

## **A rapid evidence review of the use of Payment by Results in social care – paper for ICPP 2017**

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### **Abstract**

Over recent years, there has been increasing interest in ‘Payment by Results’ (PbR) (Pay for Success in the US) as a model for outcome-based commissioning services in the public sector. Such PbR contracts link payment to the outcomes achieved, rather than the inputs, outputs or processes of a service (Cabinet Office 2011). By making some or all of payment to a service contingent on delivering agreed outcomes, PbR supposedly reduces ‘micro-management’ on the part of the commissioner, encourages innovation and transfers risk away from the branch of government commissioning the service towards the service provider because government will only pay if outcomes are achieved. From government’s perspective payments for service are deferred. Given the need to reduce public sector spending, both the transference of risk and deferring payment for services are attractive propositions for government. To date, over £15 billion of services in the UK are subject to PbR contracts (National Audit Office 2015), in areas such as criminal justice, healthcare, and social care. Payment by Results and Social Impact Bonds can be considered as the logical conclusion of outcome-based performance management (OBPM) (Lowe and Wilson, 2015), as they are intended to ensure that financial rewards directly flow from the achievement of specified outcomes. OBPM is a general term used for using outcomes as a means of assessing performance (Lowe, 2013), and different forms of OBPM have emerged since the 1990s. OBPM is associated with New Public Management (NOM) (Hood 1991). This paper seeks to examine the use of Payment by Results in social care in the UK. Although formal evaluations of both PbR and are still limited some evaluation findings are starting to be published and some tentative conclusions on the potential for innovation are drawn from the REA. It draws on a Rapid Evidence Review of the literature on PbR in social care.

### **Introduction**

Over the past twenty years there has been a growing interest in, and development of, new and different payment systems for public services. These new payment systems have been developed for a number of reasons, and are often associated with decentralisation of decision making (Wright et al, 2014) (Appleby et al, 2012), introducing competition and choice, of making better use of resources (Battye, 2015), improving public services (Battye, 2015), and realigning contract rewards to incentivise desired behaviours (Webster, 2016) (Fox, 2016). One such development is that of Payment by Results (known as Pay for Success in the United States). Payment by Results is a broad term that is applied to a number of wide variety of contracting arrangements (Battye, 2015). The common theme underlying each of these variants is that payment is made post hoc, and is contingent on the achievement of specified goals or targets. Payment by Results can therefore be contrasted with more traditional forms of public sector funding, where payment is often made ‘up front’ and may be based on previous service use, demand, and/or staffing levels, or what might be considered input-based funding.

There are a number of differences in PbR arrangements; the level at which payments are set, whether the PbR payment element is the whole or part of the overall payment, and the level at which results are measured (Battye, 2015). One key level of variation in Payment by Results schemes

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is that between case-based or activity based approaches (largely found in the funding of healthcare) (Tan et al, 2015) and outcome-based approaches. In the United Kingdom, activity-based Payment by Results was introduced by the early 2000s as part of reforms to hospital based healthcare, and was part of the then government’s attempts to introduce greater marketization in healthcare services (Appleby, 2012). It reimburses providers on the basis of ‘Health Resource Groups’; either condition-related, or related to categories of procedures, interventions, or treatments (Lee et al, 2010). Similar reforms have been implemented in a number of different countries; the first in US healthcare, and subsequently in more than half of all Organisation for Economic Cooperation and Development (OECD) countries (Appleby et al, 2012). Case or activity-based Payment by Results has been the subject of much research, a number of evaluations, and published systematic reviews, often seeking to establish and quantify the impact of Payment by Results (Wright et al, 2014). There are also a number of studies that examine the accuracy of clinical coding and the effect this has on levels of payments made under PbR schemes.

The second variant of Payment by Results, and the version that is the subject of this paper, are outcome-based approaches, where the outcomes are typically some measurable, desirable change in the condition, behaviour, or satisfaction of service users or programme participants (Finn, 2010), or of programmes, projects and public sector organisations. In the UK, outcome-based PbR is often associated with the public sector reform agenda of the Coalition Government (2010-2015) (Fox et al, 2017), as set out in the 2011 Open Public Services White Paper, although earlier examples include the active labour market interventions under the New Deal programmes in the early 2000s (Battye, 2015), and the Social Work Practices pilots in the late 2000s (Stanley et al, 2012). Outcome-based PbR is increasingly used across a range of UK public services, including active labour market programmes, children’s centres, housing related support services, probation services, social work, and family intervention programmes.

To date, the evidence base around outcome-based PbR is limited (Fox et al, 2017) (Webster, 2016), (Battye, 2015). In contrast with the availability of evidence in relation to activity-based PbR, there are a limited number of evaluations published, and even fewer evaluations that focus on the impact of PbR on achievement of outcomes. Where articles have been published, there are often theoretical or critical in nature, usually with little reference to empirical evidence. The empirical evidence that does exist tends to be found in grey literature, often evaluations commissioned by the government department that has used outcome-based PbR for a specific programme or intervention. There are a small number of peer-reviewed articles in the field.

This article aims to contribute to the limited empirical evidence around outcome-based Payment by Results. It focuses on the use of outcome based PbR in social care, an area where outcome based PbR is increasing being used across a wide range of different services, programmes and interventions. It presents findings from a Rapid Evidence Assessment (REA) of the extant literature.

### **Method**

A Rapid Evidence Assessment is a systematic, rigorous review of the extant literature on a specific subject or in a focused field. REAs aim to be explicit about search criteria used to identify relevant literature, and what criteria have been applied in deciding which literature to include and exclude from analysis. REAs can be completed in shorter timescales, and at lower cost, than systematic

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reviews. REAs are used widely in healthcare and are increasingly being used in other areas of social policy, although there are some criticisms of their use in this field (Thomas et al, 2013). Broadly speaking, there are two forms of REA. Most published REAs focus on studies that measure and attribute the impact of a service, programme or intervention (I refer to these as ‘impact REAs’). These involve undertaking meta-analysis of the data and results provided in studies that meet the risk of bias and inclusion criteria. An alternative approach, and the one adopted here, using narrative synthesis to ‘tell the story’ (Visram et al, 2016) about how, why and in what ways a service, programme or intervention has been designed or implemented (what I refer to as ‘non-impact REAs’). Both REA forms typically involves using explicit search terms to undertake searches of a number of bibliographic databases, reviews of titles and/or abstracts to select relevant studies, and review of full articles/reports of relevant studies to determine whether they meet inclusion criteria. Impact REAs then involve an assessment of each included study for risk of bias, extraction of data and results, and meta-analysis (a statistical procedure that ‘combines’ results from multiple impact studies). Non-impact REAs typically have broader inclusion criteria, and will cover empirical, qualitative studies as well as those that focus on attributing impact.

This REA was completed in May and June 2017 by a single researcher, the paper’s author. Typically, more than one researcher is involved in each stage of an REA, and mechanisms are put in place to enable researchers to compare, discuss and agree search terms, inclusion criteria, studies selected for inclusion, and findings. It is a limitation of the analysis presented here that only one researcher was involved throughout the process.

### **Research questions**

The aim of this REA is to address the following research questions:

1. How are outcome-based PbR contracts being used in social care in the UK?
2. What differences or variations in their use?
3. What challenges have commissioners and providers faced in social care services where outcome-based PbR contracts have been used?
4. Is there evidence that outcome-based PbR has resulted in any greater focus on outcomes, any innovation in service delivery, or any improvements in value for money?

Both because of the dearth of studies that measure and attribute impact in this area (Fox, 2017)(Webster, 2016)(Battye, 2015), and because of the focus of the research questions on how outcome-based PbR is being used in social care in the UK, this research has utilised a non-impact REA approach. The findings presented here descriptively summarise included studies, and a narrative synthesis was undertaken. Narrative synthesis is an overarching term to describe a family of methods (Snilstveit et al, 2012) which uses words and text to summarise and explain findings from multiple studies (Popay et al, 2003). While there are criticisms of such approaches - the lack of transparency (Dixon-Woods et al, 2005) and lack of clear, explicit methods. REAs are also a method that is often used to increase the likely impact of research on policy and practice (Visram et al, 2016).

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### Search methods

Searches were undertaken on two bibliographic databases, namely Web of Science, and Social Care Online (hosted by the Social Care Institute for Excellence), using the search terms “Payment by Results” OR “Pay for Success”<sup>1</sup>. A search was also undertaken using Google, and of the websites of relevant UK government departments (Department of Health, Department for Education, Department for Work and Pensions, Department for Communities and Local Government, all of which are involved in aspects of social care policy). The search terms were deliberately wide so as to maximise the chances of identifying relevant material. Two key issues are significant here. First, social care is a difficult to conceptualise and define. It includes interventions aimed at helping people to take control of their daily life, to maintain their personal and/or accommodation cleanliness and comfort, to enable people to engage in social participation and involvement, protection and social support. One of the issues of undertaking research around social care is that it is the increasingly fuzzy, blurred nature of the concept, with many different names being used, and much cross-over between services in health, social care, housing, criminal justice, and welfare. Secondly, many papers do not explicit distinguish between activity and outcome based variations of PbR. The wide search parameters were intended to maximise the likelihood that relevant material was identified. Searches were limited to publications since 2008, and in English.

The search process is summarised in figure 1 below. The searches resulted in n=151 articles being identified via Web of Science, and n=168 identified via Social Care Online. A further n=3 reports were identified through Google and searches of relevant government websites. The results of each search were entered onto a MS Excel spreadsheet developed for the REA. Duplicates were identified and removed, and a total of n=222 records remained. The title and full abstract<sup>2</sup> of each of these n=222 was reviewed and an initial assessment of relevance was made. Following this initial assessment,

#### Box 1: Search terms and inclusion criteria

##### Search terms:

“Payment by Results” OR “Pay for Success”, published in English since 2008

##### Inclusion criteria:

- Outcome-based Payment by Results – includes a focus on outcome-based PbR (whether the outcome-based PbR covers whole or part of funding for service, intervention or programme)
- UK focused – covers services, interventions, or programmes in the UK
- Empirical – includes details of empirical methods used (excludes literature reviews, policy statements, theoretical or critical pieces)
- Social care focus – covers the design, commissioning or delivery of services, interventions or programmes that include some element of social care

<sup>1</sup> I did not include social impact bonds in the search criteria. Although social impact bonds are often considered to be a type of outcome-based commissioning contract, and associated with PbR (Fox et al, 2017), there are some material differences in the funding mechanisms.

<sup>2</sup> A number of non-peer reviewed articles and reports did not include an abstract. In these cases, the executive summary or introduction was reviewed.

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n=14 studies were identified for full review. Each of these articles and reports was reviewed in full and was assessed against the inclusion criteria set out in box 1, and a further n=6 were excluded. The remaining n=8 articles were therefore included in the narrative synthesis.

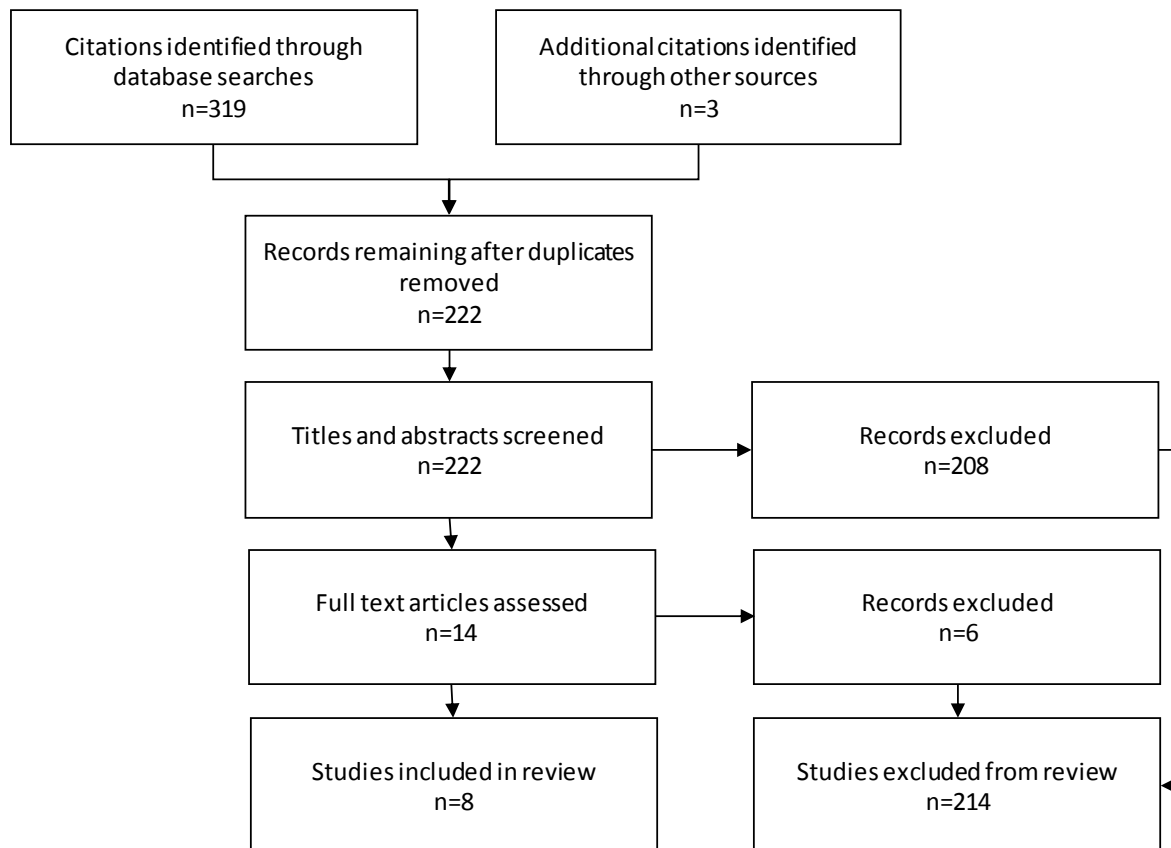


Figure 1: Search process

Table 1 overleaf provides details of the articles and reports included for full review, identifying which of these articles was assessed at meeting the inclusion criteria. (Details of all n=222 articles and reports covered by the review, including the initial assessment, are included in appendix 1.)

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Author	Title	Year	Publication/publisher	Brief description	Peer reviewed journal?	Type of PbR	Quality assessment	Social care	Meets inclusion criteria?
Bolton, J	Emerging practice in outcome-based commissioning for social care: discussion paper	2015	Oxford Brookes University. Institute of Public Care	Progress report exploring approaches taken by councils to Payment by Results in adult social care.	No	Not stated/not clear from abstract	Not empirical - discussion paper	Yes	No - not empirical
Compact Voice	Annual survey of Compacts	2016	Compact Voice	Survey of issues facing local Compacts, how they are working and how national policy developments are having an impact locally.	No	Not stated/not clear from abstract	Empirical - survey of local Compacts (n=97 responses)	Includes questions on Care Act 2015 (social care)	Yes
Cornes, M, Manthorpe, J, Joly, L, O’Halloran, S	Reconciling recovery, personalisation and Housing First: integrating practice and outcome in the field of multiple exclusion homelessness	2014	Health and Social Care in the Community, 22(2), pp134-143	Explores use of Housing First model for dealing with multiple exclusion homelessness	Yes	Not stated/not clear from abstract	Empirical - qualitative interviews with n=34 individuals with lived experience of homelessness (methods statement relates to wider study rather than basis of the paper)	Includes drug treatment services (both health & social care) & housing related support	No - not about PbR

**Table 1: Studies review in full, with assessment of whether study meets inclusion criteria**

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Author	Title	Year		Brief description	Peer reviewed journal?	Type of PbR	Quality assessment	Social care	Meets inclusion criteria?
Cundy, J	Commissioning for better outcomes: understanding local authority and voluntary sector experiences of family services commissioning in England	2012	Barnado's	Using surveys, in-depth telephone interviews and an expert roundtable event to identify barriers to voluntary sector participation in the local authority commissioning process around family services to highlight examples of promising practice, and to recommend policy and practice solutions.	No	Not stated/not clear from abstract	Empirical - surveys and interviews	Family services includes education, housing, social care and other services	Yes
Day et al	National evaluation of the Trouble Families programme - final synthesis report	2016	Department for Communities and Local Government	Process, impact and economic evaluation of phase 1 of the Trouble Families programme	No	Outcome-based	Empirical - n=20 qualitative case studies (LAs), quasi-experimental impact evaluation (secondary data analysis and interviews, treatment and match propensity score control group), economic evaluation	Troubled Families is a type of family intervention programme that includes social care	Yes

**Table 2 (continued): Studies review in full, with assessment of whether study meets inclusion criteria**

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Author	Title	Year		Brief description	Peer reviewed journal?	Type of PbR	Quality assessment	Social care	Meets inclusion criteria?
DCLG	Supporting People Payment by Results pilots. Final evaluation	2014	Department for Communities and Local Government	Process evaluation of PbR pilots for housing related support and care services	No	Outcome-based	Empirical - qualitative (report does not set out methods used)	Supporting People services provide low level, non-statutory, support	Yes
Frontier Economics and the Colebrooke Centre	Payment by Results in Children's Centres evaluation	2014	Department for Education	Report on process evaluation of PbR pilot in children's centres.. Children's centres provide and link to a number of services, some of which include social care provision.	No	Outcome-based	Empirical - telephone interviews, surveys, case study visits	Children's centres provide or refer to a number of services, including social care	Yes
KUZNETSOVA, D	Commissioning care in the 21st century: improving outcomes for people with learning disabilities	2011	New Local Government Network	Examines personalised services in social care in England, arguing the need for affordability to accelerate moves towards a new form of outcome-based commissioning. The report presents an analysis of council cost data.	No	Not stated/not clear from abstract	Empirical - interviews, panels, and case studies collated from member organisations. Secondary data analysis.	Covers the commissioning of a number of different services, including statutory social care & other social care services	Yes

**Table 3 (continued): Studies review in full, with assessment of whether study meets inclusion criteria**

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Author	Title	Year		Brief description	Peer reviewed journal?	Type of PbR	Quality assessment	Social care	Meets inclusion criteria?
La Valle, C	Feasibility study for the trials of payment by results for children's centres	2011	Centre for Excellence and Outcomes in Children and Young People's Services	Describes findings from a study of the early development of a programme running from 2011 to 2013 which seeks to trial PbR for children’s centres with 27 local authorities.	No	Not stated/not clear from abstract	Empirical	Children's centres provide or refer to a number of services, including social care	No - not available online
Lee et al	The development of care pathways and packages in mental health based on the Model of Human Occupation Screening Tool	2011	British Journal of Occupational Therapy, 74(6), pp284-292	Examines occupational needs of n=625 service users in relation to PbR in mental health services	Yes	Not stated/not clear from abstract	Empirical - retrospective, descriptive study drawing on n=625 clinical records	No - NHS mental health services	No - activity based PbR, not social care
Office for Public Management	Essex multi-systemic therapy social impact bond: interim evaluation findings (year two)	2015	Office for Public Management	Captures evidence of, and explores the extent to which the Social Impact Bond (SIB) structure impact on the implementation of Multi-Systemic Therapy (MST) and the delivery of MST through the SIB payment by results mechanism adds any further significant value in terms of outcomes or performance	No	Not stated/not clear from abstract	Empirical - surveys, interviews, secondary data analysis	Yes - about services to prevent young people going into local authority care	No - not about PbR

**Table 4 (continued): Studies review in full, with assessment of whether study meets inclusion criteria**

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Author	Title	Year		Brief description	Peer reviewed journal?	Type of PbR	Quality assessment	Social care	Meets inclusion criteria?
ROBERTS, L and CAMERON. G	Evaluation of the Essex multi-systemic therapy social impact bond: interim evaluation report	2014	Office of Public Management	This is the first of two interim reports presenting the findings from the first eighteen months of evaluation activities of Multi-Systemic Therapy (MST).	No	Not stated/not clear from abstract	Empirical - surveys, interviews, secondary data analysis	Yes - about services to prevent young people going into local authority care	No - not about PbR
Stanley et al	Turning away from the public sector in children's out-of-home care: An English experiment	2013	Children and Youth Services Review, 35(1), pp33-39	Reports on the evaluation of an English experiment which, for the first time, moved statutory social work support for children and young people in out-of-home care from the public to the private or independent sector	Yes	Not stated/not clear from abstract	Empirical - matched control with integral process evaluation. Qualitative interviews, surveys and secondary data analysis.	Yes	Yes
WARD, E, SAMPLE, E, ROBERTS, M	Testing the waters	2010	Druglink, 25(6), November 2010, pp.11-14.	DrugScope conducted a survey of its membership and other key stakeholders in September 2010 to inform their response to the drug strategy consultation.	No	Not stated/not clear from abstract	Empirical - membership survey (descriptive, qualitative)	Drug treatment services including some social care	Yes

**Table 5 (continued): Studies review in full, with assessment of whether study meets inclusion criteria**

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### **Findings**

#### ***Introduction***

Broadly, the studies included in this review are of two types. The first type includes a number of studies are evaluations of services, interventions, or programmes where PbR is being piloted (either in isolation, or as part of a new programme, intervention or model of working)(for example, Stanley et al (2013), Day et al (2016), or DCLG (2014). The second type includes studies that engage in research with organisations and individuals involved in planning, commissioning and delivery of social care, where some discussion is around the use of PbR in contracts. These studies have proved to be less useful in providing evidence on the use of PbR in social care in the UK. With one exception (Stanley et al, 2013), most studies are to be found in grey literature. A number of studies report on research that has been commissioned by the government department that has rolled out the example of PbR that is being researched or evaluated (for example, Stanley et al (2013), Day et al (2016), and Frontier Economics (2014)). There are no examples of European, UK research council or independently funded research or evaluation of outcome-based PbR in the studies included in this review.

#### ***Use of PbR for pilots, trials and new programmes***

Three themes emerge in terms of the use of outcome-based PbR in social care in the UK: (1) that it is used and evaluated as part of the pilot, trial or roll out of a new intervention, new model of working or new programme; (2) that PbR is often not used in main stream social services, long term social care for adults or older people, or statutory social services; and, (3) that is often used for complex programmes that involve multiple agencies or interventions

Firstly, studies included in this review cover a number of new and different forms of social care, or ways of organising and delivering social care. In these instances, outcome-based PbR is part of a wider piece of innovation or change. Stanley et al (2013) for example, report on an evaluation of a pilot of Social Work Practices, a reform to the organisation of social work provision for children and families that aimed to “move services for children in out-of-home care away from local government.....and relocate them in the independent sector”. The pilot was introduced under the Labour Government of 1997 to 2010, and then “enthusiastically taken up by the Coalition Government (Conservative/Liberal Democrat coalition, 2010 to 2015). Stanley et al identify that the pilot was designed in such a way that “incentives would play a role in ensuring service quality”, and thus would be consistent with the policy objectives often attributed to PbR. In reality, the study reports that PbR was a feature of just two of the six pilots covered by the evaluation. As such, the key change involved in the Social Work Practices pilot was the outsourcing and marketization of children’s services.

Similarly, Day et al (2016) report on an evaluation of the Troubled Families programme. Phase 1 of this programme was introduced by the Coalition Government in April 2012, and an expanded, slightly amended phase 2 was subsequently rolled out in 2014/15. Troubled Families was designed as a family intervention programme, that targeted dedicated support focused on reducing levels of crime and anti-social behaviour, reducing truancy, reducing worklessness, and cutting the high costs of a small number of ‘troubled’ families to the public purse. The programme’s design and implementation was “informed by the learning from Family Intervention Projects, Total Place and Think Families Programme, Family Pathfinders and Community Budget Pilots.” Although badged as a

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new programme, and allowing access to a new funding stream, Day et al report that many local authorities “‘grew’ their Troubled Families Programme from pre-existing services and tailored their approach to the political landscape and service infrastructure”.

Secondly, in where PbR has been piloted in existing services, those services might be considered outside of mainstream, and not targeted at long term, statutory social care, or delivered by professional social workers. DCLG (2014) report on PbR pilots in the Supporting People programme, a programme that was introduced in 2003 to replace multiple and complex funding arrangements for housing related support, low level and non-statutory services for a range of different client groups. Although an established programme, further changes in the funding of these services were introduced alongside the introduction of PbR pilots. (These changes included the removal of budget ringfencing arrangements and, subsequently, reductions in overall budget levels.)

One area which was neither new nor non-mainstream/non-statutory is that of Children’s Centres. Children’s Centres were introduced in the early 2000s. They were put on a statutory footing under the 2006 Childcare Act, and provide a range of services, including: childcare, health services (breastfeeding, for example), employment advice, and social services. Indeed, with the exception of the Supporting People PbR evaluation (DCLG, 2014), all of the evaluation studies included in this review focus on children’s or family services. Based on the studies covered by this review, it does not appear that PbR is being used to fund adult social care, even for those areas of social care where there are complementary healthcare services (such as services for people with mental health issues) where activity-based PbR is being used in healthcare services in the NHS.

Thirdly, a number of the programmes included in this study are complex; they involve a number of different interventions, often delivered by multiple agencies, and cross ‘traditional’ boundaries between areas of social policy. Children’s Centres, for example, either directly deliver or provide access to services in healthcare, education, and employment services, as well as social care interventions. The Troubled Families programme also either directly deliver or provide access to services in housing, healthcare, education, welfare benefits, and employment services, as well as social care interventions. Supporting People services are complex in terms of the range of settings in which such services are delivered (from sheltered accommodation for older people, through floating support services for people sustaining independent living, through to homeless hostels), and the range of different client groups covered. One study identified this as a challenge or barrier in using PbR. Frontier Economics (2014) found that the outcome measurement required for PbR was problematic for Children’s Centres because “many services are delivered in conjunction with other agencies; other agencies deliver similar services or services with similar objectives; children and families often use more than one centre...”.

### ***Innovation***

A key objective of introducing PbR is to incentivise innovation in how services are delivered, and what interventions are used (Webster, 2016). A key question for this review, therefore, was the extent to which PbR is associated with innovation. PbR was intended to generate innovation both by influencing both commissioners’ and providers’ behaviour. For commissioners, PbR was intended to change their focus: towards outcomes achieved by providers and away from specifying service delivery models and monitoring inputs and outputs, so that “the choice of method to achieve those objectives is transferred from the commissioner to the provider” (Frontier Economics, 2014). For

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providers, the flexibility and choice of how and what interventions were delivered to meet the desired outcomes, coupled with financial incentives for meeting those outcomes, was intended to generate creativity and innovation in service delivery approaches. Encouraging innovation was a common theme highlighted by the ten pilot areas involved in the Supporting People PbR pilots (DCLG, 2014). The Troubled Families programme was designed in such a way that “local authorities were intentionally given considerable autonomy to design and deliver their local response in order that they would be creative in their approach” (Day et al, 2016). Similarly, the Social Work Practices pilots were designed to generate innovation through introducing new market players, encourage professional discretion and expertise, and incentivise a focus on service quality (Stanley et al, 2013).

In none of the studies covered by this review were the services or programmes directly provided or commissioned by central government, but rather by local authorities (local government). Yet in each case, PbR was introduced through national policy. Each approach therefore involved two levels of commissioning or implementation arrangements; a national level (between central government and the relevant local authorities), and a local level (where local authorities used PbR contracts to commissioning new services or for existing services. In each of the studies, outcome measures were specified at the national level, and local authorities were also able to choose additional outcome measures relevant to their local strategies, plans and contexts. And local authorities were able to utilise a range of different ways to deliver services to address these outcomes.

Day et al (2016) identify three broad service delivery models for Troubled Families programmes, recognising that this categorisation “did not take account of the nuances of individual models” and that local decisions were influenced by a range of contextual issues of existing service delivery arrangements. Day et al (2016) suggest the three models they identify “ranged from those who created or expanded an existing team of workers (a dedicated team) to those who embedded their provision (either individuals or a team of people) within the workforce or were on a journey to transfer the whole workforce to adopt whole family working (the embedded approach)”. Along this continuum, Day et al suggest that most local authorities in their sample adopted a ‘hybrid’ model, where intervention was delivered “by a combination of a dedicated team and practitioners who were either embedded individually, or as part of a team, and those who were already working in existing services or agencies”. And while the national programme encouraged a ‘whole family’ approach to service delivery, the evaluation identified that “whole-family working was described and understood in different ways” and that “local practices varied quite considerably”. The report does not directly address whether these differences were examples of innovation or creativity; simply that there were a range of different approaches and service delivery models.

The evaluation of PbR in Children’s Centres also identified a range of approaches, and speed at which models developed (Frontier Economics, 2014). Evidence from this evaluation suggests that local priorities, local resources, levels of local support for the trial and views on PbR more generally, and existing service patterns were all important influencing factors. The evaluators state that “there was little evidence that PbR had influenced the types of services delivered in Children’s Centres”. Overall, the report focuses on differences in the selection of outcome measures between local authorities, and does not provide detail on whether and to what extent the introduction of PbR changed how services were delivered.

The evaluation of Supporting People PbR pilots addresses innovation more directly. Innovation was seen as a key objective for the introduction of PbR for housing related support services, particularly

**DRAFT – NOT TO BE CITED WITHOUT AUTHOR’S PERMISSION**

## **A rapid evidence review of the use of Payment by Results in social care – paper for ICPP 2017**

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to “encourage innovation amongst providers and/or to offer greater flexibility to construct services that enable clients to achieve outcomes” (DCLG, 2014). The study reports that “there were mixed views on Payment by Results as a means of fostering innovation and changes to working practices” and “while some providers have taken the introduction of Payment by Results terms as an opportunity to adjust their service offer, others have adopted a business as usual approach to delivery and had adapted only their monitoring processes to meet the contract reporting requirements” (DCLG, 2014). The report states that changes were directly prompted by PbR for some providers, and that one provider felt that PbR had reduced silo-working within its organisation (that is, the extent to which organisational structure affects service delivery). It also recognises that changing the behaviour of front line staff – to focus more on outcomes and to maintain records monitoring outcomes – was challenging for some providers. It is also reported that working arrangements between commissioners and providers were improved in a number of areas (DCLG, 2016). However, the report’s authors conclude that “examples of true innovation do however remain limited”.

Evidence suggests that the Troubled Families programme “encouraged innovation, and the desire to trial new ways of working” and was a “catalyst for change” that focused some commissioners on better service integration and multi-agency working (Day et al, 2016). The evaluators also report that the programme “enabled local authorities to experiment with delivery models and types of provider” (Day et al, 2016).

### **Outcomes**

Related to the issue of innovation is that of outcomes. PbR is expected to focus commissioners and providers on both measuring and improving outcomes for service users by providing financial incentives when outcomes are achieved. Webster (2016) is one of a number of authors who suggests that there is limited evidence from which conclusions can be made about the whether and to what extent PbR improves outcomes.

In its survey of members and stakeholders involved in its work, Drugscope found that a majority of respondents “disagreed or strongly disagreed that Payment by Results would result in better services and improved outcomes” compared to a fifth who felt that it would improve services and outcomes. The sample size and sampling approach means that it is not possible to determine the representativeness of their findings. The other two survey-based studies (Kuznetsova, 2011, and Cundy, 2012) do not address the issue of PbR and outcomes.

While improving outcomes was an explicit objective of the Children’s Centres PbR pilot, the evaluation team report that “the objective of improving outcomes for children was mentioned by very few” project leads and Directors of Children’s Services in survey responses (Frontier Economics, 2014). The evaluators found that 66 per cent of the local measures used in the PbR pilots were output, rather than outcome, based. The report further states that a number of local authorities used both outcome and outputs measures, but that a smaller number only used outputs measures when specifying their contracts. The authors conclude that “one reason that there was a heavy emphasis on output rather than outcome-based local measures could be related to the problem of attribution in local measures” (Frontier Economics, 2014) and that there was a “lack of influence of national measures on the choice of local ones”. Stanley et al (2013) found that there was three of

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the five Social Work Practices pilots covered by their research had a systematic approach to monitoring outcomes.

The national evaluation of the Troubled Families programme provides a greater level of insight on the extent to which PbR influenced service providers and commissioners on measuring and focusing service delivery on achieving outcomes. The evaluators’ report suggests that PbR had “helped to give a focus and structure to the programme, and influenced local authorities to become more outcomes-focussed (sic)” (Day et al, 2016), as well as “aligning local Troubled Families Programmes with the national policy objectives, whilst ensuring that practitioners understood and responded to the diversity of families’ needs and circumstances..”. The evaluators also found that PbR was associated with improvements in the data collection, data quality, and information sharing at the local level (Day et al, 2016), a finding that is echoed in relation to PbR in Children’s Centres, where “local data collection and usage was reported to have improved in most areas during the trial period”, and also that there were improvements in information sharing (Frontier Economics, 2014).

The evaluation of PbR in Children’s Centres suggests that improvements in data quality not only demonstrated what had been achieved, but also increased the “focus on services and activities that were most effective” (Frontier Economics, 2014). The authors conclude that “there was general recognition that the need for high quality and robust data created by PbR had led to widespread improvements in local data collection and usage”, though they also highlight that (1) this may reflect improvements in recording of data; and (2) more significantly, that “evidence from non-trial areas indicates that improvements in data collection and use are a more widespread trend unrelated to PbR” (Frontier Economics, 2014).

Much of the extant literature raises the challenges associated with agreeing, defining, and measuring outcomes. These challenges include issues around timing; that is, understanding the point at which an outcome has been achieved and payment triggered (Kuznetsova, 2011)(DCLG, 2014)(Day et al, 2016). Several studies also highlight the issue of attributing change to a specific programme or intervention, particularly when there may be multiple partners involved in delivering a multifaceted intervention (Day et al, 2016)(Frontier Economics, 2014)<sup>3</sup>.

Only one of the studies included in this review measured the impact of the programme being evaluated, that of the national evaluation of the Troubled Families programme. This used two different methods to measure impact: a quasi-experimental approach using secondary outcome data from national databases (including matched propensity score comparators) and a survey of both treatment and matched comparison groups. Both of these approaches focused on the impact of the programme as a whole and not on PbR as a funding mechanism; the evaluation did not include any data collection from commissioners or providers about the effects of PbR, and such data would be unlikely to assess the impact of PbR because of the lack of a comparator group (all local authorities in England were involved in the programme). It is not possible, from the extant evidence covered by this review, to assess the impact of PbR as a funding mechanism, compared to other means of funding public services, or the extent to which PbR has an effect on outcomes achieved.

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<sup>3</sup> It is worth noting that a common feature of outcome-based PbR schemes in the UK is that they do not require attribution of achievement of outcomes for payment to be triggered. Current schemes simply measure whether there has been a change over a contract period and make payment on this basis.



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### ***Incentives***

A key assumption underpinning PbR is that financial incentives will affect the behaviour of commissioners and providers. These incentives could be both intended, in that they lead to achieve the desired objectives, and also perverse, in that they lead to outcomes not intended or desired.

There are two perverse incentives that are addressed in the reviewed studies. The first, and one that is raised in the wider literature around PbR, is that financial incentives might encourage providers to engage in gaming behaviours - ‘cherry-picking’ service users who are easier to deal with and are therefore more likely to result in outcome-based payments, and ‘parking’ of service users who are unlikely to achieve outcome-based payments. The second perverse incentive is not addressed in the wider theoretical or critical literature, and relates to the disincentive to bid for or continue to deliver services involve PbR to smaller providers and particularly voluntary sector providers arising from the perceived high costs of establishing contracts and monitoring outcomes.

Two of the evaluation reports identify that gaming behaviour was perceived as an inherent risk to PbR. DCLG (2014) state that Supporting People commissioners “have been conscious that a move to Payment by Results terms could incentivise providers to prioritise clients who show greatest potential for progression rather than those in greatest need of support”. Similarly, the Children’s Centre PbR pilot report states that “there were a significant number of speculative concerns about perverse incentives and unintended consequences” (Frontier Economics, 2014). In both cases, evaluators found little evidence of such gaming behaviour actually happening. DCLG (2014) identify that a series of arrangements were put in place to reduce the risk of cherry-picking or parking behaviours, and report that “on the whole, unintended consequences of Payment by Results appear to be minimal, and the steps (taken)...have helped minimise the potential financial disincentives for providers to work with more challenging clients”. Frontier Economics (2014) also found that “very few actual adverse effects were observed”, and also highlight the awareness of risk of gaming and arrangements to minimise the likelihood of gaming may have effected levels of observed gaming behaviours.

Cundy (2012), DCLG (2014), Compact Voice (2016), and Ward et al (2010) identify a second perverse incentive that relates to the costs of bidding and managing PbR contracts, and how these discourage or prevent smaller and/or local third sector organisations from bidding for PbR related work. Jessica Cundy, in her research for Barnardo’s on the experiences of third sector organisations in the commissioning of family services, states that the upfront costs of bidding are a major barrier to third sector organisations presented by PbR (Cundy, 2012). Similarly, Compact Voice (2016) report that “PbR contracts often require a significant amount of upfront capital and can involve a degree of risk that precludes the involvement of many smaller voluntary organisations, even if they are the most appropriate provider of the service”. Part of the risk associated with PbR contracts is that of deferred payment; that a proportion of funding is provided after work has been completed, and only when outcomes have been achieved. Cundy (2016) quotes a survey response by one third sector organisation to illustrate this, stating “we couldn’t survive on a PbR contract because we simply couldn’t afford to pay our rent and our salaries. We don’t have the money that’s required in reserve for 6 months or a year”. Commissioner-side costs of implementing PbR are also identified as being high (for example, Frontier Economics (2014) and Day et al (2016) both raise this), but no evidence is



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provided on whether these high costs might create barriers to, or disincentivise commissioners from, the use of PbR.

One of the core assumptions underpinning the design of Payment by Results is that incentives matter, that “the architects.....had envisaged that incentives would play a role” (Le Grand, 2007, as cited in Stanley et al, 2013). In each of the three evaluations included in this review, a key design of PbR was its two-tier nature; that is, PbR was used both to incentivise local authorities in their commissioning of services, and also to allow local authorities to use PbR in their contracts with service providers. In some cases, local authorities were both commissioners and providers. For example, there were 26 areas in the trial of PbR in Children’s Centres, “of which 14 areas directly managed all or most of the centres, while 12 areas commissioned all or most of their centres” (Frontier Economics, 2014). Here, the evaluators suggest that there were implementation differences between those areas that directly managed or commissioned Children’s Centre, with commissioning areas being “more innovative and quicker to adopt change” than those directly managed areas (Frontier Economics, 2014). It is unclear from this research whether the financial rewards may have affected the behaviour of these areas. The evaluation report goes on to suggest that the “the rewards payments were too small” and that “the payment mechanism element of the national PbR had very little impact on local thinking and behaviour” (Frontier Economics, 2014). The report goes on to suggest that more substantive rewards may have provided a greater level of incentive.`

### **Discussion**

There has and continues to be much interest in the use of outcome-based performance and payment arrangements in the commissioning of public services, of which Payment by Results is one significant example. In theory, by providing a financial reward to providers that is triggered by the delivery of outcomes, coupled with freedoms to decide how services and interventions might be designed and delivered, providers will be incentivised to focus on service users, on their outcomes, and on delivering services that are evidenced as working. Increasingly, PbR is being used in relation to social care sector, which has only recently started to develop agreement around, and measures of, outcomes (Kuznetsova, 2011).

Despite a number of pilots and trials of PbR, and numerous examples of PbR being used to commission services, there is dearth of evidence around their impact and their effectiveness in relation to social care services. The evidence that does exist is largely in grey literature, and is typically evaluation reports commissioned by the government department responsible for piloting a PbR scheme for a programme, intervention or group of services. In two cases, the evaluations are examining how PbR operated (DCLG, 2014)(Frontier Economics, 2014); both were qualitative evaluations, and do not focus on the impact of PbR or compare it to other commissioning approaches. The third evaluation covered in this review, that of the Troubled Families programme, did include a measure of impact. However, that evaluation focused on the impact of the programme as a whole in terms of its policy objectives (reducing truancy, reducing engagement in criminal and anti-social behaviour, for example) and not the impact of PbR as a mechanism for funding social care services.

## **A rapid evidence review of the use of Payment by Results in social care – paper for ICPP 2017**

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Overall, the evidence on whether PbR does change the behaviour of commissioners and providers as intended – on whether it incentivises a focus on outcomes, encourages innovation in how services are delivered to achieve those outcomes, or leads to ‘gaming behaviours’ – is somewhat mixed. There is evidence to suggest that PbR is associated with a greater focus on outcomes, or at least more interest in collecting data around outcomes. But there is also evidence to suggest that the concept of outcomes is still a difficult one in terms of agreeing what outcomes are expected from social care intervention, over what time period, how outcomes might be measured, and whether and how outcomes might be attributed to a specific programme, intervention or service.

This may, of course, reflect the types of programmes, interventions and services covered by the empirical research included in this review. These are each complex programmes, that typically involve multiple agencies delivering a range of interventions, and intended to achieve a wide range of outcomes. It is therefore worth asking whether the programmes covered here are really suitable for piloting PbR mechanisms when PbR itself is a relatively new contracting arrangement. Of course, arguably most social care services include some level of complexity; complexity in terms of the needs of the service user, the mechanism by which the intervention is intended to address those needs, and when and what outcomes are achieved through those mechanisms. But it does seem that policy makers have selected difficult cases in which to explore, examine, and test PbR (and outcome-based commissioning more generally).

### **Strengths and limitations of this study**

This is the first Rapid Evidence Assessment (REA) of the extant literature on the use of outcome-based Payment by Results for commissioning of social care in the United Kingdom. A key strength of the REA process is that it provides a comprehensive and systematic search of the available evidence, an explicit selection process and clear statement of which studies are included and which are excluded, and a rigorous method for synthesising the findings of those studies that meet the inclusion criteria.

There are several limitations inherent in the method used in this study to undertake the REA. First, only one researcher has been involved in the search, review, assessment against inclusion criteria, and synthesis of findings from studies that met the criteria. This study has been an unfunded piece of research, and it was not possible to recruit suitable other researchers to be involved in the process. Typically, more than one researcher is involved in each of the stages of the review to reduce any potential for selection bias.

Secondly, a quantitative synthesis was not possible because of the lack of relevant studies, and because of issues of heterogeneity of study designs, contexts, and outcomes in the few studies that do focus on measuring and attributing impact. Indeed, while the focus of the study was on the use of outcome-based PbR in social care, it is clear from table 1 overleaf that this covers a wide variety of interventions and services, and in most cases only a single study on a specific type of social care intervention has been published. The study reported here therefore focused on questions of how PbR is being used, why it is being used and what objectives its use was intended to achieve, as well as the challenges and barriers faced by commissioners and others when using outcome-based PbR in social care. Because of this focus, the study utilises a narrative synthesis approach and is fundamentally a qualitative review of the extant literature.

**DRAFT – NOT TO BE CITED WITHOUT AUTHOR’S PERMISSION**

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Indeed, the term ‘social care’ covers a broad range of services, interventions and programmes, and is very challenging to define. In undertaking this review, I have assumed a broad definition of social care. The advantage of such an approach is that I have been able to examine the use of PbR in a number of different contexts, but it does mean that some studies have been included that include elements that may not be considered to be social care in the strictest sense.

Forthly, I have not undertaken any assessment of the robustness of the methods utilised, or the risk of bias associated with the method used, in any of the studies included in this review. The strength of the conclusions drawn is limited by the quality of the individual studies covered.

### **Conclusions**

This review adds to the evidence based around the use of Payment by Results, and specifically its use in social care. The review found that there was a limited evidence based around the use of PbR in social care. There were three types of empirical evidence identified in this review. These include, firstly, the piloting or testing of PbR for existing services (three studies); secondly, the use of PbR as part of a new programme (one study); and thirdly, research with commissioners, providers, and practitioners around commissioning experiences and expectations. A number of the studies covered by this review identified other, local PbR schemes, covering a wide range of social care interventions and services. These local schemes are entirely absent from the empirical literature. More research is therefore needed around the use of PbR, how it works, whether and where it is appropriate in social care services, and whether it is effective.

## **A rapid evidence review of the use of Payment by Results in social care – paper for ICPP 2017**

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