the last 6 months)".[114]

Result 3: "At least one adult in the family has moved off out-of-work benefits into continuous employment in the last 6 months (and is not on the European Social Fund Provision or Work Program to avoid double payment)".[115]

11.5 Pricing and payment model

DCLG provides Local Authorities with an upfront payment (the "attachment fee") to cover costs of initiating the program. Amounts vary with years:

Year	Per cent of payment offered as upfront attachment fee	Per cent of payment offered as results-based payment in arrears
2012/13	80 per cent	20 per cent
2013/14	60 per cent	40 per cent
2014/15	40 per cent	60 per cent

Payments are tied to the results listed in section 1.4. Local Authorities have to achieve results 1 and/or 2, or result 3 to get the total £4000 payment per family. An example of payment breakdown for 2012/13 is:

Result #	Attachment fee	Results payment	Total
1	£3200	£700	£4000
2		£100	
3	£3200	£800	£4000

Note that payment can be claimed 12 months after the intervention has started.

11.6 Key lessons

- The absence of a counterfactual limits the possibility of determining the overall success of the program
- The lack of a contractual framework, the devolved nature of the program and limited data and quality assurance restricts DCLG's ability to ensure value for money. These are characteristics one would expect to see in a full commissioned system.
- A review of the program identified key areas for the development, including:

[113] Communities and Local Government, *The Troubled Families program,* 2012
[114] Ibid
[115] Ibid

- "Work with more families that have complex and multiple problems and that are a high cost to public services continue to improve their assessment of a family's needs and co-ordination of services
- Go further in terms of other local authority services being aligned with the Troubled Families approach. For example, gangs, wider social services, Youth Offending Teams are all in such a category and there is potential for even more public sector agencies to become involved in delivery of the program
- Achieve greater joint investment, with partners, in early intervention and prevention to avoid longer term need for reactive, specialist services".[116]

[116] London Councils, *Troubled Families Program Lessons for future public service reform,* 2014

12. Fact sheet: Payment by outcomes - USA Health system

12.1 Summary

Payment for health performance models have been implemented in a range of ways in both public and private health care settings in the USA for over 10 years.[117] Recent changes implemented as part of the introduction of the Affordable Care Act[118] are likely to increase the use of payment for performance funding models both in public and in private health settings in the US.[119]

A standout example of payment for performance in the US health system is the recent Alternative Quality Contract (AQC), implemented in 2009 between health insurance company Blue Cross Blue Shield Massachusetts (BCBS) and its network of Health Maintenance Organisations (HMO).[120] Rather than the typical fee for service arrangement, health providers receive a budget that covers the full spectrum of care for the defined population of enrolees. Shared risk is taken with savings and overspends and bonus payments are available if certain quality targets are met. Participation in the AQC is voluntary across BCBS HMO network; however take up has been positive with 85 per cent of physicians and hospitals participating in the scheme.[121]

The AQC has received positive results through a number of evaluations and has since been used as a model for a new public sector funding initiative.[122] In 2012, the national administrator of the federal health insurance schemes, Centers for Medicare and Medicaid Services (CMS) began pilot contracts based on the AQC with 32 Accountable Care Organisations around the country. Since implementation it is estimated that the Pioneer ACO program has saved $384 million in the first two years of performance.[123]

12.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Alternative Quality Contract (AQC)	Massachusetts, USA	11 Health provider organisations that included large hospitals and small practices covering	Seven organisations joined the program in 2009, followed by another four in 2010	Level of risk varies with each contracted provider but includes four key characteristics: ► Budget provided based on no. of enrolees. Savings and overspend are shared ► Bonus payments for

[117] Health Affairs website, viewed on 16 July 2015, <http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78>

[118] Medicaid.gov website, viewed on 16 July 2015, <http://medicaid.gov/affordablecareact/affordable-care-act.html>

[119] Song, Z., Safran, D. G., Landon, B. E., Landrum, M. B., He, Y., Mechanic, R. E., ... Chernew, M. E., T*he "Alternative Quality Contract" in Massachusetts, Based on Global Budgets, Lowered Medical Spending and Improved Quality. Health Affairs (Project Hope)*, 31(8), 1885–1894, 2012

[120] Definition: A HMO is a subscription style model where by patients enrolled in the HMO have access to a network of HMO providers, through referral from a Primary Care Physician. Typically health providers charge fee for service in line with contracts with the HMO, HMO's then charge a health insurers a fixed cost for all health services provided to its population of enrolees.

[121] Blue Cross Blue Shield of Massachusetts website, viewed on 16 July 2015, <https://www.bluecrossma.com/visitor/about-us/affordability-quality/aqc.html>

[122] Seidman, J ., Et al, *Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract, AvereHealth*, 2015

[123] L&M Policy *Research, Evaluation of CMMI Accountable Care Organization Initiatives*, 2015

		1,600 Primary Care Physicians and 3,200 Specialists		performance against quality indicators ► Long term contract with fixed spending and quality targets Dedicated support for reporting and analysis as well as goal setting and best practice training

Results	► Reduction in overall health care spending. Contract demonstrated financial savings on average of 2 per cent in the first year when participants are compared to non-participants in the same area. After four years participants in the AQC delivered savings of up to 10 per cent when compared to the control group.[124] ► Improvement in quality of care. After two years the contract was associated with a 3.7 percentage point year on year increase in performance against targets for chronic disease management procedures. Though outcomes related performance indicators were not evaluated due to lack of pre-intervention data, unadjusted analysis suggested that groups received comparable or better outcomes relative to BCBS network averages.[125]

12.3 Rationale

There are a range of payment models for health, used in a variety of contexts around the world. As would be expected, each model has advantages and disadvantages. The predominant model of payment for health services in the US, fee for service, incentivises increased volume of activity and is relatively easily administrated but fails to incentivise quality of care, and has no measure to contain costs. Other models such as bulk funding or capitation[126] provide budget surety however create adverse incentives to either reduce output or to take on more patients than can be appropriately cared for by the provider. In addition to these issues, these payment models offer limited incentives for providers to refer patients to other health providers who may be able to offer equivalent treatment at a higher quality or lower cost.

The AQC is a mix of a variety of payment mechanisms designed to incentivise improvements in quality and performance whilst at the same time creating incentives to reduce the cost of providing care.

12.4 Outcomes and performance indicators

To incentivise quality within the payment mechanism, the AQC uses 64 performance indicators which have been based on nationally accepted, evidence-based clinical performance measures. These are made up of a mix of adherence to process, patient outcomes, and patient experience and have been shown to be stable and reliable at the level which they are reported. Outcomes-based measures such as patient blood pressure, pneumonia after major surgery, in hospital wound

[124] Avalere Health LLC, *Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract*, 2015

[125] Song, Z., Safran, D. G., Landon, B. E., Landrum, M. B., He, Y., Mechanic, R. E., ... Chernew, M. E., *The "Alternative Quality Contract" in Massachusetts, Based on Global Budgets, Lowered Medical Spending and Improved Quality. Health Affairs (Project Hope)*, 31(8), 1885–1894, 2012

[126] Capitation is a payment model where a health provider is paid based on the number of patients on its client list.

infection have added significance as they reflect actual patient outcomes.[127]

12.5 Pricing and payment model

Health providers are provided with a budget to cover the full spectrum of healthcare costs for their enrolled population. This includes: inpatient, outpatient, pharmacy and behavioural health, and ambulatory and other costs. Budgets are based on historical spend adjusted for inflation and risk (based on actuarial data of the health of enrolled patients). Savings and overspends against budget are shared with the health provider.

Quality performance payments are structured into 5 thresholds to reflect relative levels of performance. Each threshold carries a corresponding performance payment calculated as percentage of total medical costs. For example, reaching the first threshold may correspond to a bonus payment of 2 per cent whilst reaching the 5th threshold corresponds to a 10 per cent performance payment. Levels of performance payments are structured differently in each contract to match the unique characteristics of the health provider, such as size of organisation and risk profile.[128]

12.6 Key lessons

- Changing behaviour requires providers to take on risk, but payers need to meet providers expectations in the current environment
- No need to do everything at once but steady commitment is needed
- Ratcheting share of savings against budget based on performance measures is an effective way of incentivising innovative cost saving while maintaining quality
- A mix of process based performance measures and outcomes-based performance measures allows for better evaluation of program as patient outcomes are difficult to baseline prior to intervention
- Providers need detailed spending and quality information and technical support to take on risk
- Create an environment for collaboration, clinical, and managerial leadership, and continual learning
- Fostering integration across the continuum of care is key to delivering achieving best outcomes for patients and financial savings
- It is important to be clear on the goals, and agree how goals will be measured
- Having a common set of cost and quality measures and thresholds across contracts enables ease of implementation and allows better comparison of different models

[127] Blue Cross Blue Shield of Massachusetts, *The Alternative Quality Contract*, 2010

[128] Value-based purchasing guide website, viewed on 16 July 2015, <http://www.nbch.org/BCBSMA_Case_Study>

13. Fact sheet: Payment by outcomes – UK health

13.1 Summary

In many ways the NHS is at the forefront for developing payment for performance incentive schemes both in hospital and primary care settings. Multiple schemes have been trialled locally, regionally and nationally over the last 15 years. Four notable schemes are:

1. Quality and Outcomes Framework
2. Advancing Quality
3. Commissioning for Quality and Innovation
4. Best practice tariffs

13.2 Quality and Outcomes Framework [129]

13.2.1 Summary

The Quality and Outcomes Framework (QOF) is a performance based incentive scheme for General Practitioners in the UK introduced in 2004. It has been heralded as the most comprehensive primary care payment for performance scheme in the world.[130] The scheme awards points, which are converted into financial rewards for meeting quality targets on clinical, organisational and patient-experience indicators.[131] Participation in the scheme is voluntary though the participation rates are very high.

13.2.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Quality and Outcomes Framework	UK, Nation-wide	7,921 of the 9800 General practices in the UK. Over 56 million registered patients	Introduced on 1 April 2004, continuing	Incentive payment scheme targeted at improving quality of care provided by general practices

Results	▸ The scheme may have contributed to improvement in quality of care though attributing success against this measure has been difficult due to trending improvement in the quality of care provided by GP's prior to the program being introduced as well as a range of other policy initiatives introduced alongside QOF. ▸ The scheme appears to have reduced variation in performance between general practices. In particular, the program appears to have reduced the difference in patient care between large and small practices.[132]

13.2.3 Rationale

The QOF was introduced to improve the quality of care provided by General Practitioners, embed preventive measures and stimulate improvement in chronic disease management to reduce

[129] HSCIC website, viewed on 16 July 2015, <http://qof.hscic.gov.uk/index.asp>

[130] Gillam Stephen, Steel Nicholas. The Quality and Outcomes Framework–where next? BMJ 2013; 346 :f659

[131] Doran, T., Campbell, S., C Fullwoood. Et al, Performance of Small general practices under the UK's Quality and Outcomes Framework. British Journal of General Practice, 2010

[132] Doran, T., Campbell, S., C Fullwoood. Et al, Performance of Small general practices under the UK's Quality and Outcomes Framework. British Journal of General Practice, 2010

avoidable hospital admissions.[133] Domains were linked primarily to chronic conditions and indicators related adherence to clinical processes, achieving desirable organisation process such as recording and reporting of activity and quality. Only a small proportion of indicators related to patient outcomes. In the early years of the program, many practices exceeded Department expectations in terms of performance and thus raised practice incomes. Since 2014, the National Institute for Health and Care Excellence (NICE) has taken a role in recommending evidence based clinically effective and cost effective indicators. This has reduced the number of indicators and domains in total.

13.2.4 Outcomes and Performance indicators

The QOF was originally proposed with five main components, known as domains. The five domains were:

- Clinical
- Public Health
- Public Health – Additional Services
- Quality and Productivity
- Patient Experience

Each domain consists of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement. The 2013-14 QOF measured achievement against 121 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 900 points.

Points are achieved for complying with best practices to actual patient outcomes, for example:

- Asthma: The percentage of patients with asthma, on the register, which have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions[134]
- Coronary heart disease: The percentage of patients aged 79 or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less[135]

Patient experience has been tracked as a domain for the majority of the life of the program. In 2013/14 there was one indicator in this domain: Minimum consultation time of 10 minutes spent with each patient.[136] This domain has since been phased out in England in 2014/15.

13.2.5 Pricing and Payment Model

The QOF awards points to General Practices on the basis of the proportion of eligible patients for whom clinical targets were achieved. Some indicators require a lower threshold to be met before any payment is applied, and some have a maximum threshold which once achieved full points are awarded. GPs are then paid per point for points achieved, for example 2013/2014 the price per point was £156.92 for England. Points allocated to indicators and price to point are subject to change year to year.

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[133] Marshal, L. Charlesworth, A., Hurst, J.,(2014) "The NHS payment system: evolving policy and emerging evidence" Nutfield trust

[134] National Institute for Health and Care Excellence website, viewed on 16 July 2015, <https://www.nice.org.uk/Standards-and-Indicators/QOFIndicators>

[135] Ibid

[136] NHS Framework guidance for GMS contract 2014/15, 2014

Practices are able to exclude patients they deem inappropriate for an indicator so that they are not penalised for seeing patients with complex conditions. The average exclusion rate across all relevant sectors is 4.1 per cent.

13.3 Commissioning for Quality and Innovation[137]

13.3.1 Summary

The Commissioning for Quality and Innovation program (CQUIN) was introduced nationally across the NHS in 2009. The scheme makes a proportion of provider income conditional on achievement of locally agreed quality and innovation goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis.

13.3.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Commissioning for Quality and Innovation	UK, Nation-wide	Applicable by all health commissioners in the NHS for services including acute care, ambulance, community health, mental health and learning disabilities.	Introduced 2009, continuing	Incentive withholding scheme where 2.5 per cent of total funding is held conditional on achieving a mix of national and local quality and performance goals

Results	► The diversity of indicators used across providers has made the program difficult to evaluate. However program evaluation suggests that the scheme has failed to achieve initial aims of improving quality of care and patient outcomes.[138] ► Whilst the program helped commissioners and providers identify and prioritise local needs for quality improvement, findings showed that the local participation in development of indicators may have limited the impact of the scheme.

13.3.3 Rationale

The key aim for CQUIN is to improve quality of services and patient outcomes whilst maintaining strong financial management. It was assumed prior to implementation that current funding and governance mechanisms did not effectively support a focus on quality improvement and innovation by health providers. By attaching a financial incentive to quality, it was hoped that this would ensure that quality was on the agenda at a Board and Commissioner level, which was likely to increase the institutional focus upon quality and therefore improve outcomes for patients.

[137] Institute NHS website, viewed on 16 July 2015 <http://www.institute.nhs.uk/commissioning/pct_portal/cquin.html>

[138] McDonald et.al Evaluation of the Commissioning for Quality and innovation Framework, 2013

13.3.4 Outcomes and Performance indicators

Each scheme is negotiated separately in order to ensure that local needs for quality improvement are prioritised. Performance indicators agreed with health providers that participate in the CQUIN program are quite diverse (there were 5,000 different indicators across the 337 participating providers in 2011). Though most goals are negotiated and agreed locally, national CQUIN goals have been introduced and mandated for some providers. CQUIN goals for 2014/15 are focussed on patient experience, patient safety and mental health.[139]

13.3.5 Pricing and payment model

Most payments are based on achievement of a minimum threshold that results in full payment of the associated value agreed for that indicator. Value of the scheme for each participating provider is set nationally for 2014/15 at 2.5 per cent of total cost of healthcare services provided excluding expensive pharmaceuticals. This has been increased from the initial value of 0.5 per cent set at the start of the program in order to bring into line with research that suggests between 1 per cent and 4 per cent is sufficient to change behaviour at an organisational level.[140] For applicable acute care and mental health providers, one fifth of that value must to be attributed to national CQUIN indicators.

13.4 Advancing Quality

13.4.1 Summary

The Advancing Quality (AQ) scheme was introduced in 2008 in hospital trusts in the North West of England. The program was initially a hospital rating system where they are paid a bonus based on their ranking. Quality of care was measured by clinical process and outcome measures in five clinical areas: acute myocardial infarction, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement. Subsequently, the programme expanded to include additional clinical areas. After 18 months the program was halted, to make way for national roll out of CQUIN payment for performance program. The Advancing Quality program still continues but without any incentive payments.[141]

13.4.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Advancing Quality	UK, North West England	24 NHS hospitals in the North West England	Introduced 2008 – halted mid-2009.	Competitive bonus scheme paid to hospitals according to their ranking on key criteria

Results	▸ Evaluation of the program suggests that the program was associated with a significant improvement in patient outcomes.[142] ▸ Risk adjusted mortality rates for the evaluated criteria decreased significantly in hospitals that participated in the program compared to those that did not.[143]

[139] NHS Commissioning for Quality and Innovation (CQUIN) 2014/15 Guidance. February 2014
[140] Ibid
[141] Advancing Quality Alliance website, viewed on 16 July 2015, <http://www.advancingqualitynw.nhs.uk/>
[142] McDonald R, Boaden R, Roland M, et al. (2015) A qualitative and quantitative evaluation of the Advancing Quality payment-for performance programme in the NHS North West. Health Services and Delivery Research, No. 3.23.
[143] Ibid

13.4.3 Rationale

The aim of the AQ program was to improve patient care and patient experience in hospitals across the North West of England. The program was based on a US program called Hospital Quality Incentive Demonstration (HQID), and was initially supported by one of the partners that implemented the US program.[144]

13.4.4 Outcomes and Performance indicators

Indicators for the AQ program could be classified into 3 domains:

- Clinical process and outcomes for five clinical areas (acute myocardial infarction, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement). Indicators included a mix of patient outcomes (e.g. readmission rates) and favourable clinical practices
- Patient reported outcomes: Patients were given a survey about their health status before and after intervention.
- Patient experience of care provided: Patients were asked to rate their care experience out of 10.

13.4.5 Pricing and payment model

Hospitals performance against the indicators was recorded and ranked annually against all other hospitals participating in the program. Those in the top quartile received a bonus payment equivalent to 4 per cent of their total budget. Those in the second quartile received a bonus payment equivalent to 2 per cent of their total budget. There were no penalties for the poor performers.

13.5 Best Practice Tariff[145]

13.5.1 Summary

Best Practice Tariffs (BPT) were introduced in April 2010 to adequately incentivise delivery of clinical and cost effective care. BPTs incentivise treatment of conditions in a certain way. For example, a BPT exists for tonsillectomies and septoplasties carried out in day procedure settings.

13.5.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Best practice Tariff	UK, Nation-wide	Implemented as part of the National Payment by Results funding framework	April 2010, continuing	An inflated tariff paid to hospitals for treatment that complies with best practice

Results	Overall BPTs have been shown to positively impact patient outcomes, however level of effectiveness varies across the board, with some tariffs showing little or no impact.[146]

[144] Advancing Quality Alliance website, viewed on 16 July 2015, <http://www.advancingqualitynw.nhs.uk/>

[145] UK Government website, viewed on 16 July 2015 <https://www.gov.uk/government/news/introduction-of-best-practice-tariffs-qualitative-and-quantitative-evaluation>

[146] McDonald, R. Et al, *A Qualitative and Quantitative Evaluation of the Introduction of Best Practice Tariffs*, 2012 (an Evaluation report commissioned by the Department of Health. University of Nottingham)

13.5.3 Rationale

In most activity based funding systems for health care, prices for health care events are based on national average costs. Some concern exists that this incentivises health providers to reduce quality in order to reduce the cost of delivery to that below the average. In response to this concern, the UK Department of Health introduced Tariffs that paid a premium above the national average cost for delivery of an intervention adhering to best practice.

13.5.4 Outcomes and Performance indicators

BPTs exist for a range of medical procedures. For example, a BPT exists for cholecystectomy to encourage the procedure to be carried out via keyhole surgery in a day case setting as this provides a better experience for patients as well as being a more cost effective use of resources. Evaluation of BPTs has highlighted the need to use greater rigor in identifying and targeting clinical areas for development.[147]

13.5.5 Pricing and payment model

Though there is some variability in how each BPT is paid, generally BPTS are paid like tariffs for other care however the price for the tariff is set above that of the national average cost for the intervention.

13.6 Key lessons

There are a range of lessons that can be learnt from the Payment for Performance schemes implemented in the UK health setting:

- There is very little supporting evidence linking payment by performance schemes and an improvement in patient outcomes, due to a difficulty in applying schemes across the care pathway and the difficulty in measuring patient outcomes
- There is limited evidence as to the size of incentive required to generate significant change at an organisational level
- Not all measurable outcomes are equal. It is important to weight outcomes to in order of relative importance to ensure that organisations expend appropriate levels of effort against each performance indicator
- Whilst consultation is important to the design of pay for performance schemes, this should be separate from the technical design process which includes defining indicators, agreeing thresholds and setting prices
- A clear evaluation methodology should be set from the start to ensure that programs are able to be evaluated over the life of the implementation and build a body of evidence.
- Competition for additional resources can be useful for lowering cost, sharing knowledge and improving quality
- Financial levers have been shown to stimulate capacity building within organisations, as institutions will be prepared to invest in anticipation of greater revenue streams.
- Sometimes simply reporting on metrics that measure how much the system is being gamed is effective in preventing gaming
- Commitment and stability within the program provides opportunity for participating institutions to invest for the long term
- Data collection and reporting are essential to the effective implementation of a program
- Inconsistent measures may increase the administrative burden and negate benefits from activity.

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[147] UK Government website, viewed on 16 July 2015 <https://www.gov.uk/government/news/introduction-of-best-practice-tariffs-qualitative-and-quantitative-evaluation>

Appendix B Out-of-home care Case Studies: Summaries and Fact Sheets

This appendix comprises a summary of each of the OOHC case studies referenced in the report.

Illinois

Illinois had the highest total number of children in foster care in the US in 1996, with 17.2 children per thousand in care compared to a national average of 6.9.[148] The State Government decided to pursue a reduction in the numbers of children in care. Outsourcing of services to NGOs began in the mid 90's. Firstly case management responsibility was transitioned, and then performance based contracting was introduced with the objective of reducing the population in care and increase child permanency. A number of providers are also paid incentive bonuses on a number of outcome-based performance metrics in-order to drive quality improvements. Performance based residential care contracts were introduced later.

Alberta

Alberta has sought to introduce the concept of joint accountability between the government and NGOs for the outcomes of the most vulnerable young children. Alberta started implementing 'Outcome-based Service Delivery' across the province in 2009 in the areas of in-home assistance, and temporary and permanent foster care, and is still in the process of implementing this transition.

ACT

Increasing demand for OOHC services in the ACT, as well as a number of external reports, presented the case for OOHC reform and the need to develop a five year OOHC reform strategy.[149]

The ACT strategy involves an overhaul of the existing OOHC system, with the intention of migrating services to a trauma informed, child centric model of care. At the centre of the model is a lead contractor who will be responsible for the delivery of all OOHC related services and the associated child outcomes. A key aim of the approach is to ensure that services offered to children range across the continuum of care in order to generate the best possible outcomes for the Territory's most vulnerable children and young people.

Victoria

Victoria is also developing and implementing a five year strategy to transform its OOHC services. They are moving to a more integrated, child centred and outcomes focused delivery model for OOHC services. The five year plan identifies the need to improve life outcomes for children and young people in care and also involves a separate strategy for the Aboriginal cohort.[150]

UK

In the UK, a number of social impact bonds have been developed, including tools allowing commissioners to trial new services with upfront private investment, with payment at risk.[151] The Essex SIB was the first of its kind, and is targeted at the prevention end of the child protection system. The Manchester SIB was developed shortly after, and is targeted at the restorative end of the child protection spectrum.

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[148] Blackstone, et al, *Privatizing adoption and foster care: Applying auction and market solutions,* 2004

[149] Community services ACT, A step up for our kids – ACT Out of Home Care Strategy, 2015

[150] DHS, *Victoria's Vulnerable Children – Our Shared Responsibility, Out of Home Care a five year plan*, 2015

[151] UK Government website, viewed on 26 June 2015, <https://www.gov.uk/social-impact-bonds>

In the UK out-of-home care system case management is still performed by local authorities, as are a large proportion of the child welfare services offered to 'looked after children' (OOHC), including foster care. There is a push to increase commissioning within local government services in an attempt to reduce costs and increase efficiency.[152] A number of local authorities, including Gloucestershire, Devon, and Essex are implementing their own commissioning initiatives.

NSW

In Australia there is a growing need to improve personal, social, and economic outcomes for young people in care and improve OOHC funding mechanisms. NSW has a steadily increasing rate of children in OOHC, in line with the national trend. This trajectory, combined with the safe home for life reforms and the policy objectives articulated by the NSW Government, highlights the case for change. NSW have deployed a number of Social Benefit Bonds in the OOHC sector: one targeted at family preservation, and another targeting restoration to the family home.

[152] Commissioning Support Program, *Outcomes and Efficiency: Commissioning for looked after children*, 2010

1. Fact sheet: out-of-home care in Illinois

1.1 Summary

Illinois has implemented performance based contracting in multiple areas of its child welfare system, including: foster care case management, residential care contracting and independent living options.

Performance based contracting began in Illinois in 1997 when foster care case management contracting moved from being an individualised unit cost approach to payment-for-performance outcomes. The trial started in Cook County, Chicago, and then was expanded state wide due to its success.

In 2007 performance based contracting was then extended to include residential care providers, with the aim of increasing placement stability and once again targeting permanency for the child. In 2010, as a result of state budget difficulties, performance based payments ceased being paid for residential care, which effectively means the system has reverted to activity based funding for residential care. However, a performance based payment regime remains in place for foster care (further detail below).

The program is paid for by the state and commissioned by the State Child Welfare Agency, although initially developed and implemented by the Department of Children and Family Services (DCFS).

1.2 Key facts and figures

	Locality	Program size	Key dates	Program type
Out-of-Home-Care	Illinois, US (population 12.88 million people)	In 2010 Illinois spent $1.2billion on child welfare services[153] At the start of the program there were 51,000 children in OOHC (this has since reduced by 65 per cent to 18,000(2005))	Commenced: Foster care - 1997 Residential care - 2007	Foster care: Case load model with required permanency targets Residential care: Case load model with incentives and penalties (until 2010)

[153] Child Welfare League of America, *Illinois' Children,* 2013

Results	Foster Care: ► The foster care case load fell from 51,000 in 1997 to 15,000 in 2013 ► Adoptions rose by 94 per cent between 1997 and 2003 ► Permanency rates rose from 2-4 per cent to 12-23 per cent between 1997 and 2003 ► The median number of months spent in foster care fell from 40 to 25 between 1996 and 2002 ► Illinois ranked near the top of the US states at achieving permanency with some budgetary savings Residential Care: ► Percentage of youth negatively discharged[154] fell from 16.5 per cent in 2009 to 14.1 per cent in 2011 ► Percentage of youth favourably discharged[155] rose from 22.1 per cent in 2009 to 29.4 per cent in 2011

1.3 Rationale

Performance based contracting was set up in an attempt to reduce the number of children in substitute care in the state by increasing incentives to deliver permanency to children through delivering more suitable, long term placements outside of the OOHC system. The reforms also intended to align incentives of providers with desirable outcomes for children (safety, permanency, and wellbeing). Particular additional goals for residential care were set up by the project steering committee, and are as follows:

- "To improve the safety and stability of children during residential treatment;
- To effectively and efficiently reduce symptoms and improve the functional skills of children through residential treatment; and
- To improve outcomes for children at and following discharge from residential treatment."[156]

These broad objectives were used to generate the following performance measures.

1.4 Outcomes and performance indicators

1.4.1 Foster Care – performance measure tied to payment

Payment for permanency[157] is the only measure that is linked to a payment incentive – agencies must transfer a certain number of cases (24 per cent[158]) to permanency each year in order to ensure they are not managing more cases than they are being paid for (see below section regarding pricing and payment information).

1.4.2 Foster Care – other outcomes measured

Although caseload ratios and annual performance targets are the key performance metrics, agencies are also measured on a number of published program metrics; such metrics are

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[154] Definition: Negatively discharged – negative step up to a more restrictive model of care or a lateral move

[155] Definition: Favourably discharged – positive step done to a less restrictive setting

[156] University of Kentucky, *Striving for Excellence: Expanding Performance Based Contracting to Residential, Independent Living and Transitional Living Programs in Illinois,* 2013

[157] Definition: "Permanence for children in child welfare is generally discussed as one of three outcomes for children in foster care: reunification with the family, adoption, or kinship care." <http://www.nrcpfc.org/is/downloads/Reunification_FChildren_w.Fam.pdf>

[158] Blackstone, et al, *Children and Youth Services Review* 26, 2004, page 1040

independent of payment incentives. Until recently, metrics were collected independently, and include:

- Programmatic measures – rate of foster care, foster care recruitment and licensing, accreditation status
- Child safety – number of reports of abuse/neglect and number of removals from imminent risk
- Child wellbeing – placement with siblings, placement in the community, placement with relatives, and engagement with children's parents and relatives in case management/planning
- Child permanency – average length of stay in care, placement disruptions, average number of moves, and restrictive placements
- Compliance with federal regulations

1.4.3 Residential care – measures tied to payment (until 2010)

Residential care providers are measured on two performance indicators – the 'Sustained favourable discharge rate' and the 'Treatment opportunity day's rate.'

Sustained favourable discharge rate - percentage of total annual residential care spells resulting in a "sustained favourable discharge". See below:

- Sustained - Remained stable in discharge placement for 180 days
- Favourable - positive step down to a less restrictive setting or a neutral discharge in a chronic setting
- Unfavourable - Negative step-up to a more restrictive setting, disrupted placement or lateral move to another residential facility or group home

Treatment opportunity day's rate (TODR) - the percentage of days 'in treatment'. This is defined as the number of days the child is present at the residential facility, out of the total number of days the child is placed in the care of the facility during the review period. A lower TODR would reflect a higher number of unplanned or unscheduled absences from the facility (typically spent in hospital, in detention, or simply unaccounted for). Therefore, a higher percentage TODR is taken to reflect better management of the child's wellbeing.

Each agency is given a risk weighted benchmark for the above indicators to calculate their expected performance, based on the complexity of their case load mix. For example, if a provider receives a large number of children at risk of running away, their TODR benchmark will reflect this higher level of inherent complexity and risk.[159] Risk adjustment factors include historic child protection system involvement, demographic characteristics, length of time in care, severity of prior care needs, and geographic location.[160] Once identified, the risk factors are tested against a DCFS database.[161] Accurate risk adjustment is essential in Illinois since the state enforces a "no decline" policy - providers cannot choose or refuse cases.[162]

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[159] Quality Improvement Centre, *Examples of Performance Based Contracts In Child Welfare Services*, 2009

[160] Illinois Department of Children and Family Services, *Child Welfare Innovation in Illinois through the Use of Performance Based Contracting*, 2009

[161] University of Kentucky, *Expanding Performance Based Contracting to Residential, Independent and Transitional Living Transitional Living Programs in Illinois,* 2009

[162] Judge Kathleen A. Kearney (Children & family research centre – University of Illinois), Mary Hollie (Laurence Hall youth Services) PPT: *Leading Change: Using performance based contracting to improve outcomes for children and Youth in Residential care*

1.5 Pricing and payment model

1.5.1 Foster Care

The payment model for foster care in Illinois gives providers an incentive to achieve their permanency target. The target is the same for all providers state-wide: 24 per cent of their caseload should be moved into a permanent living arrangement every year. The incentive arrangement is structured so that providers who achieve above the 24 per cent target receive relatively more funding per child (for those that remain in their care). Meanwhile, those who fall below the target receive relatively less funding per child. The incentive is given effect through a 'retention of earnings' style arrangement:

- Providers are both paid, and allocated new cases on the assumption that they meet the performance target exactly. For example, if they fail (and hence have more children in their facility than expected) there is neither an upward adjustment to their funding; nor a downward adjustment to the number of cases they are allocated. In other words:
  - If providers exceed their target, the outflow of cases into permanent placements will exceed their inflow of new cases, and the provider may keep the excess available funding
  - If providers fall below the target, the inflow of new cases will exceed the outflow of cases into permanent placements, and the provider must make up the shortfall in available funding

If providers continue to fail to meet the targets, contracted capacity can be reduced, or the contract eliminated altogether.[163]

1.5.2 Residential Care

In residential care, agencies are guaranteed funding for 100 per cent of available beds. That is, activity based funding is in place. Up until 2010, there was performance based payment regime in place that complemented the activity based regime. Prior to 2010, residential care agencies were paid a bonus based on the ability of the child or youth to sustain their discharge placement for 180 days, and were penalised at a rate of 25 per cent of the cost of the bed for each bed day for not achieving treatment opportunity days rate targets.

In 2010, as a result of budget difficulties, Illinois was unable to pay bonuses. In the interest of fairness, penalties were also scrapped. However the performance indicators are still measured and agencies can be placed on performance improvement plans if poor performance is observed.[164] For reputational reasons, evidence suggests that agencies still try to hit their targets despite the bonuses and penalties no longer applying.

1.6 Key lessons

There are a range of important lessons from the Illinois experience that are relevant for OOHC and human services in NSW:

- Simplicity in terms of both contracts and incentives aids the transparency and management of the system
- Measuring and publishing results and performance indicators can drive performance; as what gets measured - gets done. This can even occur where financial incentives are not provided

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[163] Blackstone, et al, *Children and Youth Services Review* 26 , 2004, pg. 1040

[164] Quality Improvement Centre (2009) – Examples of Performance Based Contracts In Child Welfare Services, page, 18 <http://www.uky.edu/SocialWork/qicpcw/documents/QICPCWPBCLiteratureReview.pdf>

- Introducing competitive tension can lead to savings from economies of scale, and precipitate the exit of ineffective providers
- Building flexibility into contracts and adapting over time allows for the government and providers to adapt to unforeseen circumstances or policy issues.
- Market operators may assess government risks and take them into account in decisions about how and if they engage in service provision (i.e. if there is a risk that incentives will not be paid)
- Collaborative planning was an important component of success. (i.e. the CWAC Working group was established)
- Where appropriate, market development support may be necessary, especially in the early stages. In this case, a proportion of fiscal savings were reinvested back into the system to improve service
- The importance of accurate, reliable, fair and verifiable data collection around performance metrics
- Where the client group is segmented and highly complex, there needs to be a way (such as through the risk weighting strategy) to create a level playing field for providers and provide additional resources for managing additional complexity.

2. Fact sheet: out-of-home care in Alberta, Canada

2.1 Summary

In 2009, the state of Alberta in Canada began implementing an outcomes-based Service Delivery (OBSD) model as a way to shift focus of serving at-risk children and families from what services are provided to what the result of those services should be.[165]

While not completely implemented across the province, certain sites have been involved since 2009. Agencies and Child and Family Services Authority staff collaborate with parents to set goals and identify friends, relatives, and community members who can support the family in achieving their goals.

OBSD uses a new funding approach where there is increased flexibility for agencies in identifying what services they provide and how they will work with children and families. OBSD's aim is to provide agencies, communities and caregivers with more flexibility to respond to the unique needs of children and families, while focusing on intended outcomes and better supporting innovative practices.[166]

Results indicate that more children are able to be served at home with their families than would have been typical in the past, and more children are able to safely return to their home after services have been provided.

The program is paid for by the province of Alberta and services are implemented by the Ministry of Human Services, Child Intervention.

2.2 Key facts and figures

	Locality	Program size	Key dates	Program type
Out-of-Home-Care	Alberta, Canada (Pop: 4M)	Total Child Intervention Budget for 2014-15: $728M CAD ($756 M AUD (includes at home, temporary, and permanent care)[167] In 2012-13 (latest data available) there were a total of 10,033 children/youth in temporary or permanent out-of-home care [168]	Commenced 2009 Full implementation ongoing	Outcomes-based. Entire program features in-home assistance, temporary, and permanent foster care.

[165] Alberta government website, viewed on 16 July 2015 <http://www.humanservices.alberta.ca/abuse-bullying/17242.html>

[166] Alberta government presentation, viewed on 16 July 2015 <http://www.aascf.com/Outcome_Based_Service_Delivery_Alberta_Children_and_Youth_Services__October_2014.ppt>

[167] Alberta government website, viewed on 16 July 2015 <http://finance.alberta.ca/publications/budget/estimates/est2015/human-services.pdf>

[168] Alberta Government website, viewed on 16 July 2015 <http://humanservices.alberta.ca/abuse-bullying/cidata/>

Results	More children stay home and are receiving services in their home vs. out of home; more children are placed with their immediate or extended family; more children who come into care, stay for shorter durations; files are closing more quickly with lower rates of recurrence; more explicit focus on intended 'outcomes' for the child and family.[169] The program has now entered its fifth year of implementation, but is currently in the early stages of measuring outcomes. Some results to date: ► As of 31 March, 2014 in the South Zone 44 per cent of children were in home and 56 per cent were in care. This number changes quickly, however, the number of kinship or homes approved by family is on the rise ► In the last 4 year term recurrence was 10.7 per cent compared to 15 per cent provincially. Stakeholders consider some of the main benefits to be: ► Greater clarity regarding roles and purpose of an intervention ► A more explicit focus on intended 'outcomes' for the child and family ► A greater voice in planning how services will be delivered amongst contracted agencies ► Greater recognition of contribution of agency service provision to the wellness and safety of the children and families they are serving.

2.3 Rationale

The government of Alberta has made it clear that the goals of the OBSD are:

- To develop a community quality improvement and learning process that will continue to guide joint practice and identify opportunities for improvement using evidence to guide practice
- To develop a service delivery system that has the capacity to measure and focus on achievement of agreed upon client centred outcomes as the central driver for both casework and resource allocation decisions
- To establish joint accountability for outcomes for vulnerable children, youth and families.[170]

2.4 Outcomes and performance indicators

Building on the National Child Welfare Outcome Matrix (NOM) framework,[171] developed in consultation with provincial, territorial, and First Nations service providers, the OBSD tracks five outcomes:

1. Supporting vulnerable children to live successfully in the community
2. Children in temporary care will be reunited quickly with their family
3. Children in permanent care will be placed in permanent homes as quickly as possible
4. Youth will be transitioned to adulthood successfully
5. Aboriginal children will live in culturally appropriate placements and receive culturally appropriate services

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[169] Alberta government presentation, viewed on 16 July 2015 <http://www.aascf.com/Outcome_Based_Service_Delivery_Alberta_Children_and_Youth_Services__October_2014.ppt>

[170] Ibid

[171] *National Child Welfare Outcomes Indicator Matrix*, Canadian Child Welfare Research Portal, viewed on 16 July 2015 <http://cwrp.ca/sites/default/files/publications/en/NOM_Sept09.pdf>

2.5 Pricing and payment model

The OBSD, once completely implemented, will shift funding from units of service to the provision of outcomes and from multiple contracts, to a single contract, by agency. [172]

The characteristics of the current state are:

- Currently using a case rate model
- Future rates/ contracts are being developed
- Agencies have flexibility around costs
- "Exceptional" Cases (not included)

2.6 Key lessons

There are a number of key lessons that can be learnt from the Alberta model of care, which can be summarised as follows:

- Agencies need time to build capacity and partnerships required to deliver a continuum of supports
  - One model observed is for 'lead agencies' to cover costs, allowing partnering agencies to focus on care provision
- Focus on change management is critical to success. Providers need frequent opportunities to meet with government, discuss issues and confront differences
  - Co-location is positive to the building of communication and trust

The government commissioned a third party to produce an evaluation report, which gave the following feedback:

- Declare and demonstrate long term commitment to the OBSD initiative
- Develop and integrate outcome measures into the initiative
- Expand OBSD in a strategic manner, mindful of what has been learned to date
- Clarify the OBSD funding approach.[173]

The government has responded with the following:

- The Framework has been developed and is being refined
- The learning from the sites is being assessed and shared, and is creating the foundation for future steps
- The funding model is still under discussion and will be reflective of the changes in practice
- Recognition of the huge amount of work being done by Lead Agencies prior to obtaining legal status.

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[172] Alberta government presentation, viewed on 16 July 2015 <http://www.aascf.com/doc_view/12025-lessons-being-learned-through-the-implementation-of-outcomes-based-service-delivery-obsd-an-update-aascf-conference-january-25-2013>

[173] Ibid

3. Fact sheet: out-of-home care in the ACT

3.1 Summary

The ACT is in the process of developing a five year plan for the reformation of out-of-home-care services. The ACT strategy, to be implemented by 2020, involves a complete overhaul of the existing OOHC system. A key innovation of the program is the appointment, through a two stage tender process of a lead contractor or consortium that will be responsible for delivery of all OOHC and related services. The reform will also include a structural reform of the service delivery model to form a therapeutic and trauma informed child centred approach that addresses the needs of children through individualised funding.

The new approach aims to provide the best possible service for children and young people in care, in order to give them the best possible start in life. A key element of this is ensuring services are provided across the continuum of care – not just in OOHC – including preservation, restoration and support for exiting care (e.g. at age 18).

3.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Out of Home Care	ACT	ACT - $16million over 4 years, 600 children in care system	Commenced 2015 Ends 2020	TBD Will involve: outcomes-based funding and a retender of existing contracts

3.3 Rationale

Australia wide there is an urgent and growing need to improve personal, social, and economic outcomes for children and young people growing up in care. The introduction of the *Children and Young People Act 2008*[174] has contributed to increasing demand for OOHC services, and this in addition to fiscal pressures represents a need to improve outcomes, reduce demand, and create the foundation for sustainable delivery.[175]

In the ACT the new strategy was developed in response to a number of external reviews of the purchasing, delivery, and care services provided:

- Public Advocate: Emergency Response Strategy for Children in Crisis in the ACT 2011
- Public Advocate: Review of the Emergency Response Strategy for Children in Crisis in the ACT 2012
- Auditor-General: Performance Audit Report of the Care and Protection System 2013

These reviews prompted the need to ensure the quality and supply of OOHC placements for children and young people (CYP), whilst also ensuring the best possible outcomes for CYP were achieved. Modelling and research has been undertaken to support the ACT strategy and suggests that if no action is taken, the Territory will have an OOHC crisis within five years with growing demand, care shortages, and increasing costs. At present the number of children in the out-of-home care system is growing at a rate of 5 per cent per year, and this will not change without intervention.[176]

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[174] Community services ACT, *A step up for our kids – ACT Out of Home Care Strategy*, 2015

[175] DHS, *Victoria's Vulnerable Children – Our shared responsibility, Out-of-Home-Care: A five year plan*, 2015

[176] Community services ACT, *A step up for our kids – ACT Out of Home Care Strategy*, 2015

3.4 Outcomes and performance indicators

The ACT Government has developed an outcomes framework in order to guide the development of the required performance indicators and aid in their new contracting model.

The ACT's outcomes framework contains outcomes relevant to two areas:

1. Strengthening high risk families and services across the continuum of care (outcomes include, child safety, family engagement, and social and emotional behaviours). The performance indictors to be used in contractual arrangements relevant to this outcome are:
    a) CYP in long term, safe sustainable placements (family, kin or alternative) – outcome measure
    b) CYP therapeutic needs are identified and addressed when required to support improved life achievements - output measure
    c) Every CYP has an agreed and funded case plan – activity measure

2. Strengthening system accountability and capability (outcomes include accreditation, commitment, and capacity building).
    The performance indictors to be used in contractual arrangements relevant to this outcome are:
    a) The OOHC service system is well organised and co-ordinated to deliver optimal services to CYP and families – output measure
    b) Service delivery costs are well managed and proportionate to cohort needs over time and align to the OOHC five year strategy – output measure
    c) Carer or family household where CYP resides have been recruited, trained and supported to meet the needs of children in care – activity measure

These indicators are compared to a number of indicative benchmarks/targets that will align with the transition over the five year plan. The table below aligns each of the identified performance indicators with an indicative benchmark that changes over time.

Table 1: Indicative benchmarks/targets

Performance Indicator		Year 1	Year 2	Year 3	Year 4	Year 5
(a)	Placement goal met and <3 placement changes	60 per cent	70 per cent	80 per cent	90 per cent	90 per cent
(b)	Therapeutic plan identifies the need for improved mental health – CYP has access to services	75 per cent	75 per cent	85 per cent	90 per cent	100 per cent
(c)	Joint case plan sign off has been achieved between CSD and agency	100 per cent	100 per cent	100 per cent	100 per cent	100 per cent
(d)	Appropriateness of all placements relative to all available placements	60 per cent	70 per cent	80 per cent	90 per cent	90 per cent
(e)	All CYP associated costs are within budget target	+/-10 per cent	+/-8 per cent	+/-6 per cent	+/-4 per cent	+/-2 per cent
(f)	Carrera recruitment data to include training, development plans, and exits	40 per cent	60 per cent	75 per cent	90 per cent	100 per cent

3.5 Pricing and payment model

Although in the early stages of development (given that tender bids are currently being evaluated), there are a number of model features that will influence ACT's commissioning model (within the overall emphasis on child outcomes and implementing a therapeutic, trauma informed model of care). They are as follows:

- It supports the intent of the OOHC strategy – in terms of a reduction in numbers of children and young people in placements
- There is likely to be a 5 year funding agreement - service providers receive certainty and flexibility
- Performance can be directly monitored – the focus is on restoring children and young people so they are diverted from the system where appropriate
- Service providers need to be incentivised to ensure young people are restored and diverted
- Performance measurement will focus on reductions in numbers of children and young people out of the system at an individual provider level; noting that there still will be children and young people on long-term orders
- Performance will consider in-flow and effectiveness of early interventions and prevention initiatives
- Service providers are required to enter into the provision of non-placement services across the entire continuum of care

3.6 Key lessons

Although in the very early stages of reform, there are a number of key lessons that can be learnt from ACT's approach, including:

- System reform can be an appropriate way to meet the new demands on the out-of-home care sector, not just small changes to the existing system
- A relentless focus on the outcomes for children and young people to drive and incentivise improved performance of providers
- The importance of a plan to aid transition, which will need to be done over a prolonged period of time
- A deep process of market engagement is advantageous to gain a full understanding of all challenges front line services are facing
- The use of best practice models of care and intervention are an important input into the new out of home care system
- Funding reform is important to ensure a child focused approach is adopted
- It is important to consider and target issues relevant to Aboriginal children and young people
- The importance of taking a staged or measured approach when redesigning and building a market to ensure service continuity
- Market shaping is essential to ensure providers are able to deliver services across the continuum of care – e.g. through a lead provider approach which is encouraging consortia and partnerships to form in response.

4. Fact sheet: out-of-home care in Victoria, Australia

4.1 Summary

The Victorian Government is in the process of developing and implementing a five year plan for the transformation of its out-of-home-care services. Victoria is intending to develop a more integrated, client centred, and outcomes focused approach to OOHC service delivery. It also intends to develop a complimentary plan targeting Aboriginal young people in the state; a demographic heavily overrepresented in OOHC in Victoria.

4.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Out of Home Care	Victoria	Vic - $128 million over 4 years, 6,500 children in care system	Commenced 2015 Ends 2020	TBD Will involve: outcomes-based funding and a retender of existing contracts

4.3 Rationale

Australia wide there is an urgent and growing need to improve personal, social, and economic outcomes for children and young people growing up in care. The introduction of the *Children and Young People Act 2008*[177] has contributed to increasing demand for OOHC services, and this in addition to fiscal pressures represents a need to improve outcomes, reduce demand, and create the foundation for sustainable delivery.[178]

In Victoria, a 2011 Government initiated inquiry into the systemic problems present in Victoria's child protection system[179] concluded that there are "some major and unacceptable shortcomings in the quality of care and outcomes from children placed".[180] This prompted the development of a direction paper *Victoria's vulnerable children –Our Shared Responsibility Directions Paper*, which announced the State's commitment to reform and the commitment to funding, which included $650 million over three years

4.4 Outcomes and performance indicators

Victoria has developed an outcomes framework in order to guide the development of the required performance indicators and aid in its new contracting model.

Victoria's framework consists of personal, social, and economic indicators:

- Children and young people in out-of-home care enjoy good health and well-being – to include good mental and physical health indicators
- Children and young people in out-of-home care make positive personal choices and show positive behaviour – to include smoking, alcohol and drug use indicators
- Children and young people in out-of-home care have the skills and support necessary to participate in the economy to their fullest ability – to include skills, meaningful contribution, education, and housing indicators.

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[177] Community services ACT, *A step up for our kids – ACT Out of Home Care Strategy*, 2015

[178] DHS, *Victoria's Vulnerable Children – Our shared responsibility, Out-of-Home-Care: A five year plan*, 2015

[179] Ibid

[180] State Government of Victoria, *Victoria's vulnerable children*, 2013

4.5 Pricing and payment model

Victoria is currently in the process of developing an options paper to assess the range of funding possibilities available, but early considerations suggest that a model that will include a common base payment, and then additional payments depending on the assessed individual needs of the child. This is with the intention of creating a child centric approach. Contracts will be awarded on the basis of defined outcomes.

4.6 Key lessons

Although in the very early stages of reform, there are a number of key lessons that can be learnt from the Victorian experience so far. These lessons include:

- The importance of a plan to aid transition, which will need to be done over a prolonged period of time
- Understanding all funding and service delivery options available is important in developing a strategy for reform
- It is important to consider and target issues relevant to Aboriginal children and young people – a consistently over represented demographic in the care system.

5. Fact sheet: Essex County Council – Social Impact Bond

5.1 Summary

The Essex CC SIB has been developed in an attempt to reduce the number of children entering "looked after care" in that county. At present numbers in care in Essex are higher than both the national average and statistically comparable local authorities.[181] In 2014 there were 1,600 young people in care in Essex – around 500 more than there should have been.[182] The bond will enable the provision of Multi Systemic Therapy (MST), therapy done in the family home with the aim of keeping families together by rebuilding relationships, and helping families cope with crisis situations, aiming to reduce the number of children entering care. As many as 380 young people in the county who have been flagged as at risk of entering care and their families will have access to this service.

The Essex County Council SIB is the first of its kind and Essex is the first local authority to commission a social impact bond in the child welfare space. This fits in with the county's wider goal of commissioning more child welfare services on outcomes rather than inputs, a transition currently underway.

In the whole scheme of child welfare services and the provision of "looked after children" care in the UK, the bond is relatively small in scale, with just one contract with one charity (Action for Children) providing the services, but it is an example of the possibilities available to use outcomes-based commissioning to improve the lives of vulnerable young children in Essex (and NSW) today.

5.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Child Welfare	Essex county	£3.1 million over 5 years (with outcomes payments recirculated) 380 children and families	Commenced November 2012 Ends November 2017	Payment by outcomes

Results	A formal evaluation of the program is yet to be conducted, but according to Action for Children (the service provider), of the young people who have been enrolled in the program so far - 79 per cent are still living at home at the end of the program. It has also been seen to have reduced: aggression, property damage, smoking and drug taking incidence, sexualised behaviour, incidence of custody, and incidence of fire setting in the young people taking part, and has increased attendance and positive behaviours at school.[183]

5.3 Rationale

The program was set up as a trial to test the use of outcomes-based commissioning as a tool for improving child welfare services in the UK, and improving the lives of children. The key aim is to divert children from the path of looked after care; with the target of helping 110 children remain in their family homes over the 5 year period of the bond.

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[181] Cabinet Office, *Essex Edge of Care Social Impact Bond*, 2013

[182] Mötesplats Social Innovation, viewed on 26 June 2015, <http://www.socialinnovation.se/en/the-first-county-sib-in-the-uk-shows-good-results>

[183] Action for Children website, viewed on 26/06/2015, <https://www.actionforchildren.org.uk/what-we-do/services-for-professionals/evidence-based-programmes/>

In the current model in Essex, looked after care can cost anywhere in the range of £20,000 to £180,000 per child per year (depending on the severity of the case and services provided), and so diversion resulting from the SIB has the potential to generate savings for the county. Estimates suggest that the bond could save tax payers £10.3 million over the 5 year period as a result of care diversion and the maximum payment cap (discussed below). These savings are essential because between 2011 and 2017, the funding envelope available to Essex County Council is to drop by 21 per cent,[184] increasing the financial pressure and the need to drive innovative funding solutions.

The Essex Social Impact Bond set clear and objective referral criteria for entry into the funded intervention.[185] Essex county council will make use of existing referral pathways to help embed the MST service into the Council's core service offering, this is with the intent of guarding against program isolation.[186]

Finally MST is an evidence based program and independent research has shown that it can reduce the number of children placed in care by up to 64 per cent, and offending behaviours by 41 per cent.[187]

5.4 Outcomes and performance indicators

The key performance indicator for the SIB is the total number of care days saved, a frequency metric.[188] This is different to exits from care used in other SIBs, since it accounts for the aggregate number of care days saved across all children in the program.

In order to measure the number of care days the MST program has helped to avoid, the number of days children have been in care in the program is compared to the total number of days in care observed in a comparable group of children over a 30 months period, these children were identified following detailed analysis of case files of young people who met the referral criteria three years ago[189]. This is called the control review figure and this data is based on historic data that includes 650 cases. Over the five year period it is predicted that bond cohort will have 110 fewer children in looked after care in comparison to the control figure.

The use of a frequency metric as opposed to a binary metric reduces the incentive to 'cherry pick' cases, and the incentive to keep children out of care when this may not be the best option for the individual.

The bonds evaluator also measures school performance (in terms of attainment, attendance, and stability), the offending rate, and emotional wellbeing[190] – although no payment is triggered in relation to these metrics.

5.5 Pricing and payment model

An outcomes contract exists between Essex County Council and the special purpose vehicle (Children's Support Services Limited) set up to facilitate the bond. Children's Support Services Limited will also have a contract with the provider Action for Children.

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[184] Essex County Council, *The essex social impact bond – financial Innovation and service redesign in children's* Services, 2012

[185] Social Finance, *Designing Effective Outcome Metrics And Measurement Systems,* 2015

[186] Cabinet Report, *Award of contract for Multi-Systemic Therapy via Social Investment*, 20 October 2012

[187] Action for children website, viewed on 26 June 2015, <https://www.actionforchildren.org.uk/what-we-do/services-for-professionals/evidence-based-programmes/>

[188] Social Finance, *Designing Effective Outcome Metrics And Measurement Systems,* 2015

[189] Ibid

[190] Innoweave website, viewed on the 26 June 2015, <http://www.innoweave.ca/en/modules/outcomes-finance/case-studies/action-for-children-essex-county-united-kingdom>

Payments made by Essex County Council are equal to a share of the cost of the care placement that the Council would have otherwise had to pay for a weighted unit cost. They were calculated based on the average proportion of time spent in each placement type, and are subject to a cap of £7million.[191]

Intermediate pay-outs occur through the life of the bond and will begin when the first cohort has completed the program. The timeline for outcome payments was designed so that payments are made as soon as possible and so can be recycled to fund later years of the program.[192]

Returns are expected to be in the range of 8-12 per cent with the entirety of the investment at risk[193] as all risk is transferred from the commissioning authority to the investors.

5.6 Key lessons

There are a number of lessons that can be drawn from Essex's experience including the importance of early intervention into the child protection system to prevent entry into care. These include:

- Simplicity – the focus on a single outcome the delivered cashable results allowed for both political and investor buy in[194]
- Value for money – there has to be an incentive to invest[195]
- Payment for outcomes – it is important that even individual programs fit within the wider target of outcomes commissioning[196]
- Sustainability – longevity in a reform is crucial to ensuring results are delivered and benefits realised, this is particularly important in the case of out-of home care where children and their stability is at risk[197]
- Tactical – impact has to be targeted and long lasting [198]
- Marketable – mechanisms have to be used to shape and grow the market from a commissioning perspective[199]
- Replicable – the model design needs to support future application and sustainability.[200]

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[191] Cabinet Office, Essex Edge of Care Social Impact Bond,2013

[192] Social Finance, *Designing Effective Outcome Metrics and Measurement Systems,* 2015

[193] Instiglio website, viewed on 26 June 2015, <http://www.instiglio.org/en/analysis-of-the-social-impact-bond-in-essex-uk/>

[194] Cabinet Office, Essex Edge of Care Social Impact Bond, 2013

[195] Ibid

[196] Ibid

[197] Ibid

[198] PPT: Centre for Economic and Social Inclusion: Social Impact Bonds: Can they work for the unemployed? Roger Bullen (Essex County Council), Kieth Starling (Big Society Capital)

[199] Ibid

[200] Ibid

6. Fact sheet: Manchester City Council – Children in Care SIB

6.1 Summary

The Manchester City Council SIB was signed in February and initiated in June 2014. In 2013, Manchester had over 1,300 children and young people in care, with 11 per cent in residential facilities – much higher than the 2 per cent national average.[201]

The aim of the bond is to get children out of residential care and back into the family home, or to a lower level of permanent foster care. It is focused on improving outcomes for children with the highest levels of need, and highest levels of delinquency, and closing the gap between looked after children and their peers.[202] The program targets two cohorts:

- young people currently in residential care
- young people currently in foster places who are at high risk of entering residential care

In Manchester there are several interventions aimed at preventing entry into care, but none targeted at supporting a move back to the family home or to a step down into foster care.[203]

The bond is used to facilitate Action for Children delivering Multi-Dimensional Treatment Foster Care for Adolescents (MTFC-A)[204] a year-long program that provides support to young people, aged 12-17 years, with emotional and behavioural difficulties. The aim of getting them out of residential care will improve the young person's care outcomes[205] and life chances.

A recent trial in Hampshire of MTFC run by action for children[206] showed the benefits MTFC can generate. They observed:

- a 94 per cent reduction in offending
- 94 per cent of the sample were not on drugs
- 96 per cent of young people who completed the course were in education, employment, or training

The bond was only released recently and the program is still in the early phases.

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[201] Social Finance website, viewed on 26 June 2015, <http://apsocialfinance.com/wp-content/uploads/2014/05/introduction_to_the_mtfc_ECD_social_impact_bond.pdf>

[202] Manchester City council, *Report for Resolution – Young People and Children's Scrutiny Committee Integrated Commissioning Strategy: Improving Outcomes for Looked After Children – Update on the implementation of the strategy and proposals for the decommissioning of residential provision,* 2013

[203] Cabinet office, *Manchester City Council - Children in Care SIB*, 2013

[204] MTFC website, viewed on 26 June 2015, <http://www.mtfc.com/what-is-mtfc/>

[205] Emma Tomkinson blog, viewed on 26 June 2015, <http://emmatomkinson.com/2014/07/17/social-impact-bonds-in-the-uk-an-overview/>

[206] Action for children website, viewed on 26 June 2015, <https://www.actionforchildren.org.uk/news-and-opinion/latest-news/2014/june/uk-s-first-social-impact-bond-to-fund-foster-placements-for-kids-in-care/>

6.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Out of Home Care	Manchester City Council	The program will operate over 5 years and the bond will fund £1.2 million of start-up capital. The program is targeting 95 young people over 5 years	Commenced July 2014 Ends July 2019[207] (with payments available until 2022)	Payment by outcomes – social impact bond

Results	This is a newly implemented program and no results are available yet.

6.3 Rationale

The program was set up to allow the council to deliver the program to some of the young people in the local community with the highest level of need, whilst at the same time not restricting funding to other areas of the system. Similarly, as is the case with all local authorities in England, there is a requirement to save money as the public purse tightens. Residential care can typically cost around £3000 per week for local authority provided care. This means there is a saving to be gained from diverting children and young people away from residential care.

6.4 Outcomes and performance indicators

The key payment outcome for this program is getting young people out of residential care and placing them in either foster care or at the family home. There are however also secondary payment outcomes that consider educational attainment and school attendance, reductions in anti-social behaviour and better youth justice, and mental health. Note that payments for outcome only occur in year 3, as outlined in section 6.5. In year 1, payments are tied to outputs and in year 2 to proxy outputs, which are short to medium term objectives that contribute to longer term outcomes. Hence, this SIB encompasses elements of three different funding models: payment for outputs (year 1), payment for performance (year 2), and payment for outcomes (year 3).

Additionally, it is assumed that once a young person enters residential care, they will stay there for the remainder of their time in care, so the key outcome is measured by the child leaving care and remaining out of care for 3.5 years after course referral.

6.5 Pricing and payment model

Payment is made to both Bridges (the investor) and the service provider on successful attainment of the outcomes listed above. The maximum payment capped at £148,600. Payment is capped at 60 per cent for the first 12 months, and the remaining 40 per cent is received up to 3.5 years after completion of the program.[208]

Weekly payments include:

- For year 1: £1800 for each young person enrolled on the program – activity measure

[207] Bridges Ventures website, viewed on 26 June 2015, <http://www.bridgesventures.com/portfoliolist/manchester-mtfc-programme/>

[208] Cabinet office, *Manchester City Council - Children in Care SIB*, 2013 <http://data.gov.uk/sib_knowledge_box/manchester-city-council-children-care-sib>

- For year 2 - year 3.5: £350 if the young person stays out of residential care – proxy output measure

Annual payments include:

- £9500 if all well-being outcomes are achieved – outcome measure

There is no sanction for under performance, however if the child remains in residential care on completion of the program, no money will be paid out to the investor or the provider. This risk is borne by the investor and service provider. However, a proportion of the risk still lies with Manchester City Council as they will need to accrue cashable savings (from a reduction in the quantity of residential care, a service that is purchased on a spot basis[209]) in the first years of the program in-order to fund later years, as highlighted in the paragraph below.

The intent of the bond is that the first £1.2m finances the first 8 participants in the first year, with the remainder of the program funded by the cashable savings accrued by Manchester City Council.

6.6 Key lessons

Although only in the early stages of the program, and no formal review has been conducted, we can draw a number of lessons from the planning and development of the Manchester SIB. They are as follows:

- A feasibility study ensured viability of not only the target population but also the suitability of the outcomes[210]
- Buy-in from key stakeholders is vital[211]
- The program also highlights the importance of restoration services for young people in care as evidence shows that these services can have a positive impact on the life of a young person[212]
- The importance of pathways out of care; in particular residential care for children and young people under the age of 18 to not only improve life outcomes for some of society's most vulnerable young people but also to reduce the cost to the government
- The case study also draws on an example of therapeutic service (MTFC-A) that has been proven to work in restoration of those in need as well as funded in an innovative way.

[209] Cabinet office, *Manchester City Council - Children in Care SIB*, 2013 <http://data.gov.uk/sib_knowledge_box/manchester-city-council-children-care-sib>
[210] Ibid
[211] Ibid
[212] Ibid

7. The UK Child Protection System

7.1 Summary

In the UK, child welfare services are the primary responsibility of local authorities, and children in care are known as "looked after children". Services can vary a great deal between local authorities, and there is a mix of in-house and commissioned services across the full spectrum of child protection services. In some local authorities; Essex for example, there is a current drive to increase commissioning and outsource to the NGO sector.

7.2 Who operates out-of-home care services?

In the UK the majority of out of home care services are delivered by in-house government social workers, this includes residential care, recruitment and supervision of foster carers, and case management. This differs from the system in NSW where a portion of case management has been transitioned to the NGO sector.

There are a small number of independent fostering organisations from whom local authorities will purchase services. However these tend to be more expensive than council provision as they have the agency overhead and they generally pay their foster carers more. They are most commonly used when there are no in-house foster carers available or for the more difficult to place cases.

7.3 Who is responsible for the outcomes of the child?

When children are in local authority care, the local authority is ultimately responsible for the outcomes and safety of the child. A concept called "corporate parenting" has been legislated across local authorities in the UK following the Children and Young People Act, passed in February 2014. Under this scheme local authorities have a duty of care[213] to all 62,000 looked after children in the British system. All council, elected members, employees, and partner agencies are responsible for providing the best possible care and for safeguarding children under their care. No penalties or incentives are given to private foster providers.

7.4 Individual Outcomes

"Individual outcomes" is the National Framework Contract for Independent Fostering Agency placements. It is used to monitor individual desired outcomes for children and young people in care placements, and it ensures that the provided service is benefiting the child.[214] The child's social worker conducts the assessment that includes a number of outcome criteria in the following outcome areas:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well being

The information gathered is aggregated annually and used as part of the contract monitoring process.

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[213] West Sussex County Council website, viewed on 26 June 2015, <https://www.westsussex.gov.uk/about-the-council/how-the-council-works/committees-and-decision-making/corporate-parenting-panel/>

[214] Schedule 3 to the Framework Contract Individual Outcomes Monitoring

7.5 Sufficiency statement

Each council is legally obligated to supply a sufficiency statement. This statement requires the council to ensure the accommodation needs of children in care are met. They must:

- Have a sufficient number of beds
- Secure accommodation through a range of providers
- Have suitable accommodation to meet the needs of looked after children.[215]

7.6 Gloucester[216] (increased contestability model)

Due to a lack of supply in the foster care market, external providers tend to be more expensive than in-house, local authority run foster care service. In an attempt to address this issue, Gloucester has introduced some elements of contestability into their approach to securing foster care services.

Gloucester is moving towards a more commissioned approach to fostering for young people aged 12 and above. A tender for foster contracts and an outcomes-based commissioning form is sent to a list of pre-qualified external providers as well as the local authorities' in-house services. The forms detail identified needs, outcomes, and a time scale for delivery associated with individual children. All responses are anonymised, to ensure that the decision is purely needs and outcomes-based.

The aim of the commissioning strategy is to reduce the unit price, increase competition, and improve service quality. This arrangement has seen some positive market engagement, and has helped to reduce the unit cost and increase placement choice.[217]

7.7 Devon County Council[218]

In 2006, Devon county council took a child centred approach to the county's commissioning of out-of-home care services. The child's social worker is responsible for submitting a 'pen portrait' of the child - specifying their needs and desired placement outcomes to the family finding team in the Council.[219] This is passed onto a group of pre-approved providers who respond with a proposal describing how they would meet the child's needs, the specified outcomes, and the child's support requirements. Responses are assessed against the every child matters outcomes framework: be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being. Price is considered only after outcomes can be evidenced.

Devon's approach has been successful. The concept of 'finding the right match' has saved the local authority £2millon over a four year period as a result of the large (fourfold) increase in placement choices, and has contributed to a greater level of placement stability.[220]

7.8 Essex Multi Agency Allocation Group

Essex County Council has (amongst other initiatives) established two multi-agency allocation groups in an attempt to meet the needs of families before they escalate – so at the front end of the child

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[215] Havering London Borough, *Sufficiency Statement for Looked After Children*, 2013

[216] Outcomes and Efficiency: Commissioning for Looked After Children, 2010

[217] Department of Children, Schools and Families, *Sufficiency Statutory guidance on securing sufficient accommodation for looked after children*, 2010

[218] Outcomes and Efficiency: Commissioning for Looked After Children, 2010

[219] DevonChild Care website, viewed on 26 June 2015, <http://devonchildcare.proceduresonline.com/procedures/p_fam_find.html>

[220] Outcomes and Efficiency: Commissioning for Looked After Children, 2010

protection system. They allocate resources when a child needs services from more than one agency.[221]

In Essex, MAAG is not being fully utilised across the county; some districts in particular are considered to be not making enough referrals, with most referrals coming in from the education sector (58 per cent).[222]

7.9 Key lessons

- In the UK a general shortage of foster carers has led to a focus on securing sufficient supply, and maintaining existing foster carers rather than finding ways to implement outcomes-based KPIs
- The UK experience points to the fact that commissioning strategies need to consider all aspects of the child protection system, not just out of home care
- It is important that the wider population is aware of services that are available; the MAAG in Essex for example, is arguably under-used.

[221] Outcomes and Efficiency: Commissioning for Looked After Children, 2010

[222] Essex Works *Safeguarding children at risk, children in care and vulnerable families - Executive Summary*

8. Fact sheet: Benevolent Society Social Benefit Bond for out of home care restoration

8.1 Summary

This Social Benefit Bond is funding the Benevolent Society's program called Resilient Families (RF). The program will run for 5 years and will target up to 400 families, who are expecting a child or have at least one child under six years old who is assessed at risk of harm by the NSW Department of Family and Community Services (FACS).[223] The program provides intensive family support in order to keep children in their families where safe, and to avoid their entry to out-of-home care.[224] This program has a successful track record in working with vulnerable children in NSW.[225]

This Social Benefit Bond has been jointly developed by the NSW Government in partnership with The Benevolent Society, the Commonwealth Bank of Australia and Westpac Institutional Bank. It is worth $10 million and was launched in October 2013.[226]

A range of investors are involved in the program: High Net Worth individuals, Super Funds, trusts, foundations, and institutions.[227]

8.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Child protection	3 delivery sites in NSW: Rosebery, Campbelltown or Liverpool.[228]	- Up to 400 over program life. - Value is $10m upfront.	Commenced October 2013 Ends October 2018	Social Benefit Bond

Results	The RF service is operational at all three sites and the Benevolent Society and FACS are on track to meet the year one operational targets for requesting and referring families (based on 34 weeks of operation from 8 October 2013 to end June 2014).[229] Note that the final evaluation report is due January 2016.[230]

[223] Benevolent Society website, viewed on 22 May 2015 < http://benevolent.org.au/about/social--benefit--bonds>
[224] Benevolent Society website, viewed on 22 May 2015 < http://benevolent.org.au/about/social--benefit--bonds>
[225] FACS website, viewed on 22 May 2015 <http://www.community.nsw.gov.au/docs_menu/for_agencies_that_work_with_us/our_funding_programs/benevolent_society_social_benefit_bond.html>
[226] Ibid
[227] SVA website, viewed on 22 May 2015 < http://socialventures.com.au/case-studies/benevolent-society-sbb/>
[228] NSW Treasury, *Evaluation of the Resilient Families Service,* 2014
[229] Ibid
[230] ARTD consultants, *Evaluation of the Benevolent Society's Resilient Families Service,* 2014

8.3 Rationale

Social Benefit Bonds were developed as part of the NSW Government's broader social impact investment strategy to encourage innovative ways to deliver better social and financial outcomes for individuals, families and communities.[231] They were designed to deliver better services and results for families at risk, to test innovative financing models and to add to the current suite of services for vulnerable children in NSW.

This program supports the NSW Government's goal that "all children in NSW are healthy, happy and safe, and grow up belonging in families and communities where they have opportunities to reach their full potential".[232] The program also aligns with the NSW Government Keep Them Safe reform, which brings an expanded role for the non-government sector and stronger relationship between government and NGOs. [233] Moreover, it is aimed at generating savings to the Government in a sector where costs are rising, in part due to the increase in the number of NSW children in foster or kinship care, which has more than doubled in the last decade.[234]

8.4 Outcomes and performance indicators

The measures are focused on reductions in the number of times children come into contact with the child protection system. The performance indicators used are: the number of entries into OOHC; the number of Helpline reports; and the number of safety and risk assessments. Measurements are based on the experience of the youngest child in the family.[235]

Note that the Child Protection Helpline is a 24/7, state-wide call centre staffed by caseworkers to receive and screen all child abuse reports. A child or young person is assessed at risk of significant harm (ROSH) "if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent".[236]

The rate of return to investors is based on a "performance percentage", which is the difference in the improvement between children receiving the service, and matched children in a comparison group. The improvement is defined as a reduction in contact with the child protection system (that is, entries into OOHC, helpline reports, and Safety Assessment and Risk Assessments).[237]

8.5 Pricing and payment model

The bond is structured in two tranches: P and E class investors, depending on the risk they are willing to take. P class investors benefit from a 100 per cent capital protection, and E class investors have no protection.[238] Interest payments are thus different for investors in each tranche, and vary with the performance percentage as follows.

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[231] NSW Government, *Social Impact Investment Policy,* 2015

[232] NSW Government, Keep Them Safe: a shared approach to child wellbeing, 2009

[233] NSW Treasury, *Evaluation of the Resilient Families Service,* 2014

[234] The Benevolent Society's website, viewed on 22 May 2015 <http://benevolent.org.au/about/social--benefit--bonds>

[235] SVA website, viewed on 22 May 2015 < http://socialventures.com.au/case-studies/benevolent-society-sbb/>

[236] Community Services website, viewed on 26 May 2015 < http://www.community.nsw.gov.au/kts/guidelines/reporting/framework.htm>

[237] KPMG, *Evaluation of the Joint Development Phase of the NSW Social Benefit Bonds Trial,* 2014

[238] SVA website, viewed on 22 May 2015 <http://socialventures.com.au/case-studies/benevolent-society-sbb/>

Performance compared to baseline	Yield in P class	Yield in E class
<5 per cent	breakeven	100 per cent loss
5 per cent-15 per cent	5 per cent	8 per cent
15 per cent -20 per cent	6 per cent	10.5 per cent
20 per cent-25 per cent	7 per cent	15 per cent
25 per cent-35 per cent	8 per cent	20 per cent
35 per cent-40 per cent	9 per cent	25 per cent
>40 per cent	10 per cent	30 per cent

However if the performance percentage is less than 5 per cent, no interest payment is payable for investors in either tranche. The maximum interest payment payable under the senior tranche is 10 per cent, and the subordinated tranche is 30 per cent.[239]

8.6 Key lessons

- Contracting: "It was challenging to work without a precedent and contracting templates in NSW. The bond took many months to negotiate. Development of an operations manual in 'plain English' was seen to be helpful".[240] Staff in FACS have confirmed that the operations has been critical in guiding day to day management of the contracts as it sets out clearly the parameters of service provision.
- Measurement of outcomes: "Although the outcomes in each area could be specified using binary outcomes which were simple, there were seen to be challenges in the measurement and capture of savings."[241] These include, in particular, the challenges of defining the baseline with early data limitations, and moving to a live comparison group, the lack of data on families available within existing families, and the level of effort required to capture data once the bond was operational (e.g. helpline reports)
- Staff guidance: It has been necessary to guide staff around data use and recording, and to ensure all relevant staff are aware of the processes and requirements for information sharing.[242] In addition, the bond has required a significant change in culture amongst case managers as referrals are determined by a pre-agreed formula.
- Stakeholder relationships: "FACS and the Benevolent Society need to continue to work on relationship building at a local level and consider structured or systematic approaches e.g. periodic meetings and shared professional development forums".[243]

[239] KPMG, *Evaluation of the Joint Development Phase of the NSW Social Benefit Bonds Trial,* 2014
[240] Ibid
[241] Ibid
[242] ARTD consultants, *Evaluation of the Benevolent Society's Resilient Families Service,* 2014
[243] Ibid

9. Fact sheet: Newpin Social Benefit Bond for out of home care (OOHC) restoration

9.1 Summary

The Newpin Social Benefit Bond funds UnitingCare Burnside's (UCB) Newpin program. The bond aims to increase the number of children safely restored to their families from OOHC or prevented from entering care. The Newpin program is an intensive therapeutic centre-based program for families with children from 0 to 5 years old, who are either in statutory OOHC, or at risk of entering care. The program aims to increase parents' capacity to take care of their children, and build a healthy family environment to support children to be safely restored to their families or prevent their entry into care.[244]

The $7 million bond began operating in July 2013 and will operate for seven years.[245]

The bond was developed through a joint collaboration between NSW Government (FACS and NSW Treasury), UnitingCare Burnside (service provider), and Social Ventures Australia (intermediary) who took the bond to market and raised finance.

59 investors (trusts, super, individuals and foundations) are involved with a minimum investment of AUD 50,000 each.[246] They will be repaid depending on the restoration rate of children to their families.

9.2 Key facts and figures

Sector	Locality	Program size	Key dates	Program type
Child protection	Four existing Newpin centres in Western Sydney and will pay for the expansion of the program to additional locations around the State.[247]	• At 30 June 2014, the Newpin program was supporting 55 families with 80 children • Over the course of the year, a total of 136 families with 228 children participated in the program[248] • Value is $7m upfront	Commenced July 2013 Ends July 2020	Social Benefit Bond

Results	During the first year of the bond, the Newpin program achieved a 60 per cent "restoration" rate, which under the bond's terms delivers them a 7.5 per cent return to investors.[249] Results of this first evaluation have been verified by an Independent Certifier.

[244] KPMG, *Evaluation of the Joint Development Phase of the NSW Social Benefit Bonds Trial,* 2014

[245] NSW Government website, viewed on 22 May 2015 <http://www.community.nsw.gov.au/docs_menu/for_agencies_that_work_with_us/our_funding_programs/social_benefit_bonds/newpin_social_benefit_bond.html>

[246] Emma Tomkinson's blog, viewed on 22 May 2015 < http://emmatomkinson.com/2013/06/03/nsw-social-benefit-bond-returns-to-investors/>

[247] NSW Government website, viewed on 22 May 2015 <http://www.community.nsw.gov.au/docs_menu/for_agencies_that_work_with_us/our_funding_programs/social_benefit_bonds/newpin_social_benefit_bond.html>

[248] SVA, *Newpin Social Benefit Bond, Annual Investor Report,* 2014

[249] Ibid

9.3 Rationale

Social Benefit Bonds were developed as part of the Government's broader social impact investment strategy to encourage innovative ways to deliver better social and financial outcomes for individuals, families and communities.[250] They were designed to deliver better services and results for families at risk, to test innovative financing models and to add to the current suite of services for vulnerable children in NSW.

The project will be working on the assumption that the restoration rate in New South Wales is currently around 25 per cent (as per the counterfactual), whilst Newpin's services have previously achieved a rate closer to 75 per cent. If the SIB intervention meets these figures for the entire cohort, then NSW can expect to generate savings of around $80m by 2030.[251]

The bond supports NSW Government's goal that "all children in NSW are healthy, happy and safe, and grow up belonging in families and communities where they have opportunities to reach their full potential".[252]

9.4 Outcomes and performance indicators

The bond targets 3 specific cohorts: "Cohort 1" is families with at least one child aged 5 or under who has been in OOHC for at least 3 months (50 per cent); and "Cohorts 2 and 3" are families with at least one child aged 5 or under who has been assessed as at risk of serious harm (25 per cent) or who need support (25 per cent).[253] The indicator used to measure outcomes is the proportion of "Cohort 1" children benefiting from the program who are restored to the care of their family over a year.

The counterfactual is a fixed estimate for the first 3 years (based on analysis of historic data). During the operation of the bond, a control group is being built, using data from the first 3 years of operation. Families referred to the program are jointly approved by UCB and FACS; the matched control group is based on these criteria to ensure it is reflective of Newpin participants.[254]

9.5 Pricing and payment model

In the contract, returns to investors are set depending on restoration rates as follows:

Restoration rate	Yield
<35 per cent – 45 per cent	▸ Minimum 5 per cent yield over first three years ▸ No minimum yield after three years ▸ 75 per cent of capital returned if bond redeemed at four years ▸ 50 per cent capital returned if redeemed after four years
50 per cent	breakeven
55 per cent	3 per cent
60 per cent	7.5 per cent
65 per cent	12 per cent
>70 per cent	15 per cent (maximum)

[250] NSW Government, *Social Impact Investment Policy,* 2015

[251] UK Cabinet Office website, viewed on 22 May 2015 < http://data.gov.uk/sib_knowledge_box/new-south-wales-government-children-out-home-care>

[252] NSW Government, Keep Them Safe: a shared approach to child wellbeing, 2009

[253] SVA website, viewed on 22 May 2015 <http://socialventures.com.au/case-studies/newpin-sbb/>

[254] Ibid

Note that as an incentive to invest capital, investors were guaranteed a 5 per cent interest payment in the first three years irrespective of the rate of restoration. There is a guarantee that the principal repayment will not fall below 50 per cent.[255]

9.6 Key lessons

The lessons learned from the Benevolent Society bond apply here. In particular, in the Newpin bond:

- Cohort choice: The referral process has involved strong collaboration between FACS and UCB staff determining which families are ready for the program and have a genuine probability (much lower than 100 per cent) of restoration. This has resulted in positive and effective ways of working. However, the subjectivity inherent in this approach presents challenges for scaling the program: random allocations would rely on sophisticated data matching, and may not be optimal.[256]
- Case allocation: Under the bond, FACS guarantees the volume of demand and referrals are mandatory; this avoids the potential for "cherry picking" of cases and gaming the performance targets.

[255] KPMG, *Evaluation of the Joint Development Phase of the NSW Social Benefit Bonds Trial,* 2014

[256] Emma Tomkinson's blog, viewed on 22 May 2015 < http://emmatomkinson.com/2013/06/03/nsw-social-benefit-bond-returns-to-investors/>

Appendix C Glossary of key terms

Outcome-based contracting	Where the commissioner (in this case government) contracts and pays for final outcomes to be delivered by a service provider, rather than for inputs, outputs, activities, tasks or assets. A complete or 'genuine' outcomes-based contracting model could be defined as an arrangement where the majority of service delivery payments are at risk, based on the achievement of final outcomes.
Market	When referring to public sector markets, we are typically referring to the entire service system and participants, including funder/purchaser, providers, clients, brokers, regulators and evaluators.
Providers	As distinct from the market, 'provider' refers to those who are deliver services. Providers make up the 'supplier market.' 'Providers' and 'market' are sometimes used interchangeably.
Commissioning	Commissioning is the way governments and the public sector can allocate available resources – through the right mix of government, private and not for profit involvement – to secure and deliver services which meet public policy objectives while also providing sustainable value for citizens and the economy.
Procurement	"The technical process used for selecting a supplier when services are to be delivered by external providers."[257]

[257] Sturgess, G. *Contestability in Public Services: An Alternative to Outsourcing.* 2015

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