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# Applying a Strengths-Based Methodology to your Strategic Commissioning

## Pre-reading – Introducing Commissioning Aspects 1 – 8

### Feedback

We invite and welcome feedback on this toolkit, which will be kept under review. Please send your additions, observations, corrections, or changes to marketsandcommissioning@local.gov.uk

# Contents

Aspect 1. Whole system design ..... 4
Place-based factors ..... 5
A case study of a council and place that scores higher in this aspect ..... 5
A case study of a council and place that scores lower in this aspect ..... 6
Dynamic tensions to be considered with this aspect ..... 6
Equality and equity considerations with this aspect ..... 6
Aspect 2. Relationships and organisation across the system ..... 7
A case study of a council and place that scores higher in this aspect ..... 8
A case study of a council and place that scores lower in this aspect ..... 8
Dynamic tensions to be considered with this aspect ..... 9
Equality and equity considerations with this aspect ..... 9
Aspect 3. Capacity, capability and confidence ..... 10
A case study of a council and place that scores higher in this aspect ..... 11
A case study of a council and place that scores lower in this aspect ..... 11
Dynamic tensions to be considered with this aspect ..... 12
Equality and equity considerations with this aspect ..... 12
Aspect 4. User and outcome-centred ..... 13
A case study of a council and place that scores higher in this aspect ..... 14
A case study of a council and place that scores lower in this aspect ..... 14
Dynamic tensions to be considered with this aspect ..... 14
Equality and equity considerations with this aspect ..... 14
Aspect 5. Information, insight and innovation ..... 16
A case study of a council and place that scores higher in this aspect ..... 16
A case study of a council and place that scores lower in this aspect ..... 17
Dynamic tensions to be considered with this aspect ..... 17
Equality and equity considerations with this aspect ..... 17
Aspect 6. Managing the policy and compliance landscape ..... 18
A case study of a council and place that scores higher in this aspect ..... 18
A case study of a council and place that scores lower in this aspect ..... 18
Dynamic tensions to be considered with this aspect ..... 19
Equality and equity considerations with this aspect ..... 19
Aspect 7. Commissioning process ..... 20
A case study of a council and place that scores higher in this aspect ..... 20
A case study of a council and place that scores lower in this aspect ..... 20
Dynamic tensions to be considered with this aspect ..... 21

Equality and equity considerations with this aspect ..... 21
Aspect 8. Models and tactics ..... 22
A case study of a council and place that scores higher in this aspect ..... 22
A case study of a council and place that scores lower in this aspect ..... 22
Dynamic tensions to be considered with this aspect ..... 23
Equality and equity considerations with this aspect ..... 23

# Aspect 1. Whole system design

*A place that is optimally set up for wellbeing, mutual support, and care.*

This aspect of commissioning is about the design of the whole system of care, support and wellbeing in a place. Care and support means meeting needs – identifying where circumstances that are relevant to social care are preventing people from living the life they want to live, and providing various types of support to get them back to, or closer to, their idea of a good life. Promoting wellbeing, means helping people to remain, as much as possible, 'above the line' at which their circumstances mean they need care. Where people do draw on care and support services, wellbeing means ensuring that the care and support they receive is delivered in a way that enables them to continue to live the life they wish to and to work towards the outcomes they desire, in line with the Care Act wellbeing principle.

There needs to be a holistic understanding of strengths, needs, and resources including the total funding available to all commissioning bodies and the voluntary, community, faith, social enterprise, family effort, the potential to use existing assets, to enable people to help themselves. The intent is about helping people to help themselves, prevention, early intervention, and making services enabling rather than creating dependency. This aspect of commissioning inevitably takes us to a wider, place- and community-centred perspective, where the commissioner for any organisation is not at the centre, but is an influential part of a complex system. Ideally, this aspect means working based on integration and partnership across all parties in the system. This would include, for example, planning regulations, street scene inspection, community and faith groups, public transport, childcare, neighbourhood forums, businesses – all elements of the place that influence wellbeing.

However, even if a place is not working as an integrated, effective system, adult social care commissioning can play a system design role by understanding the whole system and seeking to intervene in ways that shape it positively. Understanding the local landscape better means that commissioners can play a more holistic role even if their direct sphere of control and influence is only on council or council and partner care services. Note that whole system design does not necessarily mean a single highly-planned and structured system. Viewed through the lens of individual choice and power, this can be seen as a very facilitative role, shaping a place that supports people's preferences and the provision of care (market and otherwise) that people can draw on to meet their needs.

Failing to progress this aspect of commissioning means a continuation of people falling through the gaps in the system, not able to access preventive support to delay their need for care. It can lead to an imbalance between demand and provision, a lack of cohesion of the system, and this may result in increased pressure to focus on silos, making whole place-based system design less likely. Attempting to focus on this aspect when the other aspects are not strong can end up with a lot of 'bolt-ons' to the rest of provision, that try to support prevention and early intervention but do not add up to a coherent system in place.

This is the aspect of commissioning which is the most ambitious overall. Redefining measures of economic wellbeing does not fall within the expected scope of most

adult social care commissioners but is highly relevant to this kind of fundamental change. It is easy to dismiss this as 'too difficult' given the complexity and urgent pressures which adult social care commissioners grapple with. However, done well – even if only partially – this aspect can help save money and achieve better outcomes. As with all aspects, the key point is room for manoeuvre – identifying what can be done now, in the local place, to address whole system design, and what development could expand this potential.

**Place-based factors**
The following is a set of place-based factors – consider whether they support or limit commissioners' ability to achieve whole system design:

- Levels of health and age distribution within the population
- Levels of deprivation, wage rates and employment market,
- Geographical marginality and isolation, transport ease and accessibility
- Other geo-demographics of the local place – characteristics, location, and density of population
- Population changes and mobility levels
- Urban design and the amount, quality, and accessibility of green spaces
- Funding and structures of the council and partners (and how they link together, or do not)
- Land value and planning issues
- Workforce and workforce planning

**A case study of a council and place that scores higher in this aspect**
Our place has a highly integrated health and care system, with shared organisational leadership. We have mapped out need across the area and have a simple system of identifying five levels of need. Most of our work is structured around localities, which are engaged with the community, voluntary, and faith sectors, partly thanks to our very ambitious investment programme in that space. We have not quite got the balance of in-house and contracted provision right yet, as we still have some fairly inflexible whole-place provider contracts and some are struggling, but we are planning to bundle this differently the next time we procure, to connect better to localities.

We are experimenting in a few localities with self-organising social care and district nursing teams, and in one with dementia-friendly places. In others, where there are problems with the night-time economy, mental health, and hospital admissions, on working closely with the police, particularly at 'hot spot' times, we also have a key-worker service for people with very high levels of ambulance and A&E utilisation.

Ward councillors, advice services, and community groups play a role in steering locality decisions and signposting need. We are starting to engage deeply with carers and service users and have plans to bring them in to locality governance. As we had identified mental health issues and physical health as priority areas for intervention and prevention, we are working on locality-based strategies for green spaces and fitness offers, as well as seeking innovative ideas around counselling services.

**A case study of a council and place that scores lower in this aspect**
We are trying to join up locally through sharing data and planning, but outside of the formal governance structures, this does not fully carry through. There was a legal dispute between the council and clinical commissioning group about continuing healthcare funding several years ago, which resulted in some historic "bad blood" and a lack of trust. The data, at least, is useful, though we do not think it is completely accurate, as we are a 'green and leafy' place where we see an outflow of younger families and professionals and an inflow of retirees. Though the retirees are often relatively wealthy, increased costs of living can really bite.

We are struggling with high demand for vulnerable adult services including dementia, so that is taking up a lot of our time and attention and we are seeking more funding and to create early intervention and prevention services. We are not getting much of a response from the market on innovation and new opportunities and increased funding, even though they complained when we did a care cost and quality exercise that our focus on driving down costs was holding them back from offering us new ideas and options.

We have worked with housing associations to handle access to our limited residential care but are worried about the implications of future Care Act changes. We are beginning the journey of multi-disciplinary teams in a few locations, but there is real concern about how it will impact on social worker caseloads and time with clients, particularly as some of our clients are relatively isolated and travel times are lengthy. A major concern is the increasing number of residential care planning applications being approved, which will inevitably increase our demands and costs.

**Dynamic tensions to be considered with this aspect**
- The tension between effective working within silos, development and optimal use of expertise, and working flexibly as a whole system
- The tension between prevention work and the need to respond to more acute demand

**Equality and equity considerations with this aspect**
Whole system design is likely to highlight issues of inequality and inequity in conditions and access to services. Care should be taken to include marginalised voices in governance, leadership, and delivery, and to resist picking 'quick wins' which may further exclude marginalised and under-served groups.

# Aspect 2. Relationships and organisation across the system

*A place where everyone is focused on achieving shared goals, together.*

This aspect is about the ways that local relationships enable or disable effective care. This is at the heart of all commissioning, and touches on everything from critical relationships between those who have care needs and everyone they have contact with, to relationships at the highest levels of governance, including with central government departments, inspection bodies, local politicians and NHS non-executive directors. This can equally be seen as effective networking – commissioners networked in organisations, in partnership, and in community. This is heavily influenced by funding streams and incentives.

This would ideally involve the following, all based on mutual trust, respect, an appreciation of each other's strengths, and a mindset of working together as one team:

- Strong, trust-based collaboration between all commissioning bodies and communities
- Challenging and collaborative relationships between commissioners and providers – and amongst providers
- Powerful relationships between carers and citizens receiving care
- Strong internal relationships between commissioners and key parties, such as politicians, Finance Directors, Chief Executives, other departments, procurement and legal professionals

When this aspect of commissioning is not well developed, it can lead to poor, or even poisonous, relationships, negative competition, duplication of work and services, unproductive dissent, and incentive to avoid engaging at all. Weak or bad relationships can also show up in avoidance, paying lip service, surface level agreement and compliance which is not followed through. Robust disagreement and the ability to hold each other to account is an important part of effective relationships that support effective commissioning in a place.

Relationship-building is skilled and long-term work. Relationships are likely to go through several stages of maturity. At each stage, how relationships are managed is the most important thing – how can partners work effectively, and set the ground for improved relationships in the future? A failed community engagement process or poor procurement process can be the basis for better relationships with candour and engagement. Formal relationships can be made as effective as possible with effective formal sharing of information. Combative leadership can be challenged on its own terms, and those who are most resistant to change can sometimes become the most powerful champions.

This aspect of commissioning is perhaps the one that places most demands on the combined personal skills of commissioners and their ability to understand and navigate a complex system. It is also perhaps the aspect that can most undermine effective commissioning even when other conditions are good, or most redeem problems, where they occur. Relationship-building should be treated as an important

skill and developed and supported. The simplest focus and question to ask here is whether people in the place are working as a single, connected system, or as a set of disparate parts.

**A case study of a council and place that scores higher in this aspect**
Our relationships have taken a lot of work to get where they are today. We had a legacy among lead members and senior NHS executives of some highly volatile and difficult individuals, failed attempts to engage with and form a coalition of the voluntary and community sector, tough provider negotiations, and a tradition of commissioners who were very good technically and delivered mostly good processes, but didn't engage much with individuals outside of the formal processes. There was a feeling that everyone was trying to pass on costs to everyone else, and trust was low.

Things started to change with a new political leadership which coincided with several senior leaders moving on. This offered an opportunity to address and reset some of the resentments that still simmered. We started to build a new outcomes-focused plan as we entered into ICS planning and held a facilitated session which encouraged us – in a safe way – to air all those old opinions about each other. Although that was not comfortable, we found it was safe, and important, to do, and set a new tone.

The real breakthrough was joint locality visits – we went jointly (social care, health, and political leaders) to engage with staff and citizens in various places, and to hear people's experience of our care system first-hand. That was very powerful and led to things like people with experience on our decision-making boards and regular back-to-the floor and mystery shopping exercises which have helped to keep us all focused on the big picture. That does not mean there have not been some really strong disagreements, but those have more often been useful than destructive. We are really focused on broadening beyond the ICS plans to include coproduction, providers, community groups, and other parts of the council and public services who can help.

We eventually learned that all the credit we gained with providers with really good up-front engagement was lost with a very stiff and formal procurement process – which presented providers with a fait accompli after all our talk of partnering and coproduction – and then weak contract management, even when they were coming to us with innovative ideas. We are working on that now, and that involves building a much better partnership with procurement and commercial colleagues.

**A case study of a council and place that scores lower in this aspect**
We thought our relationships were good, but now I don't think that's true. We have a place-based plan, part of our local strategic partnership, which is based on place-based data, but while everyone comes to the partnership board meetings, we have realised that agreement in that meeting does not mean that partner services change in line with this and that people working on the ground do not know about the plan at all.

A recent resident door-knocking exercise (following on from our experience during Covid) suggested that our understanding of vulnerability and care needs in our

strategic documents might not be that accurate. We created a provider forum, but that got bogged down in price discussions and attendance is really low now. We also tried to do community engagement with ward-based 'town hall' meetings but they became a miserable experience that officers try to get out of attending, dealing with complaints and negativity.

We have realised now that we do need to do something about this, and that commissioners are quite well-placed to have an influence, so we are working to connect – through listening to suppliers, citizen groups and frontline care workers, at first. And the Mayor has set up informal networking before the strategic partnering meetings. We know there is a lot of work to do on this!

**Dynamic tensions to be considered with this aspect**

- The potential tensions when local government politicians who set the direction of local government activity also act as NHS non-executive directors
- The tension between the centralised, national direction of the NHS and local direction/mandate of local government

**Equality and equity considerations with this aspect**

Good quality relationships allow the challenging of issues to be done safely. They need to be built for the long-term and embedded, for inequality to be challenged and overcome. Relationship-building must consciously include formerly-excluded groups, if it is to be valuable. Commissioners and systems need to be aware of the risk that a focus on building relationships can reduce the willingness to challenge norms and problematic issues.

# Aspect 3. Capacity, capability and confidence

*A place where people have access to what they need to live their lives well.*

This aspect of commissioning is focused on creating the capacity, capability and confidence to empower people, enable them to address things that are disabling them, and remove the barriers to a good life through providing care and support. It includes making sure that they get that care and support, or support to remove the conditions that cause them to need care. Actions to remove the conditions could include reablement, health or wellbeing interventions, or they could mean changes to the person's environment, for example with the provision of equipment, assistive technology and adaptations, or changes in the local community such as dementia-friendly community initiatives. This requires us to adopt a social model of disability (that barriers to living a good life are based on barriers created by the context or society's attitudes), as opposed to a medical model (that the person is defined by their illness or condition and "needs to be fixed").

This aspect of commissioning is technically described as building the capacity and capability to help people to achieve their purposes in life – not being prevented by care needs from pursuing day-to-day goals. This draws on a model which differentiates between "demand" (the expressed requirements for care – often converted into our "service language") and "need" (the issues, problems or obstacles in people's lives that cause them to require care and support). Traditionally, commissioning was sometimes thought of as 'development of provision' across markets and mutual aid covering private and voluntary, community, faith, and social enterprise sectors. This view of commissioning is limited in two ways:

1. It assumes that the "provision of service" is the goal of commissioning, whereas in fact positive life outcomes are the goal – people achieving what they want in their lives – which puts the focus on them and their capabilities.
2. It is fundamentally deficit-based rather than strengths based – it is better to think about how people can be enabled to achieve what they want in life, rather than simply how needs (deficits) can be met.

Capacity and capability development is about an enabling place, whether through services, support, or self-efficacy. It is about developing providers from all sectors and sources (voluntary, community, faith-based, social enterprise, private, and public) and an enabling, strengths-based approach to help people to help themselves. This obviously needs to start from a good understanding of current service performance and how this can be developed or replaced by better sources of capacity, capability and confidence.

When this aspect is very weak, there is likely to be short-term, controlled, competitive contracting that creates pain and dependency across the system, an overload of demand for the available supply, and pressure to find acute solutions that address demand, often in ways that weaken the resilience and capacity of the market or social care sector.

When thinking about this aspect, it is important to consider how 'contestability' features, even if market competition does not. Contestability means the ability to

measure the value achieved by service delivery units, hold them to account for what they have agreed to deliver, and ultimately recognise that other organisations may be able deliver the services, which may be more attractive, especially if there is consistent failure. This aspect also needs to consider how it addresses evaluation and cost/benefit analysis, and to carefully consider the knock-on effects of social care spending; is the money being recycled locally and having a real impact on those who most need it, or is it being mostly extracted from the local economy?

Finally, this requires co-production with citizens and engagement with providers of all kinds, including developing a strong understanding of the success or failure of previous attempts around market development, and their impact – this work never starts from a clean slate.

**A case study of a council and place that scores higher in this aspect**
Unlocking potential is the heart of our strategic commissioning approach. We have invested significantly in community development, shifted several large contracts over time from large commercial national providers to small local providers (leading to more money recycled in the local economy, more quickly, making a real impact on people on the edge of poverty). Adult wellness – building from our Ageing Better programme – is a core service and part of a joined-up, place-based strategy (mostly led by the council, but we're working on it!) which links with lifelong learning, town centre generation, and access to good work to try to deal with poverty, low skills, and low productivity largely due to ill health. Our community connection activities are also linked to social prescribing and remuneration for co-production work, governance roles, and consultation.

We now routinely commission with a mix of grants, contracts, and mixed models, offering long-term funding where possible, covering overheads, seeking minimal or no bid costs where possible (this has proved much harder to do for NHS spend given the regulations). Alliance contracting has proved helpful for this. Where we do traditional contracting, we have strong social value commitments – and, more importantly, contractual commitments – to social outcomes, co-production, quality of employment, and joining our provider collaborative to look at workforce development (and recruitment and retention) as a whole place. We also have a commitment to map existing assets and delivery servicing before bringing in new contracts, and to have a market development plan which shows how each contract will leave our provider markets healthier.

All of this has been really difficult, and we could not have achieved it without staunch support from senior leaders and politicians, and without linking to their priorities for the council and place as a whole. It helped to have money to invest. Many commercial providers have also been very positive, particularly about freedom to innovate during service delivery.

**A case study of a council and place that scores lower in this aspect**
We have had to cut our grants to the voluntary sector and use social prescribing and asset-based approaches as ways of mitigating service savings, as funding has reduced and thresholds for access have increased. We are currently reviewing our information, advice, and guidance contract and hope to make cuts and award to a single provider (with sub-contractors) to be able to manage the relationship better

and demonstrate better value for money. We have introduced standard social value clauses and a requirement for local investment and a proportion of local sub-contracting. We commission a lot of capability building and support services, but usually small scale and not joined up.

**Dynamic tensions to be considered with this aspect**

- The tension between fitting service provision to our own professional categories and self-direction by citizens
- The tension between worker pay (supporting economic wellbeing, recycling into the local economy) and the cost of services
- The tension between a focus on deficits and service provision and focus on strengths, assets, and community

**Equality and equity considerations with this aspect**

It is important to take a critical perspective regarding the impact of deprivation, exclusion, and intersectional factors on the capability of people to provide their own support, and not make assumptions about this capability. Additionally, some people who are otherwise in highly privileged groups will not necessarily be privileged (in terms, for example, of close and engaged social networks) when it comes to their ability to be supported in their home and community. At the same time, traditional service provision is likely to be biased and have built-in assumptions about needs and how they should be met, which will impact different groups in different ways. The same suspension of assumption and genuine exploration needs to apply to groups and organisations providing support, which may have very different perspectives, strengths, and weaknesses depending on their context.

## Aspect 4. User and outcome-centred

*A place where everyone who engages with the care system is in charge of what they get, and their assessment of whether they got what they needed is the one that counts*.

This aspect is about maintaining a strong focus on what commissioning is achieving for our citizens, in terms they set for themselves. So, this includes, most centrally, co-design – all the relevant people including the person who draws on care and support, and advocates and carers, where appropriate, working together at all stages of development, design, delivery and management of services.

This aspect includes citizen/user power over what they receive and how, with 'user choice' a subset of this, as well as strengths-based working and – critically – ways of effectively assessing the outcomes that people get from the system. While legislation provides a necessary constraint, a user and outcome centred approach must start from a real, deep understanding of what people want and need (confirmed by them), and a focus on unmet needs. This differs from many technical discussions on personalisation and is not the same as "personal budgeting"; although both, properly done, can be techniques that support this. Unfortunately, they can also be implemented without truly empowering people. Some people with lived experience ask to simply be able to commission for themselves, and this level of handing over control would certainly be a powerful statement and step in this direction – though it risks encouraging commissioners to ignore their role in shaping what is available to empower self-determination.

This aspect acknowledges that the user experience of adult social care, even for those with sufficient funds to pay for their own care, can be awful. Most people who draw on care and support services, and carers, engage with the system at the point of crisis only to find a hugely difficult system to navigate, needing people to join the dots of lost or limited reporting between providers around their loved ones, and having little understanding of how to commission the best care for oneself or one's loved one.

It also acknowledges that 'outcomes' can ultimately only be measured by the people experiencing them. Different people have different priorities with regard to their care and what they want it to support them to do in their lives, meaning outcomes cannot be aggregated by 'cohort', location, or by service contract. Subsequently, standardised measures based on standardised service specification are limited in value, except to the extent that they allow a bespoke response for each person and circumstance. This links to the need for user-led working and creating the context in which people can get the care they want. Commissioners will need to be focused on being collaborative and working from strengths rather than needs, and partnering with providers and people who draw on care and support (and advocates, where necessary).

When this aspect is weak, citizens are likely to be faced with a maze of services considered to meet their needs, even if they actually make the situation worse, and a focus on rote 'assessment' and fixed qualification criteria, along with short-term, controlled, competitive contracting.

**A case study of a council and place that scores higher in this aspect**
We work hard to base all service provision on “what do you really need?” conversations with citizens. We give social workers and others who have these conversations a lot of discretion to meet needs directly, based on these conversations (within budgetary limits), and pilots show that this reduces the overall cost of care. We have expanded this to an advocacy/case management role when appropriate. A few years ago, we mapped out entire user journeys and found that our own systems being unable to hear what people were *actually* asking for was costing us millions in incorrect specifications with serious knock-on effects. It has been a long journey to build everyone’s trust in a focus on understanding and meeting needs opposed to formal assessment processes, and we are going through another version of that journey now as we introduce more community options and social prescribing. We have some senior politicians on board and a new DASS who is really supportive. A breakthrough moment came when we took the finance director on a site visit, and they saw that we were working on real value not on budgets – but that it was also good for budgets.

To be honest, our approach has probably slowed integration and we are still struggling to make it work in the NHS, but we have confidence we will get there. We are linking to the NHS “Getting It Right First Time” (GIRFT) programme, to try to communicate it better. We also now have enthusiastic fans amongst the user base, who are powerful advocates. We still have lots of traditional contracts and formally assessed provision – but at minimum we are including user feedback (“did you get what you needed?” and so on) as part of the evaluation criteria and building in learning and adaptation – our big lesson has been that learning is key.

**A case study of a council and place that scores lower in this aspect**
We attempted once to create a marketplace for self-funders from which we would also call off services, and a combination of technological and market challenges and leadership challenges meant that it was seen as a failure, so there is a real fear of being too ambitious in this space. We are working hard on social care and health integration and hearing a lot about avoiding ‘unwarranted variations’ in provision.

We are really pushing to move to what are called ‘outcomes-based contracts’ – in fact, our providers are leading us to some extent on that. But that is usually based on our assumptions and definitions of outcomes. We are aware that access to our services is messy and confusing, and it is hard for people to get what they really want, so we have commissioned two specialist information advice and guidance services (for dementia and carer support) as tests.

**Dynamic tensions to be considered with this aspect**
The tension between the (in)appropriateness of a ‘one size fits all’ approach and the benefits of consistency.

**Equality and equity considerations with this aspect**
Equality and equity must be central to this aspect, because making assumptions about care outcomes or forcing individuals into standardised processes, services, and systems of care presents perhaps the greatest risk to a fair and equitable system. At the same time, attempts to ‘put citizens in the driving seat’ also risk a bias towards historically privileged groups and meeting or supporting the needs of those

who are best able to access decision-makers and communicate in familiar and accepted ways. Therefore, co-production and advocacy must enable appropriate representation and must be done in a way and in a context that guards against these risks.

# Aspect 5. Information, insight and innovation

*A place that emphasises commissioning innovation and creativity.*

This aspect involves the creativity and capability of commissioners, their insights and ability to 'think outside the box' and is the most focused on their individual ability to make a difference. This includes a deep focus on understanding the experiences of people and groups, and all the things that affect people's quality of life and possibilities relevant to care issues in the local place and community. However, there is risk inherent in seeing commissioners as 'heroes', and it can result in overburdening them with expectations of single-handedly transforming complex systems, which can be onerous, if there is real inertia and there are valid reasons for risk-aversion.

This aspect considers the organisations that might typically be thought of as providing health and care, but also all other factors including family, green spaces, urban design. Especially relevant is data across the whole system related to needs and budgets and the needs of hard to reach (and hard to see) groups and their needs. It involves work on how data and knowledge are managed across the system. This can also means challenging the way things are done and existing knowledge and practice. This is one reason why the individual ethics, bravery, and boundaries of commissioners become very important here.

When this aspect is weak, commissioning is thought of as 'shopping', re-procuring services within a 'commissioning cycle,' working within an echo chamber with limited reflection and challenge. This makes it increasingly appear riskier to think about the bigger picture.

**A case study of a council and place that scores higher in this aspect**

We've tried to play it clever in commissioning, since social care here used to be very traditional and siloed – we have built alliances, supported services in crisis (even when timescales meant we couldn't really follow the process we would have liked), done mini-training for everyone in the directorate, and even ensured that we win a few awards for innovations, sharing credit with the services. We work closely with the team that used to be our Health and Care Observatory, and with the teams supporting governance at council and ICS level. We also work closely with the Finance Business Partners, who are critical to what gets approved, or not, in the annual budget.

We have run dedicated external and in-house capability-building, most of it based on action learning and pulling in mixed teams from across different council services and partners to work on real problems and build relationships. We also made co-commissioning with user and citizen voice groups part of our journey from the start, and have affinity groups, citizen commissioners, and we're about to engage with our first Citizen Jury – this one is on the climate crisis so there's some important overlaps, but we want to learn the process before running one on learning disabilities and transitions from children's social care, as both are major issues in our borough.

We have also found that community groups and providers are some of our biggest allies – we recently let a home care contract in a way that both invited innovative bids and encouraged ongoing innovation in service delivery, designed by users and

care staff, and we have found even some losing providers have been in touch, keen to share the model elsewhere.

**A case study of a council and place that scores lower in this aspect**
We have had a few false starts with 'commissioning' – on one extreme we went to a whole-council commissioning model, but there was not enough clarity about how that worked, and commissioners and providers reported to the same line managers. There also was not much recognition of how adult social care was different. Then we went to the other extreme and for a while the main team with the 'commissioner' job title was the team processing direct payments. We now have a team in social care with the job title 'strategic commissioner', but they have to go to services for most of their data, and Members and our partnership boards have expressed the opinion that 'commissioning is over' (it's still associated with the 'purchaser/provider split'). At the moment, most of their skills are around important technical areas such as the legal requirements for market shaping, but we are planning some development work and actually commissioning plays a big role in our service planning, due to some major contracts coming up where big savings are earmarked.

**Dynamic tensions to be considered with this aspect**
The tension between cold, analytic 'objective' data and the warm/thick data from the richness of peoples' lives.

**Equality and equity considerations with this aspect**
Without good information, the opportunity to innovate and change, and the skill to do so, the cause of equality and equity cannot be effectively advanced. Care must be taken not to make insights a reflection of our own prejudices. Engaging excluded voices and welcoming active challenge is one powerful tool to guard against this. It is important to establish and stick to agreed values in this space. The inequality in power dynamics between commissioners and populations becomes starker when commissioners are more powerful and more effective, but effective commissioners can also be the most direct route towards redressing this balance. Empowering communities as commissioners empower themselves is a powerful way to address this paradox.

# Aspect 6. Managing the policy and compliance landscape

*A place where commissioners meet and actively shape policy requirements.*

This aspect recognises that commissioning works within a clear legal and policy framework and the constraints placed on commissioning by the legal and policy framework, by inspection, and by real financial constraints, are real, and important – but that commissioners are not just a passive recipient of boundaries and direction but actively interpret and shape the framework they work within.

This aspect calls attention to the need for a real understanding of these constraints, an ability to communicate them clearly and accurately, and the ability to work creatively within them. This includes understanding and anticipating policy changes and working across the whole system to ensure that the ways that changes are introduced have the best impact possible. It also includes being willing to challenge aspects of policy and requirements that are inequitable or counter-productive and working with insight and collaboration to shape local policy frameworks and interpretations.

The financial constraints included in this aspect also need to be treated as something to work with. This can be simply accepting and working with what is needed but can also be creative about social return on investment, lifetime value for money, and savings and benefits that come from other parts of the broader, place-based system.

Done well, being proactively good at this and making it an exclusive focus, when required, ensures that commissioners build trust and good relationships as well as meeting their legal and organisational commitments. When this aspect is not done well, colleagues might hear ‘well, we do what we’re told – and that’s pretty much all we can do’ – perhaps with regard to integrated care, or simply with regard to the Care Act and other regulatory requirements.

**A case study of a council and place that scores higher in this aspect**
We have done lots of work to make sure we really understand what we are doing regarding compliance. We built policies with the legal team, people with lived experience, and excluded groups, and we engaged with health colleagues to make sure we had a consistent approach (and necessary differences were clearly identified). We worked with policy and procurement people to shape ways of working we could reliably keep to, so that, along with all our business cases, we have a compliance case and a fuller equalities impact assessment.

It is a lot of work but because we have really worked it through, it adds value. It also makes it much harder for people to criticise our work once it has been through the whole process. We became a Social Value case study and we are talking with DHSC about adopting the new white paper guidance early, which gives us the opportunity to feed back (and is going to be quite important for our financial sustainability).

**A case study of a council and place that scores lower in this aspect**
We do occasionally run into problems with procurement telling us that our most innovative plans are not a good fit with policy, and often that has to go to the

corporate management team to get resolved. We have also had a couple of challenges under the Equalities Act which caused us to reconsider some big recommissioning work.

In general, we understand the framework we have to work within, and we stick to it – this also means that when working with users and practitioners, we have the cover of the Care Act to be able to push through required changes. We had to follow the council policy on social value, which was a bit of a missed opportunity, and our approach to market shaping actually needs to be shaken up a bit – that will be an opportunity to work with providers to come up with something a bit more fit-for-purpose – just in time for the new requirements!

**Dynamic tensions to be considered with this aspect**
The tension between the policy position, what the data says is best, and what our personal values and experiences suggest is best.

**Equality and equity considerations with this aspect**
A strong policy and compliance approach to equality is very important, as is responding to compliance requirements with equality and equity in mind. It is important to recognise that compliance with regulation is not a full answer to supporting equality, diversity, and inclusion, but just the beginning.

# Aspect 7. Commissioning process

*A place where commissioning is technically excellent and highly professional.*

This aspect recognises that commissioning needs its own effective processes and systems to work well and has to focus on urgent and high-priority needs, from financial savings and legislative requirements to provider collapse and workforce issues. This aspect is about "doing the process well" (even if it can appear boring) and being good at some core processes if big, innovative ideas are to stand any chance of success. This includes engaging with providers from all sectors, citizens, users, advocates, carers, people with lived experience, communities, professional colleagues, politicians.

This aspect is about developing and applying appropriate processes and techniques and using them skilfully and judiciously. When the commissioning process is done badly, it can offer a 'jobsworth' approach leading to failed procurement, lack of contact and relationship management, and lack of real learning. This can drive a push to ever-more compliance, exacerbating the situation. Alternatively, a lack of process or poor process can mean costly mistakes in specification, poor procurement and contract management and, in the extreme, risk legal challenge or failure to provide appropriately.

The confidence to be honest and transparent and engage properly with those commissioners hope to commission from is crucial here – being open about what is not completely clear, up for negotiation, needs to be priced in for future variance, and so on. At best, a good commissioning process ensures that needs are met through strong contracting, good use of social value, an equalities focus, and strong and appropriate compliance built in, in a way which is economic, strategic, and supports the positive shaping of markets and place.

**A case study of a council and place that scores higher in this aspect**
Increasingly, all our commissioning is done across partners, with providers and in co-production with people who draw on services. This means that we are putting much greater emphasis on getting a good and legally compliant process in place – but we see that as a platform to work together on ongoing learning and practice. In a recent homecare contract, we were participating in weekly sprint meetings at one stage as service patterns were developed jointly with carers and service users. We were paying close attention to the implications for cost, but it did come in within the budget envelope, and we learned a lot. We have found it useful to blend different sources of data to understand what a service can provide – from service users, practitioners, population data, things we've picked up from elsewhere, and so on. Extra Care housing was a major capital investment, so that side of things was a much stricter, more formal process, however we want to go back to prototyping how the service actually works once the buildings are ready to run.

**A case study of a council and place that scores lower in this aspect**
We follow the classic commissioning process. The challenge is that we never have enough time. When we can do it, we really go to town and thoroughly analyse high-quality data to identify needs, current provision, gaps, opportunities for innovation etc to come up with a 'perfect spec'. The challenge is that, often, we just get squeezed

out of time to do that properly and by the time we go to market we often find we are having to make in-year savings, so a lot of that work can feel insignificant.

Even in less-than ideal contracts with problematic providers, we often end up running the contract for an extra year to give ourselves time to run a proper OJEU process. As part of trying to stretch budget to meet needs, we are increasingly letting very long contracts to try to support lower prices and meet some of the needs of the voluntary and community sector. Because we want to start at the start and get the specification right, and because of all these challenges, we probably are not great on contract management. When we get the time, we do a thorough lessons learned exercise at contract close – part of feeding into the needs specification. Overall, I think we could be closer to practice, and we find co-production hard to get right. We have also found it hard to align our processes with those of partners, who seem to operate in very different ways.

**Dynamic tensions to be considered with this aspect**
The tension between contestability and collaboration?

**Equality and equity considerations with this aspect**
A strong process needs to build in the following elements:

- Understanding of unmet and marginalised need
- Access for those who may be excluded
- Strong equality and equity in specification and contract management
- Co-design and shared learning with excluded groups

# Aspect 8. Models and tactics

*A place where commissioners design and develop delivery models that are fit for purpose, effective, and sometimes innovative.*

This aspect recognises that the design of delivery models – the way practice works on the ground, from enabling work and community support to service provision – is ultimately what good commissioning is aiming for. This means that commissioning requires competence at designing and implementing the right delivery model, at the right time, for the right part of the whole system and needs to be engaged with actual day-to-day practice. However good the strategy, implementation will fail without this in place.

This includes measuring and managing the technical aspects of delivery, and looking at optimisation across and between models, at a tactical level (as opposed to whole system design). In the absence of work in this space, lack of innovation or attention to delivery models, technology opportunities, workforce issues and quality will see large-scale strategic changes that do not impact citizens and commissioners, and may lead to partners battling over costs. While in many ways this is the most fundamental and basic aspect of commissioning, this also remains critical in whole system design.

This aspect considers true service model innovation, good practice and changes in practice, the choices between in-house and external provision, the possibilities of mutualisation, trading companies, shared services, aggregation and disaggregation, different funding approaches, and introducing new technologies. It also must take account of economic realities and, particularly of workforce issues, coherence of the whole system, and co-design with residents as the main source of innovation.

**A case study of a council and place that scores higher in this aspect**

We work on service design alongside strategic commissioning and have a system of 'circles' which connect selections of practitioners, carers, those with lived experience etc to talk about practice and share and expand on good ideas. These have enabled us to really build on earlier assistive technology work and this is becoming a major feature of some of our work. We have also identified lots of opportunities to improve joining-up and signposting between services, which has saved significant amounts from our advice contract as well as provided much earlier intervention to support citizens who would otherwise have been put off from asking for care until much later.

We have recently merged three smaller contracts, shared one across health and social care, and considered a public sector mutual for a former in-house service (though in the end the employees preferred the TUPE option). We have co-designed a new carer support service which is borough-wide and mostly provided through mutual aid. In general, we find that really understanding delivery model options and how they might affect practice on the ground is a 'superpower' when it comes to getting buy-in from social workers and other staff, and from politicians.

**A case study of a council and place that scores lower in this aspect**

We tend to consider delivery models only at the contractual level, and probably miss some opportunities for innovation. We did recently put out a tender for some innovation work, particularly around new technology, and we are looking forward to seeing how that goes. We recently consolidated our information, advice, and guidance contracts and saved a lot of money along with creating improved referral journeys. We have noticed that second-tier councils and housing providers are a

significant part of competition for workers with our care services, so we need to work out how to address that. Most of our work with providers post-contract is monitoring and focusing on cost reduction opportunities and making sure they stick to the service provision agreed in the contract.

**Dynamic tensions to be considered with this aspect**
The tension between detailed service design and big picture strategy.

**Equality and equity considerations with this aspect**
It is with practice on the ground, enabled by delivery models, that equality and equity are either supported or fail. It is important to think about the implications of changes in delivery models, particularly innovative ones and those using novel technology (or with digital access) for those who are traditionally marginalised and excluded, and groups who could be marginalised or excluded by the new model.